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John Armstrong, Actuary / Health Economist

The case for reform of the Irish health sector is compelling. Not only is health critical to the well-being of our population but it is also a significant source of cost within the economy. Recent data compiled as part of the System of Health Accounts suggests that we paid approximately €20.042 billion or €4,324 per person on health expenditure in the calendar year 2014[1]. The public share of this is about 69% of this figure or €2,984 per person. Put another way, this represents more than 80% of all income tax receipts we get in the country. Of course, income tax may only be one source of income to the country but it is an important source so these figures give a sense of the scale of public health expenditure.

This level of expenditure is significantly higher than that paid by many other comparator countries within the OECD.[2] Demographic (size and profile) pressures, population expectations, and technological pressures mean that this expenditure is likely to grow in the next 20-30 years.

In the last two decades, we have put in place a number of important initiatives to improve the performance of the Irish health system. These include (and are not limited) to changes in the way we fund public and voluntary hospitals through activity-based funding, initiatives to reduce the cost of pharmaceuticals, changes in governance within the health system and efforts to improve the standards of services delivered to patients.

These changes have undoubtedly brought some successes to our health system and often we are too complacent about considering such improvements in measures such as mortality and morbidity rates[3]. Nonetheless, these improvements have undermined by significant issues around access and equity within the health system, efficiency therein and, in many cases, with the quality of the service being provided.

It is therefore apparent that continual reform is necessary in our health system and that we need to consider this reform in the context of:

Whether we get value for money in what we spend in terms of the outcomes and the access and;

> Whether we can sustain the spending into the future of the health system without significant changes to our funding model.

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[1] The System of Health Accounts 2014 report from the CSO (published June 2016) indicates we spent €20.042 bn (including capital expenditure) on healthcare in 2014. With a population of approximately 4.635m (Source CSO at April 2014) this equates to €4,324 per person.

[2] OECD health data (2016)

[3] The obvious example is in relation to mortality and morbidity. See papers from Walsh and Armstrong to Statistical and Social Inquiry Society (2008) "Recent Trends in Mortality and Morbidity in Ireland" *Journal of the Statistical and Social Inquiry Society of Ireland, Vol. XXXVII*

It is my view, that we urgently need a new approach to solving some of the most intractable problems within the health system in order to ensure we have a better performing system. This approach must address the following four pillars:

Tackling access and equity issues;

Meeting challenges of the health system into the future;

Funding reform; and

Ensuring the quality of all the services that are delivered to our population.

There are many different stakeholders within the health sector and in order to understand the significance of each of these groups within the health sector it is fundamentally important that there are clear discussions of the role of each, be it as the funder of services or the deliverer of services. One important example for the work of the Committee, in this regard, is the role of private healthcare. Whether we like it or not, in all countries there is a role for private healthcare. This includes within health systems as diverse as Canada, China, Germany, and the United Kingdom, on one hand, and Singapore and the United States on the other.[4]

In Ireland, non government persons and healthcare agencies represent approximately 30% of all healthcare funding (including out of pocket) and provide approximately 50% of all services delivered within the system.[5] Nonetheless, much of debate has been about the public health sector. The work of the Committee provides an opportunity to consider this important aspect of the system.

In coming up with its conclusions, the Committee should structure their analysis based on data and evidence and consider not just short-term but long-term sustainable solutions to our health challenges.

This submission is made up of three parts:

Part 1 (contained in Section 2) identifies some performance highlights for the system;

Part 2 (contained in Sections 3 and 4) outline some of the key principles that are necessary for undertaking this analysis and presents some important pre-conditions that are necessary before implementing a health reform agenda; and

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[4] Each of these countries is interesting in its own way as they all have a significant private involvement for the delivery and/or the funding of services. For example, almost all care in Canada is privately provided be it in public or private institutions and 67% of the population purchase complementary insurance which is complete at odds with what most people perceive as being true. See “International Profile of Health Care Systems”, Commonwealth Fund (January 2016) Ed. E Mossialos and M. Wenzl

[5] OECD (*ibid.*)

Part 3 makes a number of important suggestions as to how we make these fundamental changes (Section 5-9).

These suggestions include:

Demographic pressures should be managed through first a better understanding of the likely impacts second changes in the delivery of care to changes in demand resulting from these pressures.

Access and equity should be improved through a number of measures including changes to the reimbursement system for medical providers to encourage behaviour that will lead to better outcomes. One such example, in this regard, is that an allowance is made to encourage the provision of rural primary care services.

Efficiency should be targeted by extending the use of cost effectiveness studies, clinical guidelines and payment reforms.

Quality should be improved by extending the use of over-sight and strengthening the availability of data for monitoring purposes.

Funding considerations changes should be wide-ranging. We need to consider the required level of funding for the health system into the future and understand how this funding may be attained. In this regard, an actuarial review should be undertaken on this health system and, as part of this, a full cost-benefit analysis undertaken of potential other sources of funding[6] for the health system including an evaluation of the equity dimension. While no significant change in the mix of funding mechanisms is proposed the introduction of 'ear-marked' funding options is suggested.

Background

This submission is provided by John Armstrong, Actuary/Health Economist. The submission is made, on a personal basis, and should not be considered to be the views of any of the organisations to which the author is currently or has been previously affiliated. Over the last twenty years, I have directly advised over 20 different governments on health reform and financing on behalf of various international organisations such as the World Bank and the European Union.

The need for reviewing the future of healthcare

The case for reform of the Irish health system is compelling. We spend a significant amount of money on healthcare in Ireland but yet it is not entirely clear that we are getting sufficient value for money. Recent statistics published by the CSO suggest that we spent over €20 billion on healthcare in 2014. This spending needs to be put in the context of what our comparator countries spend. Figure 1

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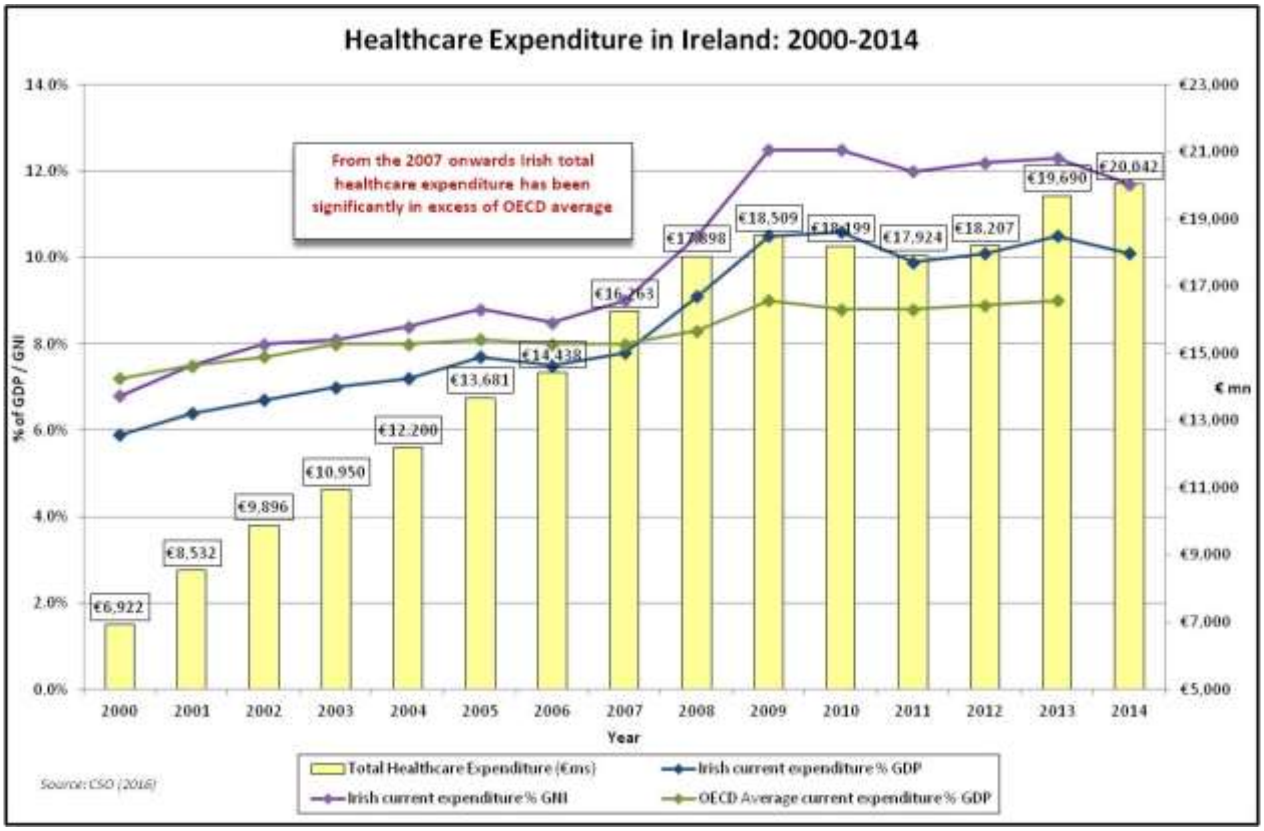
[6] This includes the potential sugar tax as envisaged in the 'Programme for Government'.

presents an outline of the evolution of our health expenditure from 2000-2014 and compares our expenditure to other countries within the OECD using the measure of how much we spend as a proportion of our national income (GDP).

Figure 1: Health Expenditure in Ireland: 2000-2014



Healthcare Expenditure in Ireland: 2000-2014

From the 2007 onwards Irish total healthcare expenditure has been significantly in excess of OECD average

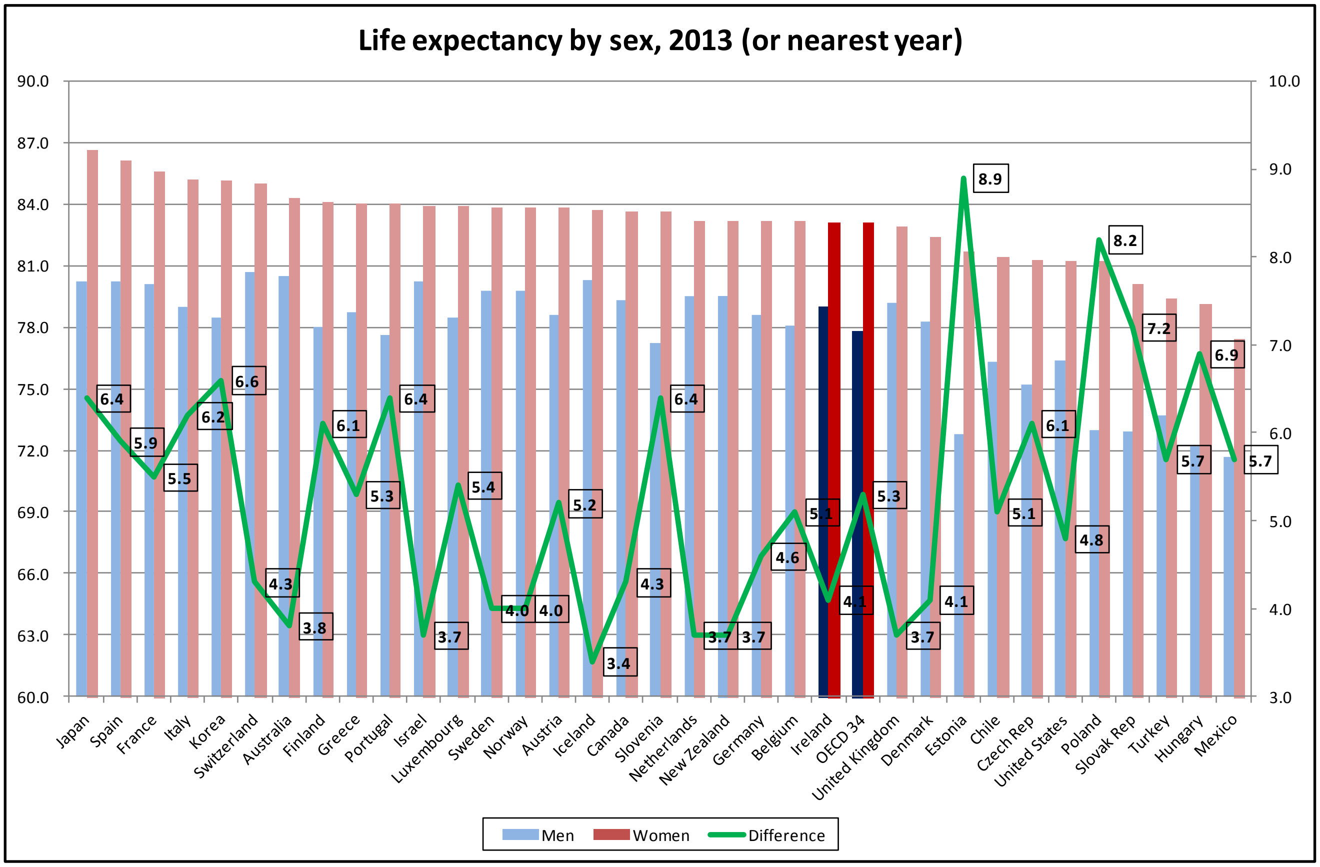
Source: CSO (2016)

The figures are interesting in a number of aspects. First, we have grown our expenditure significantly over the period. Second, even allowing for our relative improvement in wealth and notwithstanding the affects of the economic downturn we still continue to spend a considerably higher proportion on healthcare compared to other OECD countries. When considered in the context that our population profile is relatively younger than the average within the OECD group of countries this is even more surprising.

Like many other countries Ireland is facing a period of ageing within the population, changing household composition and changing demands on healthcare given the higher expectations of the population and the level of advancement in medical technologies. This means that over the near term healthcare expenditure is likely to continue to grow into the future. We must, therefore, seek to find new ways to get more value for money out of what we pay for healthcare.

The performance of the healthcare system compared to other countries suggests a number of positive aspects that are often over-looked. A full exploration of these is not possible here. Nonetheless as an example, Figure 2 provides details on life expectancy compared to OECD countries for 2013 or the nearest year for which data is available. The figures are ranked from left to right by the life expectancy for females (with the highest on the left hand side). As can be seen, for both males and females our life expectancy is better, albeit slightly, than the average for the OECD countries. This is an impressive change when you consider that in the mid-1990s our mortality rates were much higher than the OECD average.[7]

Figure 2: Life expectancy by sex, 2013[8]



However, it is also clear that we have considerable challenges in our health system that affects our ability to have a so-called one-tier system for everyone. Our performance for certain conditions is poor and we rank quite poorly across OECD countries. One example that is noteworthy is in relation to breast cancer rates for females. Figure 3 demonstrates that we rank the poorest in the OECD with the exception of Denmark for breast cancer mortality. While our mortality rates improved significantly between 2003 and 2013 we are still performing worse than most other countries.

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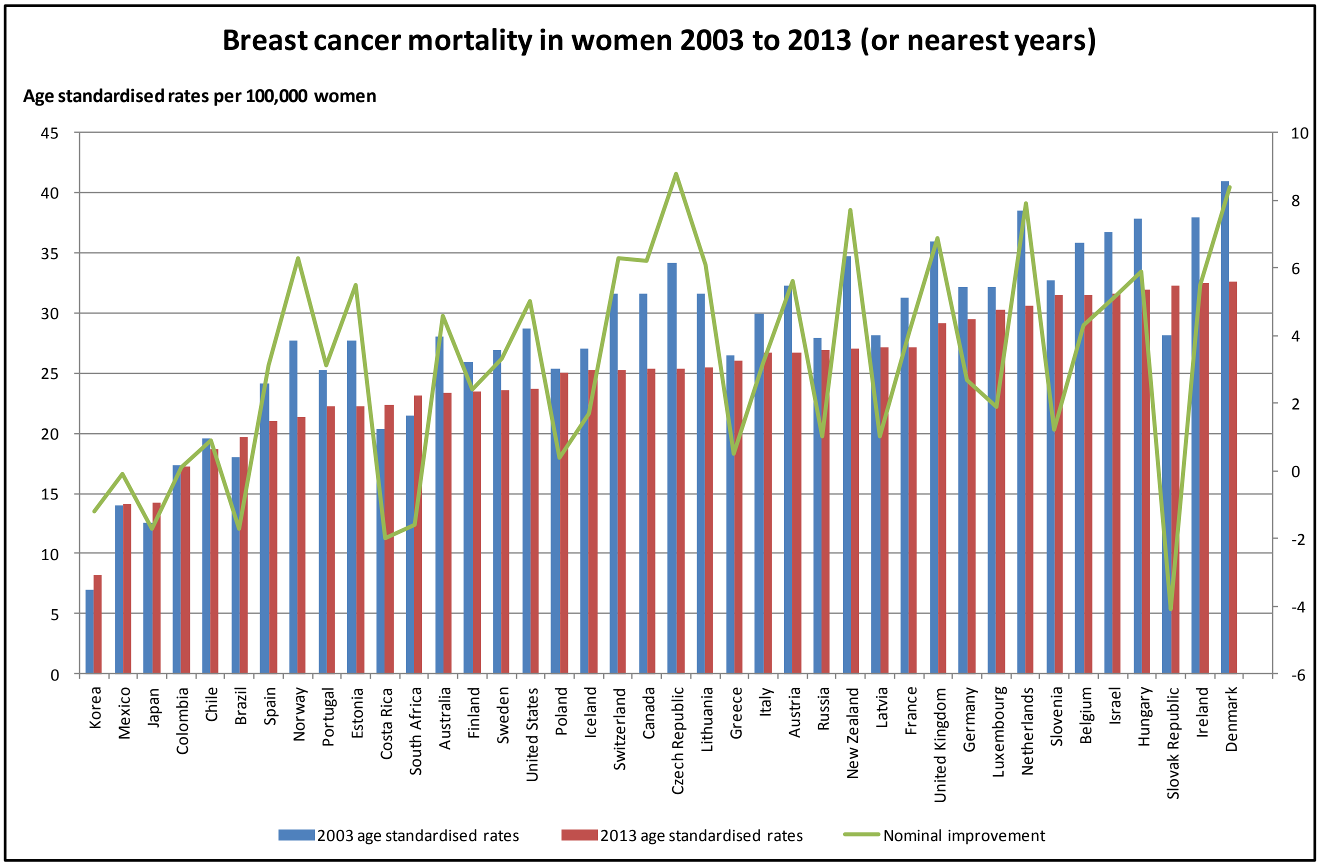
[7] This is not presented here but is summarised in Armstrong et al (2007): "Recent Irish mortality trends". Available at www.actuaries.ie

[8] Source OECD (2016)

Figure 3: Breast cancer mortality in women 2003 to 2013[9]



As well as having challenges in terms of the outcomes there are more fundamental access issues relating to level of access within the system to treatments, as measured by the average waiting times. International evidence on this is difficult to come by and even the OECD has had significant challenges in comparing these numbers. Nonetheless in Ireland it is clear that our most recent experience is that our waiting times are high and importantly increasing in duration. Figure 4 shows this for a variety of selected procedures for which data is reported by the OECD.

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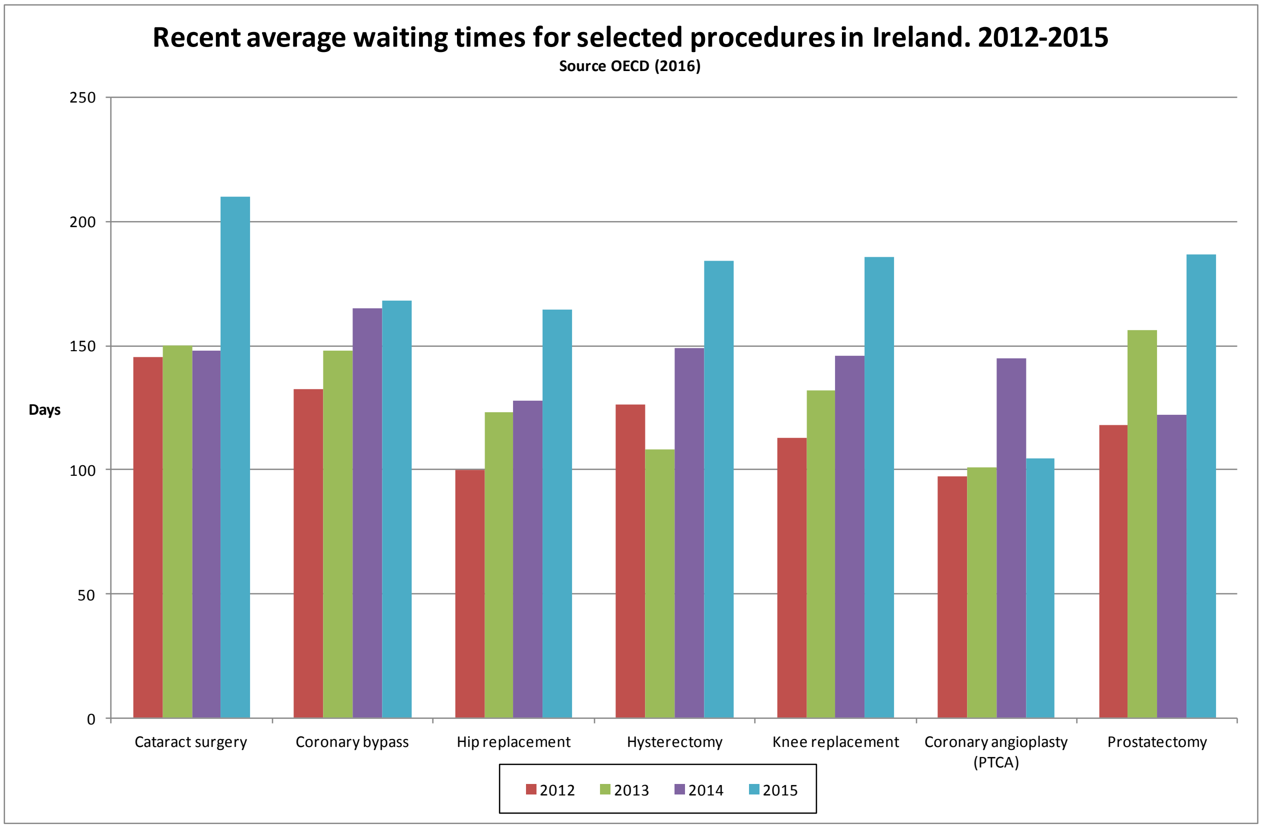
[9] Source OECD (2016)

Figure 4: Average waiting times for selected procedures in Ireland 2012-2015[10]



The selected evidence presented in figures 1-4 show that while we spend a considerable amount of money on health care, the amount we spend does not seem to deliver outcomes and access to healthcare that are commensurate with our spend. This suggests there are deep-seated issues around efficiency and equity within the system.

This evidence is supported by perceptions of the health system where there appears to be a growing view that, while care is delivered excellently by practitioners gaining access to this care is problematic for certain income groups and for those in need of treatment for certain chronic conditions. Furthermore, strains are emerging around the geographic access to certain treatments in particular in relation to accessing primary care services in certain parts of the country.

The problems are not confined to access. There is some evidence of inefficiencies within the system as evidenced by significantly different average costs per patient for certain procedures across the health system and the absence of treatment facilities for patients with certain conditions outside of the hospital sector.

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[10] Source OECD (2016)

Both of these suggest that the work of the Committee is timely and that collectively we now need to address the changing needs of the health system.

THE DEVELOPMENT OF A STRATEGY

The development of a strategy for healthcare reform is a complex task and once that should be based upon sound principles. The complex nature of healthcare markets is such that simply fixing one problem we have may have potentially adverse consequences elsewhere. It is therefore important to ground the development of any proposed strategy based upon sound principles. To help with the development of these principles a number of key observations are outlined.

It is also important to carefully consider the use of terminology as often it is unclear as to what is meant by the use of certain key terms such as equity or one-tier as different people have different views as to what these mean.

Some starting points

Observation 1: Objectives for the health system

In considering the future of healthcare we need to be clear as to what are objectives are for the health system and what are the goals of any consequent reform agenda?

I believe there are four clear reform goals that need to be considered by the Committee.

How can we meet the challenges of the health system into the future?

How can the major issues of ***access and equity*** are addressed?

How can the health system be designed to ensure that there is ***efficiency*** in the provision of services within it?

How can we ensure that ***quality*** is prioritised in the delivery of services to lead to the best outcomes for patients and service users?

Observation 2: Evidence Based

All analyses needs to be evidence based and grounded using appropriate data from reputable international sources using common data methodologies.

In this regard, it is important to understand that there are significant challenges in comparing health expenditure and outcome statistics across countries. My experience in advising many different governments suggests that the best data is likely to have been provided by government agencies using standard methodologies developed by some of the international organisations.

Particularly note-worthy in this regard is the work of the OECD who has compiled a rich set of regularly updated data on health system performance.

For example, the data on Irish health expenditures has been recently updated through the Systems of National Health Accounts project managed jointly by the CSO and Department of Health. Comparisons using the previously reported data could lead to different policy conclusions.

Observation 3: Cross-Country Comparisons

All countries have different cultural, historical, institutional backgrounds and the health system is based on this background and therefore what works in one country will not necessarily work in another one. It is therefore unlikely that there will be any one country that will be able to be used as a benchmark for the work of the Committee.

Nonetheless, having access to international comparisons from organisations such as the Commonwealth Fund and the OECD is important to give context to some of the problems within our health system and understand some lessons that are relevant to Ireland.

Observation 4: Timeline for health reform

Experience of health reform across countries is that the process of health reform takes many years and what is needed is a targeted approach that identifies through robust data analysis, problems areas within the health system with specific measures being put in place to address these issues.

Observation 5: The review must consider the entire health system

The entire health system must be considered including the role of private healthcare within the system rather than narrowly focusing on just the ‘public system’ (whatever that means!)

Observation 6: Incentives within the health sector

We must align the incentive structure within the health system to meet our goals. This includes quality, efficiency and equity. One obvious tool for this is through the reimbursement of medical providers. Pay for performance reimbursement systems are increasingly being used in this regard and should be explored for Ireland.

Observation 7: Any recommendations need to be fully cost and their projected benefits evaluated

In any healthcare review a range of possible proposals will be outlined. All of the proposals need to be evaluated to determine their relative cost and benefit and where resources will be insufficient to meet the cost of all proposals (as most likely will be the case) they need to be prioritised based upon their likely costs and benefits.

PRE-CONDITIONS FOR HEALTH REFORM

Certain pre-conditions need to be met to bring about reform within the health system regardless of the funding model.[11] Of course, depending upon whether, for example, an exclusively insurance based model or a taxation based model is adopted there may be differences in the way these pre-conditions are applied and for certain in a model of insurance based funding others will be required.

In the context of Ireland it is assumed that it is assumed that we are aiming to have a comprehensive model of healthcare that reflects elements of choice being given for patients and funders and competition within it. Evidence would suggest that choice and competition leads to better outcomes for patients.[12,13,14]

To support this model of consumer choice and competition there needs to be regulation to ensure that the over-arching objectives within the system are met in terms of quality, governance and meeting the twin objectives and efficiency and equity.

Outline of the pre-conditions for health reform

For ease the pre-conditions are outlined here that are required to deliver such a model of healthcare. In considering the pre-conditions the focus is predominantly on the institutional and structural arrangements that must be put in place.

It should be noted that the preconditions are necessary but not sufficient in themselves. If any of the pre-conditions are not fulfilled, there is a risk that society's objectives of affordability and efficiency are not met. In the context of Ireland, where we want to health reform as soon as possible, the lesson is that we must be careful to ensure that we meet these preconditions prior to its introduction.

Free choice for consumers

Where possible consumers should given the ability to make choices themselves as to the level and type of care they want within the system. Of course, imperfect information will mean they will need assistance in this choice. In the Irish context, where there is a large group within the population who have a medical card and consequently may get subsidised care, it will be important to ensure that

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[11] The pre-conditions required for health system reforms in a UHI context were outlined by Armstrong (2011) "What is required to make Universal Health Insurance work in Ireland?" Proceedings of the MacGill Summer School. This follows on from work undertaken jointly with Professor Wynand van de Ven from Erasmus University, Rotterdam and also

[12] See, for example, Cooper Z, Gibbons S, Jones S and McGuire A (2010) "Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms" Working Paper No 16/2010 LSE Health

[13] Kessler, D.P. And Geppert, J.J (2005), "The Effects of Competition on Variation in the Quality and Cost of Medical Care" *Journal of Economics and Management Strategy (14), pp.575-589*

[14] Kessler, D.P. and McClellan, M.B. (2000) "Is Hospital Competition Socially Wasteful" *The Quarterly Journal of Economics 115,577-615*

they have free choice of provider in an identical manner to those who are not part of the medical card system.

Effective competition

There is a need for effective competition both in relation to the provision of health care services and between the different funders of services. Effective competition tends to lead to more efficient outcomes, will encourage costs to be contained within the system and should lead to better quality outcomes in terms of the delivery of health care and directly from the insurers themselves.

There are a number of separate aspects to this:

a) *Consumer information and transparency*

   Sufficient information must be available of the price, quality and other aspects of the services to be offered by providers and by the funding agencies within the system.

b) Contestable markets

   All elements of the healthcare market should be contestable in the sense that there should be no barriers to entry and exit to the market. Barriers to entry restrict competition and may lead to outcomes that are not efficiency. Barriers to exit (such as the support for failing providers) lead to inefficient outcomes also as efficient organisations are not rewarded sufficiently for their efficiency.

c) Freedom to contract and integrate

   Individual providers of care and funders within the system should be free to contract in order to ensure that they deliver care and service to consumers in the most efficient manner as possible. For insurers, this means they should have freedom to determine the providers they contract with (subject to minimum accessibility standards), negotiate the prices with individual medical providers and determine the quality standards those providers must meet.

d) Adequate competition regulation

   Competition regulation should apply to all aspects of health care and should stop anti-competitive practices such as the abuse of dominance and the mergers and takeovers that are not considered in consumers' best interests. In the context of healthcare markets where the geographic definition of the appropriate sub-market is unclear this makes the use of competition policy more complex.

Facilitation of cross-subsidies to encourage affordability

Fundamental to health reform to lead to more equitable outcomes is that there are robust systems in place to ensure that the affordability objective is met. This has a number of aspects:

Robust risk cross-subsidies are in place

Providers (and as relevant insurers) should be discouraged from selecting better risks (e.g. the young) to the detriment of poorer risks (e.g. the old). Without some form of cross-subsidies between these groups individual providers/insurers will be likely to target the better risk profile.

Adequate income related cross-subsidies

Consumers who cannot afford to meet the cost of the healthcare should be compensated in part or in full by society. In reality what this means is that the Government should pay towards the cost for these persons. The optimal way to administer this is through the income tax system and through forcing all persons to register for tax even if their income levels mean they won't have to pay any tax. To facilitate this there needs to be a national system of income/asset determination that will allow easily for determinations of eligibility to be made.

No incentives for free-riders

All consumers should be part of the system to ensure affordability, as if consumers have to choice to participate or not in the system they will only do so when they are about to incur medical expensive will shift an unfair burden to others.

Adequate quality supervision

Consumers should be protected against poor quality service delivery by medical providers. Good quality should be rewarded and poor quality penalised. The evidence is that that this can be done in a number of ways through reimbursement arrangements, on-going quality assessment and even the publishing of performance league tables. The measurement of quality is not straight-forward and requires a well-resourced quality supervisory institution.

Guaranteed access to care

Having timely access to care within a short distance of home is a pre-requisite to ensure that consumers achieve an equitable service. Regional population profiles mean that this pre-condition is difficult to balance with the need to have a quality level of service.

Benefit package scope

There should be absolute clarity as to what is covered within the scope of any national package of healthcare. Thus there is a need for Government to explicitly outline a standard package of services that should be covered. Not all health services are easily able to be incorporated into such a framework (e.g. community related services) so it is important that as well as being explicit about what should be included we should also be clear about what is not included. To assist in this task the use of health technology assessment and health economic evaluation can assist in deciding what should be included.

MANAGING DEMOGRAPHIC PRESSURES

As already indicated the impact of future population growth, ageing and household composition will lead to significant pressures on the health system into the future. This pressure will need to be managed through first understanding the nature of the demographic pressures and, secondly, then reconfiguring the delivery of services within the health system to allow for differences in the types and volumes of services required.[15] The recommendations below are made on this basis.

Changing in population profiles will have an important regional dimension and need to be considered

Actions to allow for demographic challenges

Recommendation 1: Development of actuarial funding valuation of projected costs and funding options

As part of understanding the financing needs of the health system an actuarial valuation model of the health system should be developed as already has done within many other countries.[16] This should project expenditure for all health services and consider the various options to fund these services over a reasonable time horizon (most likely 10-20 years). Such a valuation model will not only look at demographic changes but will also allow for changes in utilisation rates, medical practice, the scope of benefits to be provided and the economic assumptions underpinning the estimates.

Recommendation 2: Enhancement of the community based delivery of services

To reduce the demographic burden it will be necessary to shift people out of more expensive hospital inpatient settings to receive their care in community settings. This will need an enhanced investment in community and primary care.

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[15] There is a wide body of literature on this topic that is relevant. Examples include Rechel B, Doyle Y, Grundy E. and McKee M (2009), “How can health systems respond to population ageing?” *Health Systems and Policy Analysis, World Health Organisation, Technical Paper.*

[16] See for example Armstrong (2006, 2016, 2008) relating to Egypt, Saint Lucia and South Africa.

Recommendation 3: Development of further long term care policy options

There will be a need for the state to plan adequately for the long term care needs of the population and encourage pre-funding of long term care. This may include the provision of further tax incentives for long care pre-funding. At present, while such tax relief has been in place there has is no consumer interest in such products.

Recommendation 4: Further integration of services

There is a need to integrate formal and informal care that is provided within the health system including the provision of chronic disease management services that are often provided by the charity sector.

Recommendation 5: Increasing labour force participation

The best way to plan for the ageing population within the economy is to increase labour force participation rates within the population. Not only will this have a direct positive impact on the funding of the system but it will also have wider health and social benefits. One way to facilitate this is through the development of secondary labour markets where those nearing retirement can choose to work longer. This will prolong their working life and potentially their health.

IMPROVING EQUITY AND ACCESS

The most tangible demonstration of improvements in the health system will be seen in people's perception of changes in equity and access within the health system. For each person their definition of equity and access will most likely be informed by their own or their family's contact with the health system.

Actions to improve equity and access

Recommendation 6: Targeting conditions of greatest influence in improving outcomes

As outlined previously, there are some areas of the health system that need to be initially addressed where we lag behind our comparator countries. An example presented above is for female breast cancer outcomes. These should be targeted first to ensure more equitable outcomes within the health system.

Recommendation 7: Creating incentives for rural primary care

Increasingly we are seeing a lack of primary care physicians in rural areas. This is a problem that is not unique to Ireland. To alleviate this problem various incentives systems need to be put in place to encourage the provision of services that otherwise would not be provided. For example, this may include income related incentives (see later).

Recommendation 8: Consideration of the use of pay for performance incentives

Pay for performance reimbursement systems are increasingly being used successfully as ways to encourage access to care for 'at risk' groups such as those with chronic diseases or those with adverse lifestyle habits (such as smoking). It is recommended that consideration be given to the use of such mechanisms in Ireland.

Recommendation 9: Development of National Eligibility File

One of the key impediments to accessing the health system is delay in evaluation of whether a person is eligible for 'free care' at the point of use. This leads to both a number of equity issues and also to a range of inefficiencies in the health system. A better process would be to develop a national eligibility system (cutting across all sectors even beyond health) under which information would be available to validate eligibility rights easily. This system would need to be developed with the Revenue Commissioners and other agencies within the civil service. The means test level for particular types of benefits could be set independently of this system.

HOW TO IMPROVE EFFICIENCY?

As shown earlier a considerable amount of money from both public and privates sources is spent on healthcare in Ireland. While much of this spending is leading to good health outcomes some of it is not been spent in the most efficient way. Measurement of inefficiency within any health system is difficult and no country has come up with a precise methodology to do so. However, it is clear that the Irish performance outcomes in relation to a host of outcome metrics place us as performing poorly. For example, survival rates for some cancers are lower than in other countries and levels of obesity are higher than in many comparator countries.

There is a significant volume of published literature considering efficiency or rather inefficiency within the health sector.[17,18,19] Much of the literature focuses on measures that can lead to both allocative efficiency (i.e. money is being spent on the wrong things) and/or technical efficiency (i.e. where there is a waste in the system) improvements. Some suggestions on the use of such measures in Ireland are outlined below.

Actions to improve efficiencies within the health sector

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[17] Productivity Commission (2015), "Efficiency in Health, Commission Research Paper", Canberra, Australia. JEL codes: I10, I18. This is an excellent report on efficiency in the Australian health system that is very relevant to Ireland.

[18] Smith P (2012)"What is the scope for health system efficiency gains and how can this be achieved?" *Eurohealth Observer 18, No 3*

[19] Cylus J, Smith P. Comparative measures of efficiency. In Papanicolas I, Smith P (Eds). "Health system performance comparison: an agenda for policy, information and research." Buckingham: Open University Press, 2012.

Recommendation 10: Extension of the use of cost effectiveness studies

The use of Health Technology Assessments (HTAs) is considered best practice in order to determine whether the use of scarce resources is efficient. So far, there use has been largely limited to pharmaceuticals in Ireland. It is recommended that their use is extended to a range of other services areas including for medical devices.

Recommendation 11: Increased development and use of clinical guidelines

The Department of Health has published a number of clinical guidelines for use by health professionals. These are supported by Health Technology Assessments (HTAs) from HIQA. This is to be commended. Evidence internationally is that extending clinical guidelines can improve efficiency and outcomes within a health system.

A discussion of some payment mechanism recommendations related to efficiency is provided in the section on funding considerations

QUALITY MANAGEMENT

Quality improvements are an important part of building trust and confidence in the health system and will also lead to more efficient use of resources within the health system. This is a topic where extensive work has been undertaken previously. Of particular relevance to the Committee should be the recent work of the National Quality Board in England. They outline a number of important proposed changes for the NHS.[20]

Actions to improve the quality of services delivered

Recommendation 12: There should be enhanced publishing of performance measures for all providers

The use of such measures has been shown to be useful in driving quality improvements within health systems. In this regard, the National Healthcare Quality Reporting System needs to be extended as fast as practicable.

Recommendation 13: Continued over-sight of healthcare providers

The work of the Health Information and Quality Authority has been important in bringing issues of quality of care to the fore. It is important that this work is continued and extended as necessary into the future

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[20] National Quality Board (2015), “Quality in the new health system”, Department of Health United Kingdom.

HEALTH FUNDING CONSIDERATIONS

It is safe to say that each country has devised its own arrangements for managing its health system to meet the three basic goals of preventing people from getting ill, providing care for the sick and protecting families and individuals against financial ruin from medical bills. However, in broad terms there are only a limited number of options for deciding how to finance the health system. They range from the national health system (NHS model) used in the United Kingdom; to the social insurance system used, for example, in Germany; to the compulsory insurance model (used, for example, in the Netherlands and Chile) or to a government run health insurance model (used, for example, in Canada).

In addition, many countries, including Ireland, use a hybrid model of health funding where general taxation under a NHS type delivery model is combined with a private health insurance market and out of pocket payments to fund the health system.

There is no right funding model and it would be fool-hardy to think there is once ideal one.

What we can day is that each of the models create different incentives leading to different outcomes for certain areas of the health system. A critique of each of the methods is not provided here but the Committee would be well served to understand the positives and negatives of each model.

What is more important for a country is to decide how much it believes it can afford to spend on healthcare and then decide how this money can be funded and by whom. The reality is that it will be a mixture of taxation, insurance related payments (flat premium and/or employer or employee related) and out of pockets that will fund the system to a greater or lesser degree.

The choice of model can have significant consequences on the group in society to which the funding burden of healthcare expenditure falls. This can have significant equity implications for each contributing group of the population.

In respect of the NHS model it is evident that this is a system that can only be entertained if the country’s income level is high enough to generate the revenues required to sustain the universality undertaken and the high quality of care desired. While, in principle, this remains an attractive model because of its very strong capability of delivering Universal Health Coverage it can only be viewed as a second best option at a time when government resources are limited.

What we know is that health outcomes depend on both how the health system is *designed* and how the system is *funded*. A system that is well designed but badly funded may still yield unpleasant results. Here some researchers point to the UK experience with waiting time as an example. However, we can also face obnoxious outcomes in a system that is badly *designed* but adequately *funded*. Here the country most mentioned is the USA prior to the Affordable Care Act, 2010.

Actions on healthcare funding

Recommendation 14: We need to understand how much we will need to spend on healthcare.

While for the first time, with our System of Health Accounts reports compiled by CSO, we now know what we spend on healthcare in terms of functions and services provided and who funds it we still have no idea if this level of funding is adequate. In this regard, we need to understand how much we really need to spend on healthcare in the future. To do this we need proper cost estimates of likely future demand for a defined package of benefits. The compilation of a full actuarial funding valuation as proposed earlier is important to facilitate such an understanding. Such a valuation will then allow a determination as to the scope of what will be the main entitlements for patients.

Recommendation 15: We need to consider options to manage the cost of care into the future and it is recommended that the use of health technology assessments be extended to ensure value for money. Furthermore, the use of cost sharing arrangements, while potentially politically unpopular should be considered.

If is unlikely as a society that we shall be able to afford all of benefits that we may want to as part of our healthcare envelope of benefits. There are a range of options that could be considered to prioritise the areas of spend and to dampen the cost. These include the use of health technology assessments (HTAs) and the use of cost sharing arrangements such as co-payments and deductibles.

Recommendation 16: Cost sharing should only be carefully introduced, so as not to undermine access and equity for those who really need care, through as system of waivers and subsidies.

When using such cost sharing arrangements the level of co-payments should only be set with reference to the type of benefit, the needs of the individual, the aggregate cost of the type of benefit being considered for copayments and evidence as to the effect of such cost sharing measures that are being introduced. This is to ensure those who really need the service can receive it and to ensure no inefficiency is introduced in relation to the collection of any copayments. Given the level of out of pockets funding for many types of care in Ireland the extension of the use of cost sharing is likely to be limited.

Recommendation 17: The choice of funding options should be based upon a mixed system of general taxation, ear-marked taxation, insurance related payments and out of pocket contributions.

It is clear from the international literature that all countries are moving more and more towards a mixed system for the funding of healthcare expenditure. Furthermore, there is evidence that countries are converging to the mean split of funding. Thus, for example in the United Kingdom more and more of the expenditure is being funded from private sources while countries who have a higher proportion of private funded healthcare, such as the United States are moving towards more public spending.

One of the strengths of the Irish system is its mixed funding model. It is recommended that this mix of funding continues into the future although the introduction of new funding streams including the use of ear-marked taxes such as the ‘sugar tax’ should also be considered. Any funding from the ‘sugar tax’ should be transferred directly to the health sector.

Recommendation 18: Different payment models should be used depending upon the type of service

There is no one correct payment model for providers. Depending upon the type of service being provided different payment models should be adopted within the health sector.

For hospital care (in both public/voluntary and private hospitals) activity based payments should be introduced.

For primary care, capitation type arrangements should be introduced with regional adjustments as proposed earlier to allow for different costs and to encourage provision.

For both services types, performance related payments should be introduced to encourage quality improvements and to target specific outcomes. Evidence internationally suggests that performance related payments arrangements are increasingly considered best practice and can have significant advantages in creating incentives for providers to improve the quality of the service provided. There has been limited use of such a mechanism in Ireland heretofore. Their use should be extended.

Recommendation 19: It is not clear integrated funding models could work in Ireland

Integrated funding models are another example of how care for certain services can be funded. Under this approach a bundled payment is made to a single provider who sub-contracts to purchase other services on behalf of their patient. However, such models rely on good information being available to determine the appropriate level of bundled payment. In the absence of such information it is not clear if such funding models could be easily introduced into Ireland at this time.

Recommendation 20: A longer-term view of capital funding should be initiated.

Given the recurring requirement to replace older and obsolete capital stock within the health sector it is important that a more formal mechanism is put in place to fund capital expenditure in the medium to long term. Part of this could include the state working together with private providers on public private partnership arrangements though it is acknowledged that these have attracted controversy in the past, perhaps fairly in some instances. Regardless of the approach, capital costs spread over the lifetime of the asset should be factored into the budget allocation to individual health providers from central government.

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Katharine Howard Foundation

Research clearly indicates that:

- ✓ **Pregnancy and the early years of life are the most effective times to intervene in the lives of children**
- ✓ **Early intervention creates lasting positive outcomes for children and families**
- ✓ **Early intervention prevents more entrenched difficulties arising later in childhood and in adulthood**
- ✓ **Early intervention is cost effective and can save money in the medium to long term.**

On this basis, the vision for the future of the Irish Health Service needs to:

- ✓ **Emphasise a "wellness" focused service with the capacity to respond to illness**
- ✓ **Promote health and wellbeing in order to significantly reduce the incidence of illness**
- ✓ **Intervene as early as possible – prior to pregnancy, during pregnancy and in the early years of a child's life**
- ✓ **Operate on the principle of "progressive universalism" – providing key supports to all parents and additional supports to those with additional needs**
- ✓ **Provide all parents with the knowledge, skills, supports and confidence to support all aspects of their child's development**
- ✓ **Screen for children and parents with additional needs and have effective pathways for them to access the supports they need**
- ✓ **Work in partnership with parents**
- ✓ **Promote a "whole-of-government" and "whole-of-society" approach to health, seeking to build effective cooperation across state services and with the community and voluntary sector.**

To achieve this, there is a requirement to:

- ✓ **Frontload investment in prevention and early intervention services and subsequently have a phased transfer of funding from acute to primary care services**
- ✓ **Provide staff with the skills, resources and supports necessary to adequately fulfil their roles**
- ✓ **Develop data systems which inform service planning and evidence whether services are achieving their intended outcomes.**

The Katharine Howard Foundation welcomes the establishment of the Oireachtas Committee on the Future of Healthcare. In particular, we welcome the commitment to:

- A long term vision and strategy with cross party support
- A single-tier universal health service based on need
- A focus on primary and community care
- An emphasis on prevention and early intervention.

This submission is being made by the Katharine Howard Foundation in the context of with our work with the Health Service Executive in developing and implementing the Nurture Programme – Infant Health and Wellbeing.

Because of the nature of our work, this submission focuses on how the Irish Health Service should respond to the needs of all parents and their children during the key periods of pregnancy and the first years of life.

We also provide evidence about how the delivery of quality supports early in life will have a lifelong positive impact throughout a child's life and will reduce their need for acute services later in life. Evidence clearly indicates that expenditure on evidence-based models of prevention and early intervention can create significant financial savings throughout the lifetime of the child.

The Katharine Howard Foundation

The Katharine Howard Foundation is an independent Foundation which was established in 1979 and is focused on improving the lives of young children and their families by working with others to identify needs, building on existing initiatives, formulating new initiatives, making strategic grants, gathering and sharing learning, contributing to the development of policy and practice.

Through our Parenting Support Initiative (2013-2016), the Foundation has provided support and advice to 58 projects spread throughout Ireland which support parents of children under three. These projects have utilised a range of innovative approaches and worked in partnership with the Health Service Executive and a range of other services for children and their families.

Through the Nurture Programme – Infant Health and Wellbeing (2015-2018) the Foundation is working with the Health Service Executive to develop a universal integrated approach to service planning and delivery to improve health and wellbeing outcomes for infants and their families from pregnancy to the child's third birthday.

http://www.khf.ie/

The Nurture Programme – Infant Health and Wellbeing

70,000 babies are born in Ireland each year. On average a baby is born every 7½ minutes.

The Nurture Programme – Infant Health and Wellbeing has been developed with the aim that every parent receives the best possible advice, information and support from conception to the child's third birthday so that each one of these babies gets the best possible start in life.

The Nurture Programme is a three year programme (2016-2018) funded by Atlantic Philanthropies. The grant is managed by the Katharine Howard Foundation, the programme of work is delivered by the Health Service Executive and its related agencies and implementation support is provided by the Centre for Effective Services.

The Programme is being evaluated in order to inform the development of the Programme and to identify the learning for other systems-change initiatives within health and public sector services.

Within the Health Service Executive and within related health, wellbeing and family support services, there is a wealth of expertise and good practice in place in relation to pregnancy and the early years of a child's life. Much of this work has been developed within HSE Maternity, Primary Care and Health and Wellbeing Services while other significant developments have occurred under a range of programmes funded by Atlantic Philanthropies and others including the Prevention and Early Intervention Programme, the National Early Years Access Initiative, the Parenting Support Initiative and the Area-Based Childhood Programme.

If you have just become pregnant, you can expect to meet health professionals on a minimum of 25 occasions by the time you celebrate your child's third birthday. This is made up of contacts with Maternity, General Practice and Primary Care services. Under the Nurture Programme, it is intended that parents are given relevant, clear, consistent, timely and evidence based information and advice on each of these visits. In other words, to ***make every contact count***.

Some of the key developments planned under the Nurture Programme include:

- A new parenting and child health website for parents and for healthcare staff.
- Information and advice to people planning to become pregnant so that they can give their child the best start in life.
- Information and supports during pregnancy strengthened and standardised.
- Universal access to the Child Safety Awareness Programme to guard against accidental deaths and unintentional injuries.
- Infant Mental Health to inform the key messages to parents, covering topics like bonding with your baby, parent-child communications and supporting your baby's early learning and development.
- Breastfeeding encouraged and supported.
- Training, coaching, development and resources provided to support frontline staff in their work

The evidence to support this submission

This submission draws on the combined experience of the Katharine Howard Foundation, the Health Service Executive and the wider sector as well as on the growing body of Irish and International evidence of:

- Effective interventions in pregnancy and early childhood
- The societal and financial benefits of effective early intervention.

Proposition 1: Pregnancy and the early years of life are the most effective time to intervene in the lives of children

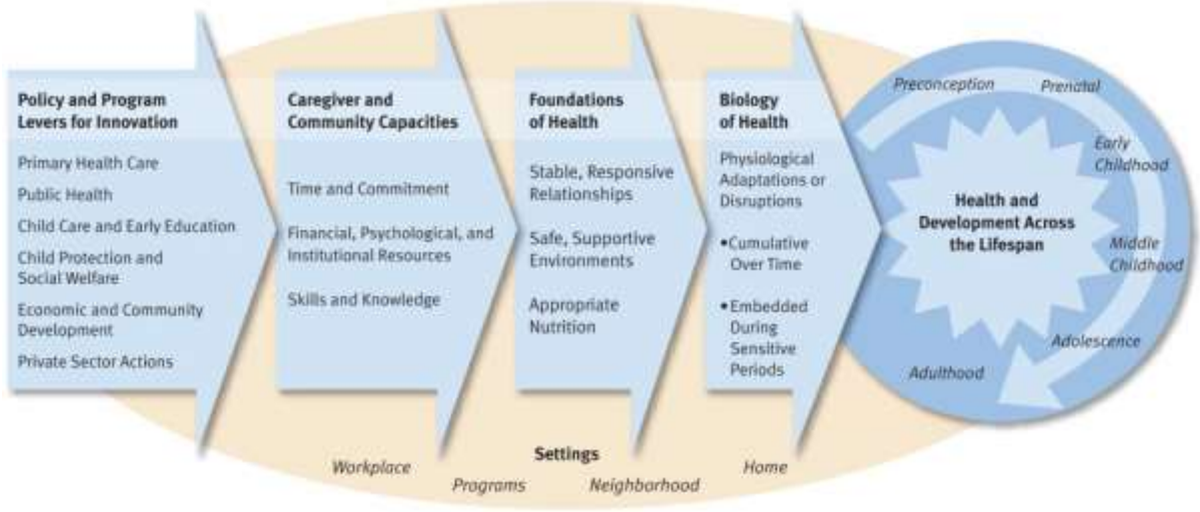
Evidence:

The early years are a vital time for all children due to the rapid growth that is taking place in their brains and their other body systems, laying the foundations for their future health, development and wellbeing.

"Health in the earliest years – beginning with the future mother's wellbeing before she becomes pregnant – strengthens developing biological systems that enable children to thrive and grow up to be healthy adults…. Early experience literally is built into our bodies, for better or for worse."

There are three basis foundations for lifelong health:

- A stable and responsive environment of relationships
- Safe and supportive physical and built environments and
- Sound and appropriate nutrition



(Centre for the Developing Child, Harvard University)

Proposition 2: Early intervention creates lasting positive outcomes for children and families

Evidence:

Obesity and social, emotional and behavioural difficulties are particularly amenable to early intervention (Institute of Public Health / Centre for Effective Services 2016).

Prevention projects in Ireland have increased immunisation rates, established healthy eating, promoted home safety and enhanced parenting skills (McAvoy et al 2013)

Recently published findings from the evaluation of the Preparing for Life Programme on Dublin's Northside by the UCD Geary Institute for Public Policy found that children who had participated in the Programme compared favourably than their peers in the following ways:

- Better physical health and wellbeing
- Less likely to use hospital services (e.g. Emergency Department, outpatient clinics)
- When they did attend hospital, they were less likely to have conditions defined as "urgent"
- Less likely to fracture their bones
- More ready for school
- Displayed less hyperactive behaviour
- Better number skills
- More emotionally mature and socially competent, with better communication skills (Preparing for Life 2016).

Proposition 3: Early intervention prevents more entrenched difficulties arising later in childhood and in adulthood

Evidence:

Irish research based on the TILDA data shows that "The experience of adversity during childhood was associated with increased risk of disease in midlife and older age across a large number of chronic disease types including cardiovascular disease, lung disease and emotional, nervous or psychiatric disorders". (McCrory et al 2014)

The prevalence of obesity and hypertension of adults in their mid-30s is directly related to their Body Mass Index (BMI) at age 1 (Campbell et al 2014)

"Investing wisely in both clinical and community preventive services is essential if we are to successfully address the leading causes of death and disability, namely chronic diseases and their risk factors." (Partnership to Fight Chronic Disease)

Proposition 4: Early intervention is cost effective and can save money in the medium to long term

Evidence:

Early childhood programmes can make a substantial contribution to improving the health of adult Americans and reducing the burden of healthcare costs (Campbell et al, 2014)

Spending on programmes that are of high quality, based on effective interventions, and implemented well can save significantly more than they cost over a number of years.

For instance:

Early Childhood Care and Education:

- USA – return of $2.50 - $16 for every $1
- Ireland – return of €4 - €7 for every €1

Educational attainment

- UK - Cost of a child failing to learn to read: £44,797 - £53,098

Parenting

- USA - Nurse Family Partnership: return of $2.37 for every $1

Child behaviour

- UK: Unresolved conduct disorder can cost £1,000,000 per child over their lifetime
- Ireland: Incredible Years Programme creates a saving of €4,021 - €4,824 per child over a ten-year period (Institute of Public Health / Centre for Effective Services 2016)

Preventive services provide important health benefits at a reasonable cost. Some preventative services are cost saving; others are cost effective. (Partnership to Fight Chronic Disease)

Strategy

- **What are the key priorities for inclusion in a ten-year plan for the health service?**

The Irish Health Service needs to become a **wellness-led service** with a capacity to respond to illness as opposed to a sickness-led service.

The key emphasis of the health service must be reoriented **to promote health and wellbeing and reduce illness.**

This requires an initial **frontloaded investment** followed by a **phased transfer of resources** from acute services to primary care services. In particular, there needs to be a **ring-fenced budget for Child Health and Wellbeing** and strategic investment in this area.

Interventions should start at the earliest possible point: **prior to pregnancy, during pregnancy and in the first years of a child's life**.

The emphasis should be on giving all parents and parents-to-be the **knowledge, skills, supports and confidence** to:

- Look after their own health and wellbeing so that they are fully available to provide quality parenting to their children
- Parent their children to the best of their ability in all aspects of their children's development.

Parents should be seen as key partners and acknowledged experts in their own lives. They should be consulted regularly in relation to service plans and evaluations and their feedback – positive and negative – should be actively sought and carefully considered.

Services should be based on the principle of "**progressive universalism**":

- All parents should receive key information, advice and support
- Parents / children with additional needs should receive additional services specific to their particular need.

Parents should receive **evidence based, consistent, timely and relevant information** at each stage of their child's development from all the key services they encounter, in particular from maternity services, General Practitioners, Public Health Nurses and other Primary Care staff - **making every contact count**.

Every parent-to-be and every parent should have **easy access to accurate and reliable information and advice through a range of media** about all aspects of pregnancy and parenthood: their own health and wellbeing, the physical process of the birth, the child's health and nutrition needs and the parenting of the baby to ensure its healthy emotional as well as physical development.

Every parent should be offered access to a **Preparation for Parenthood Programme** delivered in their local community during their pregnancy as well as a **Parenting Programme** early in their child's life.

Under the Progressive Universalism model of service delivery, health care professionals should be skilled at **constantly screening parents and children to identify those who may be in need of**

additional supports. Following identification of an additional support need, health care professionals need to have the information and expertise to:

- Provide direct support or advice
- Refer on to other services including specialist health services, Tusla – the Child and Family Agency, local parenting and family support programmes.
- These services need to have the capacity to provide timely quality interventions.

Currently Public Health Nurses deliver a generalist "cradle to grave" service providing supports to new-born babies and their parents right through to providing nursing supports and end-of-life care to the frail elderly. Careful consideration should be given to the potential benefits of restructuring this service to create **Public Health Nurses who have specialist skills in supporting infant and child development** alongside Public Health Nurses who have specialist expertise in the care of adults and older people.

Healthy Ireland is built on the belief that our nation's health is not the sole remit of any one Government Department or Statutory Agency but requires a "**whole-of-Government**" and "**whole-of -society**" approach. There is much truth in the saying "**It takes a village to raise a child**". Children's wellbeing and healthy development needs to be nurtured by their immediate and extended family, by the community they live in and by a wide range of statutory, voluntary and community organisations. Effective interventions in the lives of children and families call for effective cross-agency working. This is aided by:

- Local structures to ensure a **joined up approach to identifying and addressing the needs of children and families** in each community. This process is being spearheaded by the **Children and Young People's Services Committees.**
- Effective protocols for the **sharing of information and for effective joint working**. Tusla's Meitheal Process is a good example of this.
- **Co-terminosity of boundaries between agencies** so that effective local working relationships can be developed and sustained and efficient local service planning can take place on a cross-agency basis.
- **Cross-agency training** so that frontline practitioners have a shared understanding and approach to the needs of the children and families in their community.
- Up to date **information on the range of services available** to children and families in the local area and how to refer to them.
- Opportunities to identify and address **unmet and new / emerging needs** and to develop effective responses to them.

Data driven services so managers can plan services based on need and practitioners can know whether or not their interventions are successful in achieving their intended outcomes.

- **What are the key challenges, in your view, to achieving a "universal single tier health service, where patients are treated based on health need, rather than ability to pay"?**

Achieving cross party agreement on a shared vision, leading to a willingness to give the necessary change process space, time and support.

Achieving the buy-in and active support of all stakeholders.

- **What actions are needed to plan for, and take account of, future demographic pressures (population growth, ageing population), and their impact on the health system?**

Data driven service planning and an ability to predict future patterns of need based on current and planned service provision.

Integrated Primary and Community Care

- **What steps are needed to move from the current model towards a model based on integrated primary, secondary and community health care?**

Cross party agreement, buy in by all key stakeholders and a frontloaded investment strategy.

An effective change process based on the growing field of Implementation Science – the implementation of systems-change processes in health and social services.

Realistic timeframes and supports for change to occur across the entire health service and to become embedded in practice.

- **What are the key barriers to achieving this, and how might they be addressed?**
  - **In your experience, what are the key roadblocks you encounter in your particular area of the health service?**
  - **How would you ensure buy-in from health care professionals to progress towards an integrated health care model?**
  - **Are there any examples of best practice that the Committee should consider? Please refer to any evidence you have to support this.**

The Health Service has a very capable and committed workforce who welcome anything that allows them to provide the best possible service to the children and families they serve.

However, there is a significant level of change-fatigue for staff who are working in a system which has had frequent change, which has been subject to significant cutback and which is more likely to receive negative rather than positive feedback and reporting (media / HIQA).

A number of previous and current change processes have been time limited and have created a sense of disillusionment among the staff who have contributed to them with passion and creatively.

As a result, there is a need to convince staff that this change process is genuine, permanent and sustainable. Staff need to be consulted and kept up to date with developments so that they can feel a sense of personal ownership of the future Irish Health Service.

It is essential to have a transparent resource allocation system and a robust staff support system which ensure that staffing levels are commensurate with the role that staff are expected to fulfil and that staff have the skills, resources and support to fulfil their role.

There is a need to ensure community support for the vision for the Irish Health Service and for its implementation as the most important stakeholders.

Best practice examples and supporting evidence are outlined in Section 5 – Evidence. Further examples can be provided on request.

Funding Model

The overall funding model for the Irish Health Service is beyond our competency.

However, we would propose that the following key principles are integrated into any proposed funding model:

- Multiannual service planning and budgeting.
- Recognition that early intervention saves money later in life.
- Frontloaded investment in early intervention in order to achieve returns in the medium to longer term.
- The percentage of funding currently spent on prevention and early intervention services should be identified, ring-fenced and steadily increased.
- All services should be subject to Cost Benefit / Return on Investment Analysis to identify if they are achieving their maximum potential of economic efficiency. This needs to be a cross departmental process so that the impact of expenditure in one government department which results in savings in another can be visible and can inform overall government fiscal policy.

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Kieran Henry, Advanced Paramedic

1) **Capacity** - Increase the availability of access to healthcare from what is essentially a basic 40hr week when elective work is being carried out to double that capacity within the 168hrs in a week.
2) **Community Healthcare** – Create a team approach within healthcare with the focus of keeping people at home. Establish Community Healthcare Champions and they will be advocates for the people they serve.
3) **Emergency Departments** – Establish specialist centres for the 'Care of the Elderly' and those with 'Mental health and Addiction issues'
4) **Funding** – make healthcare accessible and equitable to all by charging a percentage for everyone but giving back credits for incentives for taking part in health promotion and prevention programmes. Put a value on our health and on our healthcare system.

Capacity

We need to increase the elective time and reduce the out of hours /emergency time within our healthcare setting. The average working week of 9am-5pm (40hrs) for elective procedures / out patients etc. gives rise to a situation where the balance between a hospital being on 'elective 9am-5pm (40hrs) ' or on 'emergency care' status is 5pm – 9am (128hrs) of the 168hr week. We need to flip this and make it minimum 80hrs elective and 88hrs emergency.

This cannot meet the demand on the service and hence longer waiting lists etc.

- Why aren't people getting OPD appointments for 7.30pm in the evening?
- Could someone have their elective gastroscopy on a Sat morning at 11.30am?
- The NCT car testing system faced the same issue of demand and adjusted to meet this and hence you can get expect to get your car tested at all hours and weekends, why not your health?
- Most Pharmaceutical industry and many others carry out planned work outside the 'standard' hours because it's efficient and is needed; we need to do the same in healthcare.

Introducing this would certainly be challenging from a range of points including IR etc. but introducing a team (shift) approach where e.g. one would cover the morning 8am – 2pm and the others would be on from 2pm- 8pm with a possible extension to 10pm and Saturdays would be covered 8am – 4pm

Our staff/ hospitals and indeed community services need to adjust to meet the ever-increasing capacity that will be placed on the health service in the future. It's not good enough on a bank holiday weekend for all non-emergency services to practically shut down from 5pm on a bank holiday Friday to the following Tuesday morning for example. We need to use every possible resource e.g. theatre time to it's maximum.

Community Healthcare

We need to change the culture of the public, patients and staff as to how we use our manage our health by encouraging

Creating teams within the community and identifying champions who will be responsible for ensuring that people on their 'watch' only go to hospital as a very last resort. So therefore the ambulance service / GP's / community intervention teams need to be in constant contact and refer people to each other's appropriate service with support from the hospital within their jurisdiction. We need to instill a buy in from all, including family that the patient belongs at home and will have a better outcome rather than hospital admission. (there is evidence for this)

- Encourage communities / parishes to plan for the future of their by building 'Care of the Elderly' villages within their area and managing these with support if needed.
- Extend community responder schemes to include home visits and promoting things like medication compliance etc.
- Establishing community champions who would be advocates for the people residing in their area especially the elderly. They may be clinical or non clinical and would act as a conduit between the person and the statutory health services. Currently if an elderly person doesn't have a relation or neighbour to depend on then dealing with the healthcare system i.e. booking hospital appointments etc can be extremely worrying. Having a contact number for a local 'healthcare community champion' who they can rely on and trust would be of great reassurance.
- Incentivize communities to support their own people through health promotion and prevention

- NUKA model of healthcare in Alaska is worth looking at for community involvement.

Emergency Department - Specialist Receiving Centres

Currently paediatric patients are treated independently in either separate emergency department areas or indeed hospitals, which is correct, but we need to extend this to two other groups.

We should treat the Elderly as a specialty group within emergency medicine and introducing separate Geriatric sections to Emergency Departments will support this, where their needs are met and treated by specialists in this area and they are in a safe environment. Specific designed suites etc. and a very close link with the community service and family liaison would be central to this.

The other group that I would suggest as having a separate specialist department especially in larger regional centres would be for those with mental health and acute addiction problems. These need to be integrated and given the priority they deserve which doesn't happen in the current busy system.

Funding

Healthcare should be equitable and accessible but it also needs to be valued and in this case everyone should pay a certain amount whether through means related percentages or other ways. We should not turn people off from using the health service but abuse of it should not be tolerated either. A certain credit rating should be allocated and not exceeding this unless certified should be policy Incentivized schemes where taking part in health promotion, smoking cessation programmes etc. can buy you back credits.

Laois Faculty ICGP

Medical Board Midlands Regional Hospital, Portlaoise, Laois Faculty ICGP, MIDOC

The Dublin Midlands Hospital Group senior management team, in conjunction with a number of national clinical leads, has submitted to the Department of Health a draft plan for the future of acute services at MRH Portlaoise.

This draft plan, if implemented, would downgrade MRH Portlaoise to a Model 2 hospital and result in the closure of acute services including Paediatrics, Obstetrics and Gynaecology, Accident and Emergency and Intensive Care. Additionally, if implemented, the plan would severely curtail Acute Adult Medicine and General Surgery. If implemented, services that can effectively and safely be provided at MRH Portlaoise will cease to be provided there, and patients who currently rely on MRH Portlaoise will be forced to look elsewhere, in an already overcrowded hospital system, for care.

Such a plan does not provide for safe, effective or patient-centred care. Rather it repeats past mistakes. There is an ongoing crisis of capacity within the Irish health system. There are neither sufficient beds available for patients currently attending MRH Portlaoise elsewhere in the hospital system, nor sufficient ambulances to safely transport them to alternate hospitals. Additionally it is recognised internationally that attempting to centralise high volume essential services produces risks for patients and does not achieve cost savings or improve care. For patients in the Midlands, where the bed-stock is already low by national standards, and where there is no Model 4 or “hub” hospital, the risks of down-grade outweigh any argument that might be put forward in its favour.

We recognise the pioneering work of the Dublin Midlands Hospital Group in fostering the managed clinical network between MRH Portlaoise and the Coombe’s Women’s and Infant’s University Hospital. This initiative provides a template for safe, sustainable, and patient-centred care at MRH Portlaoise and should be extended across the range of clinical specialties.

We believe that the safe and correct way to proceed is to continue to provide acute services at MRH Portlaoise with appropriate support from the hospital group. We do not make an argument for the status quo. People in this area of the Midlands have seen their health care under-resourced. They deserve just provision for their healthcare.

Background

The Midlands Regional Hospital at Portlaoise is a Model 3 hospital. It is one of seven hospitals in the Dublin Midlands Hospital Group. It provides Emergency Medicine, Adult and Paediatric Medicine, Surgery, Obstetrics and Gynaecology, Diagnostic, and Allied Health services. In addition, there is an Acute Psychiatry Admissions Unit on site.

The hospital serves Laois and surrounding counties. Laois residents account for over 60% of inpatient discharges with the remainder of inpatient activity coming primarily from Kildare, but also including Offaly, Tipperary and Carlow. The nearest alternative Obstetric and Paediatric units are at a distance of greater than 50 Km from Portlaoise.

The Dublin Midlands Hospital Group senior management team, in conjunction with a number of national clinical leads, has over the last two years engaged in a process with the aim of setting out a plan for re-configuration at MRH Portlaoise. This process has been conducted at a remove from local stakeholders.

We understand that a process of meetings and consultations concerning MRH Portlaoise has concluded with a plan that remains in draft format. This draft has been submitted to the Department of Health.

We understand that this draft envisages a significant downgrade to services at MRH Portlaoise, including a cessation of Emergency Medicine, Intensive Care, Paediatric, Obstetric and Gynaecology, and Acute Surgical services.

Sustainability of Services

The sustainability of services at Portlaoise has been a concern for the CEO Dublin Midlands and the National Clinical Leads.

Some services provided at regional level may require re-configuration due to low frequency of demand. Low demand for services may result in levels of service provision that are either too limited to justify continuance or to facilitate maintenance of an adequate skill-base. In certain situations technological developments in healthcare may favour centralised provision of care. Such provision is in place nationally largely on a sub-specialty basis, for example patients with ST elevation myocardial infarction are transported to one of the primary PCI centres rather than to a regional unit.

The sustainability of services, however, may also be threatened by a lack of investment and a failure to provide adequate resources. When we examine statistics for MRH Portlaoise we see clinical activity that matches or exceeds that of many Model 3 hospitals. We also see funding levels that fall short, in some cases considerably short, of these comparable hospitals.

For patients, there is further injustice if past failure to invest in services is offered as a reason to deny future investment in their care. There is a risk of real harm to patients if services are disbanded without the provision of viable alternative options.

We believe that the vast bulk of care currently provided at MRH Portlaoise is sustainable into the future with appropriate resourcing and proper network support from the hospital group.

Policy Background: The need for new thinking.

In preparing this document we have reviewed:

- ‘The reconfiguration of clinical services. What is the Evidence’, The King’s Fund, 2014
- ‘National Standards for Safer Better Healthcare,’ Health Information and Quality Authority, 2012
- ‘Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise’, Health Information and Quality Authority, 2015
- ‘Report of the National Acute Medicine Programme’, Royal College of Physicians of Ireland, 2010
- ‘A strategy to improve safety, quality, access and value in Emergency Medicine in Ireland’, National Emergency Medicine Programme, 2012
- ‘Securing the Future of Smaller Hospitals: A Framework for Development’, Department of Health & HSE, 2013
- ‘National Adult Critical Care Capacity and Activity Census 2015’, Acute Hospitals Division. Critical Care Programme & Health Service Executive, 2016
- ‘A National Model of Care for Paediatric Healthcare Services in Ireland’, National Clinical Programme for Paediatrics and Neonatology, HSE, RCPI, December 2015
- ‘Performance Diagnostic. Midlands Regional Hospital Portlaoise. HSE Dublin Mid Leinster’, Acute Hospitals Divison, 2014
- ‘Creating a better future together - National Maternity Strategy 2016-2026’ Department of Health 2016
- ‘The Medicine Needed for the Emergency Service.’ Royal College of Emergency Medicine & Royal College of Nursing 2016

The National Standards for Safer and Better Healthcare speaks of quality dimensions including: patient-centredness, safety, effectiveness, efficiency, access, and equity.

Re-configuration of acute general services within the Irish health service has focused on achieving centralisation. While there is scope within the documents provided by the clinical programmes for a more nuanced approach, reconfiguration to date has seen units that have provided a range of general services as Model 3 hospitals downgraded to Model 2 units. Services users who relied on these units are now required to look elsewhere for care.

The proposed downgrade to Model 2 status for MRH Portlaoise would result in a cessation of acute services including Paediatric and Maternity services.

The downgrade would force patients who are currently managed safely and effectively at MRH Portlaoise to seek care elsewhere in a system that does not have capacity to meet their needs.

We do not see how such centralisation of itself advances the values set out in the national guidelines. Of grave concern to us are reports in the international literature highlighting the considerable risks for services users inherent in such centralisation of essential high-volume services. Closer to home we note the problems of overcrowding and trolley-waits that have bedevilled health-care here in Ireland. Furthermore a policy of centralisation that is built on a concept of sustainability that depends in turn on historic under-funding will exacerbate inequality in health care. If this policy is accepted, communities who endure under-resourced healthcare will find that a failure to provide adequate funding in the past becomes the reason to deny adequate funding in the future.

The documents from the Clinical Programmes do not address the challenges of centralisation for a hospital with the scope and throughput of MRH Portlaoise. Experience to date with centralisation is limited to units smaller than Portlaoise (Roscommon, Navan, Nenagh and Ennis), none of which offered paediatric or obstetric services. There is no blueprint and no national experience to help us predict and manage the fallout from the proposed down-grade.

The concept of sustainability has been invoked to make an argument for this down-grade. Sustainability is however critically dependent on resourcing.

The past failure to provide resources at MRH Portlaoise cannot be put forward as the reason to justify not doing so now.

The issue of under-resourcing highlighted in the HIQA report of May 2015 must be addressed. It would however be a perverse response to a community's needs, to suggest a further withdrawal of healthcare resource as a solution to the problem of under-resourcing. Such a policy, should it be generally adopted, would exacerbate the inequalities in healthcare funding across the state.

New thinking is needed nationally, along with a new set of solutions to support acute services in regional hospitals. This issue is not unique to MRH Portlaoise.

We believe that the pioneering developments at the Department of Obstetrics and Gynaecology at MRH Portlaoise provide a template as to how the hospital network generally can be re-configured to strengthen and support patient care in regional centres. A managed clinical network is in development, under the guidance of the Dublin Midlands Hospital Group, merging MRH Portlaoise and Coombe Women's and Infants University Hospital. This arrangement aims to ensure that resources and expertise in both units can be drawn on to the benefit of patients. Under the auspices of this clinical network shared protocols, pathways of care and shared appointments have been implemented at MRH Portlaoise. This pioneering model ensures that access to care for patients attending MRH Portlaoise is on an equal footing with patients directly attending the tertiary unit.

This model of managed clinical networks provides a way forward for communities who rely on the regional hospital network for care. Among the deficiencies in the current conceptualisation of Model 3 and Model 2 units is the lack of integration between these units and tertiary centres.

A hospital model which is based on managed clinical networks offers the best way to ensure that patients have access to safe, high-quality and nationally-consistent care.

Such arrangements, in addition to augmenting the delivery of care at regional hospitals, can also drive efficiency in the health system nationally. When regional expertise is developed, the ability of regional units to provide subspecialty care will expand. As a result fewer patients will need transfer to tertiary units, and patients can return to regional units earlier after intervention at tertiary level. In this way, such arrangements can help to maximise the efficiency of tertiary hospitals.

We explain in this document how such clinical support within the hospital network combined with a linked-up approach to the individual clinical care programmes should be applied to plan a safe, effective and sustainable regional service at MRH Portlaoise.

Previous Communications with the Hospital Group: Key Issues.

We, the Laois Faculty ICGP and the Medical Board at MRHP, have communicated independently on a number of occasions with the CEO of the DML group and the relevant national clinical leads.

The Paediatric National leads have engaged in dialogue with the Paediatric team at MRH Portlaoise.

In a series of previous communications we have returned to three key issues:

1. The Accident and Emergency department at MRH Portlaoise is the busiest department outside the major urban centres. 12000 children and 24000 adults present each year to the department. Demographic trends suggest that this demand is likely to increase. Portlaoise has the highest proportion of children under 18 in the country. According to census figures the population of Laois has risen by 20% since 2006.
2. There is no alternative capacity within the health service to care for people who currently rely on MRH Portlaoise for acute care, neither is there ambulance capacity to transport patients to alternative locations for care. MRH Portlaoise provides care across a range of clinical specialities. No other paediatric nor obstetric unit exists in this region. In the event of a downgrade, women and children would need to seek care in maternity and paediatric units in Dublin - at some distance from home and in units that are already over capacity. While there exists regional adult units, each lacks the capacity to meet its current demands and people attending each endure trolley waits and severe overcrowding.

3. In the event of a downgrade to a model 2 hospital, acute services at MRH Portlaoise would cease. No paediatric or obstetric admissions can take place at a Model 2 unit. Additionally, ICU or A&E services cannot be provided at a Model 2 Unit. In the absence of ICU and A&E,

acute medical or surgical services cannot be safely provided. A Model 2 hospital cannot safely admit patients who are ill and must transfer out patients who exhibit any level of clinical risk. Such an institution cannot contribute effectively to the acute care needs of this community.

Policy Formation - Community Involvement

HIQA in its national standards for Safer Better Healthcare stresses the need for person-centred care. The obligation this places on those who plan services is set out in Standard 1.1:

'The planning, design and delivery of services are informed by service users' identified needs and preferences',

Planners are reminded that among the key features of services that meet this standard are:

'1.1.3 Involvement of service users at key stages in the planning and design of healthcare services. Service users are kept informed of key decisions during this process and how their needs and preferences have been considered.

1.1.4 Provision of services at a time and place which takes into account the expressed preferences of service users, where this provision can be achieved safely, effectively and efficiently.'

The process of formulating this draft plan has not shown regard to these obligations. There has been no service-user or local stakeholder involvement in the formulation of the draft plan. The process has been characterised by a deficit of transparency.

A consultation process is promised, but this consultation is to begin only after the plan has been finalised. There has been no consultation process with the communities in Laois and surrounding counties that will be impacted by the proposed down-grade.

Guiding principles

HIQA and the clinical programmes have set out principles to guide the provision and planning of healthcare.

A key distinction must be drawn between re-configuration and rationalisation of services. In a re-configuration process, the structures of care delivery are examined to see how they might better be arranged to improve outcomes and experiences for patients. This evidence-based consultative process has as its central concern the best interests and the preferences of service users.

Rationalisation of services is pursued for other reasons, most typically to drive down cost or make resource savings. Rationalisation may be required at times of financial constraint.

We submit that any rationalisation of healthcare should be shared equally across society rather than fall disproportionately on any section of the community.

In any event, international experience tells us that rationalisation of essential services does not produce a financial benefit for national health care organisations. Any cost savings accruing from a downgrade at MRH Portlaoise would be exceeded by the financial costs of ambulance transport and the costs of providing care elsewhere within the health system.

The starting point for reconfiguration must be the needs of the individual service user. Plans for healthcare in the Midlands need to answer the basic question: how is the individual who requires care to access that care? It is essential that capacity be in place within the service to accommodate and care for that individual and to provide emergency transport when it is necessary.

Clinical programmes recognise that healthcare capacity should be in place as near as possible to the communities they serve and that the care provided must reach an appropriate standard.

Where care cannot be provided locally, pathways need to be in place to support access to specialist care.

When planning the future of service provision, it must be recognised from international and national experience that the process of reconfiguration itself carries significant risks for service users.

We recommend that a code of practice be developed to guide the planning of reconfiguration within the hospital service.

We recommend that the views of service users and local stakeholders be sought and demonstrably taken into account when reconfiguration is considered.

We recommend that concepts of clinical justice and fairness are considered when planning access to health services.

We recommend that re-configuration should occur only where it can be shown to be in the interests of patients.

We recommend that where reconfiguration is required to improve the health resource available to a community then that reconfiguration should involve the least change possible from established services in order to minimise the risks inherent in the process.

Departmental Plans

Critical Care

Critical care helps people with life-threatening illnesses. In the absence of contingency for safe and effective critical care, acute clinical care cannot be provided.

The MRH Portlaoise Critical Care Unit is a Category 2 ICU. The unit can accommodate either 4 HDU or 2 ventilated patients. The critical care unit is staffed by the anaesthetic department. The anaesthetic team also support the obstetrics, general surgery, cardiology and mental health services at MRH Portlaoise. In MRH Portlaoise between 40-50 patients annually require the life-saving intervention of invasive ventilation. A further 200 adult patients receive ICU/HDU care. The critical care team also carry out the initial stabilisation of critically-ill children prior to the involvement of the Paediatric Intensive Care retrieval team.

This critical care resource is an essential safeguard; were it to cease, acute care could no longer take place on site. The throughput of ventilated patients may be low by national levels, but few post-operative patients require ventilation in Portlaoise and these cases would account for most of the patients requiring such care in many units with similar overall activity to MRH Portlaoise.

The Acute Medicine Programme sets out two options for critical care support for a Clinical Strategy Programmes Division (HSE) Model 3 Unit (Section 17.9):

- Category 1 ICU: *'Invasive ventilatory support (48-72 hours), earlier transfer if severe critical illness'*

- Category 2 ICU: '*General critical care, multi-organ failure support incl. CRRT*'
  (CRRT - Continuous Renal Replacement Therapy)

The Acute Medicine Programme further recommends:

> *'For the safe and prompt regional or supra-regional transfer of critically ill patients within the hospital models system, a critical care retrieval team service is required.'*

We recommend that the current Critical Care unit at MRH Portlaoise be re-configured as a Category 1 ICU.

As a Category 1 ICU, the unit would continue to provide life-saving treatment on a 24/7 basis, for patients who become critically unwell while in hospital or who present critically ill to the hospital. However the focus would change. No longer would the patient’s ICU stay in its entirety be expected to be completed at MRH Portlaoise. Rather, initial care, including stabilisation and establishment of ventilatory support, would take place at MRH Portlaoise with subsequent care taking place after transfer to a Category 2 or 3 ICU unit. This transfer would be sought should invasive ventilatory support be required for longer than 24 hours, or immediately if complex or interdisciplinary intervention was required or deemed likely to be required.

The anaesthetic team would continue to fulfil its current service commitments, in particular, for example, to the operating theatres, the surgical, maternity and paediatric departments.

We recommend that functioning reliable networks and pathways be established through shared appointments and protocol-led seamless patient transfers with a regional Category 2 or 3 ICU.

Emergency Department

The Emergency Medicine Programme describes the role of the Emergency Department (ED):

> *‘Emergency Medicine (EM) provides an essential service for patients and communities and fulfils a unique and crucial remit within the national healthcare system.’*
> *‘EDs provide 24/7 access for undifferentiated emergency and urgent presentations across the entire spectrum of medical, surgical, trauma and behavioural conditions.’*

The programme highlights the critical interdependencies between the ED, the in-house hospital teams and the wider network.

> *‘EDs require the on-site presence of core supporting specialties and services and must have seamless access to regional medical and surgical specialties and more complex diagnostic imaging facilities within an Emergency Care Network.’*

The Emergency Medicine programme acknowledges that there is great uncertainty as to what might be seen as an optimum configuration for provision of Emergency Medicine services. The authors recommend centralising:

> '*only those services for which a benefit can be demonstrated, while providing as much care as can be provided safely as conveniently as possible for patients.*'

The authors acknowledge that a safety benefit cannot be demonstrated in the literature for centralisation of services generally. There is however, an important exception in terms of major trauma (a trauma bypass both for adults and children is in operation for Portlaoise for some time now).

The authors quote The College of Emergency Medicine's guidance on ED configuration for England. It states that:

> *'Where the next nearest ED is more than 20 km away there is a strong argument for retaining an emergency service.' (The Way Ahead 2008-2010 Strategic Guidance for Emergency Medicine in the United Kingdom and the Republic of Ireland.)*

(The closest ED is at MRH Tullamore 40 Km from Portlaoise. Naas Hospital is 52 Km from MRH Portlaoise)

The authors point to international evidence indicating that hospital restructuring comes with the risk of increased ED overcrowding.

The overcrowding crisis in the Mid-West region, St Vincent's University Hospital, the Saolta Group and OLOL Drogheda have followed the closure of much smaller ED units than the one apparently under threat at MRH Portlaoise.

The reliance on Accident and Emergency departments for urgent care has, in response to this over-crowding crisis, been questioned and alternative methods for patients to seek acute care have been proposed. International experts have concluded however that re-organisation of urgent care is confusing for the public and may make it difficult for patients in crisis to find the services that they need.

In Scotland, 'The Report of the Auditor General on Emergency Departments 2010' warns that:

> *“the distinction between the role of EDs and Minor Injury Units is not always clear, making it difficult for staff and the ambulance service to know where to bring patients”.*

The number of EDs per head of population is similar in the Republic of Ireland to that found in Scotland. Numbers of EDs per head of population in Northern Ireland exceed that in the Republic.

The Royal College of Nursing and the Royal College of Emergency Medicine in the United Kingdom offer this advice for health-care planners who attempt to curtail Accident and Emergency in the hope that patients might be directed to other services:

> ‘*After more than twenty years of unremitting growth in attendances, the power of the A&E brand shows no sign of weakening. Instead of mounting endless initiatives in the hope rather than expectation that demand might in some way be curbed, the government of the day would be better served by planning for the reality of higher attendances and admissions.’*

(The Medicine Needed for the Emergency Service. Royal College of Emergency Medicine & Royal College of Nursing)

The ED at MRH Portlaoise is a high-volume service. Attendance levels at 36,000 per annum are among the highest of any of the hospitals outside the major urban centres. In formulating a strategy for patients in the Midlands, planners must have regard for these figures and ensure that there is capacity to meet this demand.

There is however, no capacity within the region to accommodate people elsewhere who currently attend ED at MRH Portlaoise. TrolleyGAR figures for the first 6 months of 2016 show a crisis of capacity with trolley figures at MRH Portlaoise, MRH Tullamore, and Naas General Hospital all increasing.

The ED at MRH Portlaoise has suffered historically from under-resourcing. Under-resourcing that threatens the viability of this unit, notwithstanding the clear demand for the service.

The National Emergency Medicine Programme recommends that a type A2 ED be located at a DCSP Model 3 hospital. The core specialities and diagnostics

recommended by the Programme are established on site at MRH Portlaoise to support a type A2 unit.

An A2 unit provides care 24/7 for patients with unselected undifferentiated emergency problems who self present or are brought by ambulance to the unit. According to the Programme *'Unstable or higher acuity patients, whose care needs cannot be met at this unit can be transferred according to national protocols and by appropriate means to a designated networked hospital.'* Paediatric patients can attend A2 EDs and each should employ at least one Consultant with sub-specialty training in paediatric emergency medicine among the department's staff.

In terms of staffing resource, the programme recommends:

'Consultant in emergency medicine staffing levels should be such that it is feasible and sustainable to provide a Consultant presence in the ED from 08:00-20:00hrs on weekdays with a sessional commitment at weekends.'

'There will be 24/7 Consultant in EM on-call cover for this ED.'

'There will be a full range of appropriate therapy and Medical Social Worker services for this unit.'

We recommend that the ED at MRH Portlaoise be resourced and staffed to provide a type A2 Emergency Department in keeping with the DCSP Model 3 hospital.

We recommend that the ED is supported by a AMAU in keeping with the DCSP Model 3 plans for acute hospitals.

We note that key interdependent services as outlined in the Emergency Medicine Programme are available on site. **We recommend that these services be developed as set out in sections 7.1, 7.3, 7.4, 7.5, 7.6, & 7.7 of this document.**

We recommend that the ED at MRHP be integrated in the Emergency Medicine Network.

We recommend that protocols are developed to allow seamless access to services not available on-site at MRH Portlaoise.

Department of Obstetrics & Gynaecology

The obstetric department at MRH Portlaoise comprises a 29-bedded ward, an Early Pregnancy Assessment Unit, OPD, and a Special Care Baby Unit. The department is supported by the anaesthetic team. HDU care for obstetric patients is provided in the ICU at MRH Portlaoise. Key interdependencies for the obstetric & Gynaecolgy department are with paediatric, surgical and medical units.

As there is no Obstetric & Gynaecology service in either Naas or MRH Tullamore, there is a large geographical catchment area for the service (Laois, Offaly, South Kildare, North Tipperary and parts of Carlow).

In all, 1606 babies were delivered at the unit last year. There is no capacity in the region or in units in Dublin to absorb these numbers in the event of a downgrade.

'Creating a better future together - national maternity strategy 2016-2026' outlines a vision for maternity services in Ireland where:

> "*Women and babies have access to safe, high quality care in a setting that is most appropriate to their needs; Women and families are placed at the centre of all services, and are treated with dignity, respect and compassion; parents are supported before, during and after pregnancy to allow them give their child the best possible start in life".*

The realisation of this vision requires that:

1. A health and wellbeing approach be adopted
2. Women have access to safe, high-quality, nationally-consistent, women-centred maternity care
3. Women's choice be facilitated
4. Maternity services be appropriately resourced, underpinned by strong and effective leadership, management and governance arrangements, and delivered by a skilled and competent workforce in partnership with women.

MRH Portlaoise women's services are attempting to realise this vision by participating in Ireland's first Managed clinical network with the Coombe Women and Infant's University Hospital (CWIUH) under the guidance of the Dublin Midlands Hospital group.

This clinical network envisages a women-centred approach locally with streamlined access to more specialised care in the tertiary centre. The Managed clinical network has a steering group consisting of the CEO of DML hospital group, the Master /CEO CWIUH , the General Manager MRHP and the Clinical Director for Integration.

Appointments made to date under the auspices of this network have included; Clinical Director for Integration, Director of Midwifery, Two Consultant Obstetrician /Gynaecologists with joint appointments with MRHP and CWIUH, and two Consultant Neonatologists again with Joint appointments with MRHP/CWIUH/OLHC.

To date, access to ultrasound services has been greatly enhanced for women attending MRHP and a training programme for Midwives in MRHP in Ultrasound scanning is in progress in CWIUH. Such services will be provided locally in the future with access to specialised Fetal Medicine consultants using the NIMIS system.

Patient pathways in both hospitals have been developed and they have been reviewed by women attending the services and are in the process of being implemented.

Women's services will be ultimately under the governance of CWIUH.

This first managed clinical network using the women's services as a pilot offers an alternative to centralisation of services.

We recommend that this clinical network continues to be pursued at the Department of Obstetrics & Gynaecology MRH Portlaoise.
We recommend that this template for healthcare delivery be extended to other clinical departments at MRH Portlaoise to help ensure safe, high-quality, nationally-consistent services locally in addition to streamlined access to tertiary services.

Paediatrics

The hospital has a 25-bedded paediatric ward and an 8-bedded special care baby unit (SCBU).

Approximately 12,000 children present for emergency, unscheduled care each year to the hospital, 7,000 of whom are cared for directly by the paediatric medical team. The remaining 5,000 children are cared for by the ED and surgical teams. This overall figure has doubled in the past 15 years.

There are four Consultant Paediatricians who provide 24/7 on call to; the labour ward, Special Care Baby Unit, paediatric ward and the emergency department. Subspecialist interests of the paediatricians include: diabetes and endocrinology, respiratory medicine, neurodisability and neonatology.

As there is no paediatric service in either Naas or MRH Tullamore, there is a large geographical catchment area for the service (Laois, Offaly, south Kildare, north Tipperary and parts of Carlow). Paediatric services rely on anaesthetic (critical care), ED, radiology and surgical support.

A neonatal transport team is available 24/7 to ensure the safe transport of babies requiring tertiary neonatal care.

The Paediatric retrieval team is currently available 9-5, Monday-Friday for assistance in the transfer of children to Paediatric Intensive Care Units in Our Lady's Children's Hospital Crumlin or Children's University Hospital, Temple Street.

The Paediatric Early Warning Score (PEWS) and Irish Children's Triage System (ICTS) have been implemented in MRH Portlaoise. The department has formal academic links with both University College Dublin and University of Limerick medical schools. It plays a vital role in the training of junior doctors including; General Practice, Paediatric (SHO and SPR) and emergency medicine trainees.

Downgrading Portlaoise hospital to a model 2 hospital will mean that safe acute paediatric services can no longer be provided or sustained. As a consequence there will be no maternity service.

We believe that families and children who use the paediatric service deserve a well-resourced, safe and effective service so that care can be delivered locally and as close to home as possible, as per the paediatric model of care.

Two Consultant Neonatologists have been appointed to take up position in November 2016. The appointments are structured as part of the Managed Clinical Care Network with the Coombe Hospital. These specialists will divide their time on a structured basis between the Special Care Baby Unit in MRH Portlaoise, the Coombe Women's and Infants University Hospital and Our Lady's Children's Hospital Crumlin.

Challenges for General Paediatrics at MRH Portlaoise include:

1. Consultant numbers remain below that recommended by the paediatric clinical programme / model of care.
2. Two separate points of access remain for children presenting acutely. Those with surgical issues are triaged in the main ED and those with medical paediatric problems are triaged on the paediatric ward
3. There is no social worker available in the hospital: this causes particular problems relating to child protection cases

- **We recommend that the general paediatric department at MRH Portlaoise be resourced according to the Paediatric Model of care.**

- **We recommend that the paediatric team continue to provide 24/7 cover to the ED, Special Care Baby Unit, Paediatric ward and the labour ward.**

- **We recommend that key supporting specialities of Critical Care Medicine, Obstetrics & Gynaecology, General Surgery, Emergency Medicine and Radiology be developed as set out in sections 7.1, 7.2, 7.3, 7.6 and 7.7 of this document.**

- **We recommend that the paediatric ED be co-located with the adult ED to enable all children, whether presenting with a medical or surgical problem to have a single point of access and triage.**

- **We recommend the commissioning of a paediatric assessment unit (PAU) to manage children who require a short stay admission (<12 hours).**

- **We recommend that formal links between the National Paediatric Hospital Group continue to develop to allow shared care of sick children with complex medical problems and to enable more of that care to be delivered locally.**

We anticipate that the appointments of consultant neonatologists as part of the Managed Care Network with the Coombe Women's and Infants University Hospital will strengthen and extend the level of care that can be delivered at MRH Portlaoise, facilitating both the return of children earlier from intensive care in major centres to the local unit and the transfer of children to those central units.

Acute Medicine

The hospital has a 39-bedded medical unit. This includes a 4-bedded CCU. There are five consultant physicians, who provide a 24-hour on-call service admitting unselected medical patients. Support services include cardiac diagnostics, cardiac rehabilitation, nurse-led heart failure, valvular heart disease, diabetes including rapid access diabetes, and general medicine clinics.

The national early warning score, and the national sepsis protocol have been implemented in MRH Portlaoise.

Medical inpatient attendances have increased from 3024 in 2008 to 4000 in 2015. Occupancy rates for the medical unit at MRH Portlaoise exceed 100 percent. TrolleyGAR figures show that unacceptably high numbers of patients requiring general medical care are accommodated on trolleys in ED. This year to date on average between ten and fourteen patients were boarded overnight on trolleys in ED at MRH Portlaoise (the corresponding figures in 2015 ranged between 4 and 9).

A bed-utilisation review in 2014 found that a complement of 46 medical beds minimum was required at MRH Portlaoise (current complement 39).

Challenges for general medicine at MRH Portlaoise include:

Workload exceeds available resources. MRH Portlaoise did not share in the expansion in consultant numbers in the Celtic Tiger years. The unit's funding has been cut from an already low base in recent years. These years of cut-back have coincided with a sharp increase in activity.

There is a concentration of sub-specialty resource in the major urban centres. Beds in these centres are difficult to access for in-patients elsewhere in the system as ED patients at those units take precedence.

An AMAU awaits commissioning on site.

ICU care for complex medical patients is provided by in-house medical teams. The range of disciplines available in larger centres to care for people with complex illness is not available at MRH Portlaoise.

No consultant specialising in care of the elderly is in post at MRH Portlaoise.

We need to support this unit to provide a service for the patients it can efficiently and safely care for, while ensuring that patients have access to appropriate subspecialist care when required.

We reject the solution set out in the draft plan for acute medicine at MRH Portlaoise. Large numbers of patients rely on MRH Portlaoise for care, which can be provided there safely and effectively. In the unwelcome event that the hospital is downgraded, our patients will find themselves reliant on distant units that do not have capacity for them.

We recommend that the acute medicine at MRH Portlaoise be resourced according to the Acute Medical Programme (AMP).

We recommend that the in-house acute medicine team continue to provide 24/7 cover for the ED department at MRH Portlaoise.

We recommend that consultant numbers be expanded in keeping with the AMP.

We recommend that the commissioning of the AMAU be advanced.

We recommend that key supporting specialties of Critical Care Medicine and Emergency Medicine be developed as set out in sections 7.1 & 7.2 of this document.
We recommend a protocol-driven transfer policy for appropriate patients escalated to ICU level care, as set out in section 7.1.

We recommend that the pioneering managed clinical network between MRH Portlaoise and the Coombe Women's and Infant's University Hospital be adopted as a template for sub-specialty care at the Department of Acute Medicine (See Section 7.3). This pioneering model ensures that access to care for patients attending MRH Portlaoise is on an equal footing with people directly attending the tertiary unit. Adoption of this template for healthcare delivery will help ensure safe, high-quality, nationally-consistent services at MRH Portlaoise. In addition the managed clinical network concept can streamline access to services at tertiary level. We recommend that a strategy of shared appointments and shared governance be pursued with a range of tertiary centres in general medicine. We recommend that physicians appointed to such positions have the bulk of their commitment at a tertiary unit. This tertiary unit would in turn provide network support for patients attending MRH Portlaoise in terms of access to diagnostics, treatments and MDT support. These physicians would attend MRH Portlaoise on a sessional basis to assist with the development of protocols, to provide consultation and OPD services, in addition to supporting the AMAU. Services such as respiratory medicine, dermatology, neurology and gastroenterology could all be augmented significantly for the benefit of patients attending MRH Portlaoise in this manner.

General Surgery

The surgical department at MRH Portlaoise provides emergency cover for patients presenting to the ED, in-patient, day-case and OPD services. The team of consultant surgeons provide a 24-hour on-call service. In addition to admitting adults and children who require acute surgical care, the surgical teams provide a consultation service for the medical, obstetrics and paediatric teams.

The surgical unit comprises a 24-bedded inpatient ward and a 15-bedded day ward.

There are 3 operating theatres which are shared with the Department of Obstetrics and Gynaecology and an Endoscopy suite.

Over 4,000 procedures are performed annually by surgeons at MRH Portlaoise

General Surgery at MRH Portlaoise is supported by the Dublin Midlands Hospital Group and patients requiring complex care have access to surgical services elsewhere in the network.

In common with all other centres that are not part of the cancer program, patients who require surgical resection of tumours identified at MRH Portlaoise are transferred to a cancer centre.

We recommend that the surgical unit be resourced according to the surgical programme.

We recommend that key supporting specialties of Critical Care Medicine and Emergency Medicine be developed as set out in sections 7.1 & 7.2 of this document.

We recommend a protocol-driven transfer policy for appropriate patients escalated to ICU level care, as set out in section 7.1.

Diagnostic Radiology

The department of diagnostic radiology at MRH Portlaoise provides 24-hour access to plain films, ultrasound and CT. MRI scanning is provided within the hospital group. Images taken at the department are stored on the National Medical Image Management System (NIMIS). This system allows images taken at Portlaoise to be accessed by teams based elsewhere within the health system.

A rota of four consultant radiologists provide diagnostic support for the clinical departments at MRH Portlaoise, including the emergency department, on a 24 hour basis.

The diagnostic radiology department is in this way configured to meet the requirements set out for Type A2 EDs in the emergency medicine programme:

> '*24/7 immediate access to plain XR in a co-located, dedicated suite.*
> *Immediate 24/7 access to CT and US.*
> *Emergency MRI and Interventional Radiology access 24/7 within the HSE region via protocolised transfer/retrieval.'*

Additionally the department provides direct access scanning for General Practitioners.

There are a number of challenges:

Consultant numbers remain below levels required to meet the workload at MRH Portlaoise. This workload is likely to increase with the commissioning of the AMAU. At present with 40,000 studies per year the recommended complement is 5 full time radiologists.

MRI scanning is provided off-site at MRH Tullamore. The single scanner at MRH Tullamore serves Longford Westmeath General Hospital in addition to MRH Portlaoisr and MRH Tullamore. The MRI provision for the region is not sufficient to meet demand and the waiting times for out patient scans are not acceptable. In addition off-site scanning complicates access to acute MRIs for hospital inpatients at MRH Portlaoise.

We recommend an expansion in consultant radiology numbers at MRH Portlaoise. We recommend that this be pursued through shared appointments.

We recommend that this policy of shared appointments in radiology be developed in tandem with shared appointments in other clinical specialties. These appointments should be configured to facilitate access for patients attending MRH Portlaoise to subspecialty Multidisciplinary Team (MDT) opinion.

We recommend on-site MRI scanning facility be developed at MRH Portlaoise.

Conclusion

This document sets out our vision for services at MRH Portlaoise. We do so in response to a process which has resulted in a draft report which has yet to be shared or discussed with stakeholders and service users.

The proposal that consultation with local stakeholders and service user should start after the report has been finalised is neither an adequate nor a reasonable method of ensuring that the voice and needs of service users guide the future for MRH Portlaoise.

Reconfiguration of health services in Ireland has involved the centralisation of services. The downgrade of MRH Portlaoise from a Model 3 to a Model 2, if implemented will result in the closure of the hospital’s acute services, including the centralisation of paediatric and obstetric services to Dublin hospitals. It will force patients who currently rely on care at MRH Portlaoise to look elsewhere within an already over-crowded system.

International evidence can be found to support centralisation of services only for patients with certain illnesses that require specific interventions. Centralisation of services otherwise creates many risks for service users. These risks are compounded in a context where there is no alternative capacity to care for patients who currently rely on MRH Portlaoise for care.

We believe that the safe and correct way to proceed is to continue to provide acute services at MRH Portlaoise. We have emphasised the interdependencies that are critical for maintenance of safe acute services at MRH Portlaoise. We recommend that the managed clinical network between MRH Portlaoise and the Coombe's Women's and Infant's University Hospital provide the template for development across the range of specialities at MRH Portlaoise. We believe that our plan provides for safe, sustainable and effective care.

We do not make an argument for the status quo. People in this area of the Midlands have seen their health care under-resourced. They deserve just provision for acute and sub-specialty care according to the values of patient-centredness, safety, effectiveness, efficiency, access, and equity, as espoused in the National Standards for Healthcare.

Recommendations

A code of practice must be developed to guide the planning of reconfiguration within the hospital service.

The views of service users and local stakeholders must be sought and demonstrably taken into account when reconfiguration is considered.

Concepts of clinical justice and fairness must be considered when planning access to health services.

Re-configuration must only where it can be shown to be in the interests of patients.

Critical Care

We recommend that the current Critical Care unit at MRH Portlaoise be re-configured as a Category 1 ICU.

We recommend that functioning reliable networks and pathways be established through shared appointments and protocol-led seamless patient transfers with a regional Category 2 or 3 ICU.

Emergency Department

We recommend that the ED at MRH Portlaoise be resourced and staffed to provide a type A2 Emergency Department in keeping with the DCSP Model 3 hospital.

We recommend that the ED is supported by a AMAU in keeping with the DCSP Model 3 plans for acute hospitals.

We note that key interdependent services as outlined in the Emergency Medicine Programme are available on site. We recommend that these services be developed as set out in sections 7.1, 7.3, 7.4, 7.5, 7.7 of this document.

We recommend that the ED at MRHP be integrated in the Emergency Medicine Network.

We recommend that protocols are developed to allow seamless access to services not available on-site at MRH Portlaoise

Department of Obstetrics & Gynaecology

We recommend that the clinical network between MRH Portlaoise and the Coombe Women's and Infant's University Hospital continues to be developed.
We recommend that this template for healthcare delivery be extended to other clinical departments at MRH Portlaoise to help ensure safe, high quality, nationally consistent services locally in addition to streamlined access to tertiary services.

Department of Paediatrics

We recommend that the paediatric department at MRH Portlaoise be resourced according to the Paediatric Model of care.

We recommend that the paediatric team continue to provide 24/7 cover to the ED, Special Care Baby Unit, Paediatric ward and the labour ward.

We recommend that key supporting specialities of Critical Care Medicine, General Surgery, Emergency Medicine and Radiology be developed as set out in sections 7.1, 7.2, 7.5, 7.6 and 7.7 of this document.

We recommend that the paediatric ED be co-located with the adult ED to enable all children, whether presenting with a medical or surgical problem to have a single point of access and triage.

We recommend the commissioning of a paediatric assessment unit (PAU) to manage children who require a short stay admission (<12 hours).

We recommend that formal links between the National Paediatric Hospital Group will continue to develop to allow shared care of sick children with complex medical problems and to enable more of that care to be delivered locally.

Acute Medicine

We recommend that the acute medicine at MRH Portlaoise be resourced according to the Acute Medical Programme (AMP).

We recommend that the in-house acute medicine team continue to provide 24/7 cover for the ED department at MRH Portlaoise.

We recommend that consultant numbers be expanded in keeping with the AMP.

We recommend that the commissioning of the AMAU be advanced.

We recommend that key supporting specialties of Critical Care Medicine and Emergency Medicine be developed as set out in sections 7.1 & 7.2 of this document.

We recommend a protocol-driven transfer policy for appropriate patients escalated to ICU level care, as set out in section 7.1.

We recommend that the pioneering managed clinical network between MRH Portlaoise and the Coombe Women's and Infant's University Hospital be adopted as a template for sub-specialty care at the Department of Acute Medicine**.**

General Surgery

We recommend that the surgical unit be resourced according to the surgical programme.

We recommend that key supporting specialties of Critical Care Medicine and Emergency Medicine be developed as set out in sections 7.1 & 7.2 of this document.

We recommend a protocol-driven transfer policy for appropriate patients escalated to ICU level care, as set out in section 7.1.

Diagnostic Radiology

We recommend an expansion in consultant radiology numbers at MRH Portlaoise. We recommend that this be pursued through shared appointments.

We recommend that this policy of shared appointments in radiology be developed in tandem with shared appointments in other clinical specialties. These appointments should be configured to facilitate access for patients attending MRH Portlaoise to subspecialty Multidisciplinary Team (MDT) opinion.

We recommend on-site MRI scanning facility be developed at MRH Portlaoise.

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LauraLynn, Ireland’s Children’s Hospice

Estimates suggest that there are almost 4,000 children with a life-limiting condition in Ireland, half of whom have palliative care needs. For children with palliative care needs, parents are most often the main providers of care and despite struggling to cope with the diagnosis of a life-limiting condition; home remains the care location of choice for most parents. As a result of limited primary care services in Ireland parents often struggle to access the care that their child requires. Ultimately children’s palliative care needs are best met through an integrated coordinated approach involving all stakeholders including hospice, hospital-based teams, voluntary organisations, community and primary care teams, and specialist palliative care where necessary.

LauraLynn, Ireland’s Children’s Hospice has cared for more than 300 children and their families over the last five years and as such is well placed to contribute to the discussion and development of future models of healthcare in the area of children’s palliative and hospice care in Ireland.

We would ask this Oireachtas Committee to give consideration to a suitably resourced and funded approach to children’s palliative care based on an equitable, integrated coordinated approach involving all stakeholders to ensure that families have choice and access to holistic care across the disease trajectory to enhance the quality of life of children and adolescents with life-limiting condition.

We would ask that the Committee also consider the delivery of healthcare within the third sector. The sector is a significant contributor and is a vital resource in the delivery of healthcare in Ireland. Sadly it is often overshadowed by poor governance and a lack of regulation but this should not detract from the valuable contribution made by the highly skilled professionals who are employed by the healthcare charities and not for profit organisations.

Background

It is estimated that there are close to 4,000 children with a life-limiting condition Ireland, half of whom have palliative care needs. Sadly about 350 children die each year from life-limiting conditions, most within their first year of life.

LauraLynn, Ireland’s Children’s Hospice is the only paediatric hospice in the State. Our vision is that all children who need palliative care can access it. Opened in September 2011, LauraLynn has cared for more than 300 children and their families, supporting 95 children to die well. Referrals rates have risen greatly, with 78 new referrals received from across Ireland in 2015.

LauraLynn care is delivered by team of healthcare professionals and volunteers in our hospice, at hospital, in the community, or in the family home, depending on the child and family’s preference. It focusses on enhancing quality of life, which includes physical comfort and wellbeing, as well as the emotional, social and spiritual aspects of care of the family, supporting them from the point of diagnosis to end of life, and throughout bereavement, with a range of nursing, practical, emotional and medical care.

Children’s Palliative Care

“Children’s Palliative Care is an emerging subspecialty. It provides holistic and integrated care across the disease trajectory to enhance the quality of life of children and adolescents with life-limiting conditions”[1].

Children’s palliative care is marked by uncertainty. In particular it is difficult to predict how long a child will survive with a life-limiting condition. Depending on diagnosis many children experience several episodes where it appears that they are at end of life; therefore planning for care is challenging with each episode requiring the same level of support whether the child dies or not. As children with life-limiting conditions may be close to death many times, this presents a compelling argument as to why childhood deaths are a poor indicator of the need for end of life and palliative care. Furthermore despite having a life-limiting condition and often having experienced several potentially end of life episodes when a child dies, parents often report feeling unprepared.

For children with palliative care needs, parents are most often the main providers of care and despite struggling to cope with the diagnosis of a life-limiting condition; home remains the care location of choice for most parents. In children’s palliative care, the child and family are viewed as the unit of care. Ideally support for children with palliative care needs should begin at the time of diagnosis and for many children with life-limiting conditions this can be at the time of birth. Most children have their care needs met by their family at home with mothers usually taking on the role of primary carer often with the support of locally based services. Currently, the provision of services to children with life-limiting condition depends on diagnosis and the geographical location of the family home.

As a result of limited primary care services in Ireland parents often struggle to access the care that their child requires. Respite (either in the home or away from the home in units such as LauraLynn) is viewed as a key component of children’s palliative care enabling parents to cope with the everyday routine of caring for their sick child and allowing them time to undertake everyday tasks such as shopping or importantly spending time with their other children.

For children with life-limiting conditions the preferred place of care and ultimately death is the family home. The provision of support such as respite and the break that this provides enables families to continue caring for their child. Whilst many parents wish their child to die at home this is not always possible and in such cases families may choose hospital or hospice as their desired place of care at end of life.

We would ask the Committed to give consideration to a suitably resourced and funded approach to children’s palliative care based on an equitable, integrated coordinated approach involving all stakeholders to ensure that families have choice and access to holistic care across the disease trajectory to enhance the quality of life of children and adolescents with life-limiting condition.

Third Sector Healthcare Delivery

Community / Volunteer Involvement

Community involvement extends beyond that of health care professionals and many third sector organisations rely heavily on volunteer support. Such community ownership and involvement in local healthcare services is beneficial for society as a whole and has been shown to contribute to individual wellbeing. There is also the obvious advantage of reduced pay costs.

Governance

In addition, the third sector has been called upon, more so in recent times, to provide clear evidence of how donated and fundraised income is used for service provision, producing a level of accountability which can only be good for the healthcare sector as a whole. The requirement to clearly demonstrate how funds are used requires sound governance and good financial management – both of which are clearly required in any service delivery model.

Service gaps

Many charity and not for profit organisations were established to provide a much needed service and to fill a recognised gap in the current service delivery model. The majority focus on delivering care in a community / primary care setting. The provision of hospice care is one such example whereby care is provided either in a hospice setting or in the home. Hospice care in Ireland is reliant on fundraised income and many services would cease to exist without it. LauraLynn Children's Hospice is the only children's hospice in the Republic of Ireland and depends on the generosity of the public and corporate donors. Approximately 300 families have used the children's hospice since it opened in 2011. Without such services, choices regarding the care of a child with a life limiting condition and the location for end of life care are very restricted, with many children having no option but to attend the acute services for palliative care, care that could and should be provided in a hospice.

Many children and adults who access acute care do so because the care they require is absent in community and primary care. Of the estimated 4,000 children in Ireland who are life limited, the majority can be appropriately cared for in the community with the support of the community healthcare teams and their GP, in addition to hospice care for those who require palliative care.

Skilled workforce

LauraLynn cares for children with extremely complex and unpredictable health needs who require constant care and attention. Such care requires highly skilled and specialised clinicians with a clear education and training and competency assessment programme in place. Organisations such as LauraLynn who provide 24/7 care in the community, must operate within a framework of good clinical governance, risk management is vital given the potential impact of an incident on the reputation of the organisation and funding sources.

Funding

Many charity and third sector organisations are in receipt of some HSE funding through a service level arrangement, with some operating as a section 38 or 39 service provider. I would ask the committee to consider greater equity regarding the allocation of funds to those organisations who do and to those who don't receive any funding, with an increased focus on those services providing direct care. Commissioning of services to those within the private and third sectors requires further exploration and has the potential to deliver an increase in the quality, access and value of care provided. Such a move would require the clear streamlining of care and services – clinical pathway development – a function the national clinical care programme currently provides, but with a limited resource.

Third Sector contribution

Services such as LauraLynn have a valuable contribution to make in the provision of healthcare within the community setting, supporting primary and acute care services. I would ask the committee to consider increasing the involvement and use of such services in the overall provision of healthcare and to ensure they are included in future model and pathway development.

We would ask that the Committee also consider the delivery of healthcare within the third sector. The sector is a significant contributor and is a vital resource in the delivery of healthcare in Ireland. Sadly it is often overshadowed by poor governance and a lack of regulation but this should not detract from the valuable contribution made by the highly skilled professionals who are employed by the healthcare charities and not for profit organisations.

https://lauralynn.ie/

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1. Collins A, Hennessy-Anderson N, Hosking S, Hynson J, Remedios C, Thomas K. (2016). Lived experiences of Parents Caring for a Child with a Life-Limiting Condition in Australia: A qualitative study. Palliative Medicine

Laya Healthcare

Laya healthcare (LHC) is a major contributor to the Irish economy, employing more than 500 people in its offices in Dublin and Cork. LHC is Ireland's second largest private healthcare insurer with more than half a million members and the largest health and wellness provider in the country. While looking after health insurance requirements and supporting health and wellness needs are our top priorities, we are an integral stakeholder in the Irish health system and want to play a role in designing and implementing a better healthcare model that benefits *all* of society**.**

LHC believes that in order to move to a one-tier system that is equitable and achieves better patient care, a reconfiguration of the healthcare model is required in collaboration with key stakeholders including Government, hospitals, public representatives, clinicians, governing bodies, patients and health insurers.

However in order to have a successful transition to a one-tier health system, a robust private health insurance (PHI) market is critical.

More than 272,000 people dropped their PHI cover[21] between 2008 and 2014 because of the rising cost of premiums. Premiums continue to be negatively impacted by the significant increase in the cost and volume of claims, largely driven by public hospitals.

For most people with cover, PHI isn't a luxury, it's a necessity. This is understandable; Ireland has an overstretched public health system experiencing record waiting lists, with 530,000[22] people currently waiting for an outpatient appointment, surgery or diagnostic procedure. Rising premiums will not only drive current and potential members away from PHI, it will lead to more pressure on the over-stretched public health system.

Furthermore, government policy decisions that increase PHI premiums are counter intuitive to the Government's Lifetime Community Rating initiative, which saw an additional 95,000[23] take out PHI in 2015/2016, and the long-term goal of universal health insurance for all.

LHC has identified six priority areas we believe will have a transformational impact on the provision of an efficient healthcare service in Ireland, while continuing to have the patient at the heart of all future policy decisions. LHC recommends:

Restoring stability and affordability to the PMI market

1. The evolution of the primary healthcare service to one in which GPs provide a wider range of services than currently on offer
2. The implementation of Care Pathways which take a multi-disciplinary approach to diagnosis, treatment and care in a co-ordinated manner
3. Incentivising best practice and addressing inefficiencies in the health system through collaboration with healthcare providers and insurers and implementing more efficient practices through reviewing current practice and best practice guidelines
4. The universal use of DRGs across the healthcare system for a more efficient and equitable service

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[21] Health Insurance Authority, May 2016 newsletter

[22] National Treatment Purchase Fund statistics, published in August, 2016

[23] Health Insurance Authority, May 2016 newsletter

5. Government policy support of healthier choices and keeping people well through the introduction of initiatives to incentivise companies to support the health and wellbeing of employees in both the public and private sectors.

We are aware our recommendations are not without challenges, which we outline in this document.

LHC welcomes the opportunity to consult and collaborate further with Government, and our wider partners in health, to finalise a vision and strategy that deliver on our shared goal of creating a fair and equitable model of healthcare that drives greater efficiencies and better patient outcomes.

Key Priorities

Restoring Stability & Affordability to the PMI Market

In 2008, 2.3 million people (50.9% of the population) held health insurance in Ireland. The figure today stands at 2.1 million, with multinationals accounting for 10+% of the market[24].

Health premiums have been steadily increasing over the past decade, largely in line with a corresponding increase in the volume and cost of claims. The issue was highlighted in an independent report[25] submitted to the Minister for Health and Health Insurance Council by Pat McLoughlin, Chair of the Government's Cost Review Group. This report concluded that unless the rising cost of health premiums is tackled robustly, the percentage of the population covered will continue to drop, thereby **exacerbating the burden on the public system**.

McLoughlin warned of further significant rises in claims costs and volumes driven by a reduction in **income tax relief**, **bed charges at full economic cost for private patients in public hospitals,** and the **new charges for private patients who occupy public beds.**

As well as the impact on individuals, if premiums continue to rise, many businesses may be forced to remove a core benefit of employee PHI, which will also impact on Ireland's economic competitiveness.

As the country continues its economic recovery, stabilising the PHI market and making health insurance affordable for as many people as possible is critical for the transition to a one-tier system that champions better patient outcomes for all.

<u>To achieve these goals, LHC recommends restoring stability and affordability to the PMI market through the following means:</u>

A reduction of The Public Beds Re-Designation Charge. In 2014 the Government increased the costs for private patient stays in public hospital beds from €75 up to €813 a day, on admission via A&E, with no increase in services. Two years on, LHC is seeing the full financial impact of the public bed charges and a detailed analysis reveals:

- A **26 per cent increase in the cost of claims**
- A **10 per cent increase in the volume of claims**

with no simultaneous increase in efficiencies.

Risk equalise for a single advanced product and a single non-advanced product. Regarding the **Risk Equalisation Scheme** there is a need to ensure that the combination of age credits, HBUC and any other future proxy for health status do not overcompensate any insurer. The compensation level for any age group should be maintained at or above a net claims cost of 130% of the market average net claims cost.

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[24] American Chamber of Ireland Budget Submission, 7th October 2014

[25] Review of Measures to Reduce Costs in the Private Health Insurance Market 2013

Increasing Tax Relief at Source: Budget 2014 reduced the amount of tax relief at source for health insurance policies on premiums in excess of €1,000, resulting in 90+% of policy holders having to pay more for their health insurance.

Develop Primary Care Services

The primary care service is the lynchpin of a robust health system and the cornerstone of prevention and early intervention to support general health. Further developing primary care services is fundamental to achieving a more efficient health service and is a significant step towards greater and more equitable access to timely healthcare for all citizens. This would be of direct benefit not only to patients but to hospital waiting lists, currently standing at 530,000[26].

The development needs to incorporate:

Treating patients in an appropriate setting

At LHC, we have conducted a clinical review of hospital procedures across a range of specialties, identifying a significant number of procedures that do not necessitate hospital admission and could be carried out in a primary care setting if the right infrastructures were in place.

Patients would benefit by being provided with efficient, localised care in an appropriate setting and at an appropriate cost. The benefit to the healthcare system is that it would simultaneously result in a decrease in unnecessary hospital admissions for minor surgical procedures, freeing up acute hospital services and beds for more complex and acute admissions.

Resourcing facilities

While modern primary care centres do exist, many are not adequately or effectively resourced to cope with a wider breadth or increased complexity of patient procedure.

Telemedicine

Incorporating telemedicine into primary care services appropriately could also help patients with non-emergency ailments and decrease pressure on local primary care centres.

LHC recommends the evolution of a healthcare service that would see GPs provide a wider range of services than currently on offer.

Integrated Care Pathways

Any plan for the future of healthcare in Ireland needs to allow for the development and implementation of a standard set of tools that manages the quality of healthcare patients receive. The WHO's Reproductive Health Library states that: *The use of clinical pathways appears to have a favourable impact on patient outcomes, length of hospital stay, hospital costs and professional practice*[27]*.* It is imperative that there is a reduction in the variability, inconsistency and even the 'element of luck' that exist right across the health service, depending on where you live, where you are being treated and by whom.

Care Pathways promote organised, efficient and consistent levels of care based on evidence-based practice, which optimises outcomes for patients. An example of this approach can be seen under the National Cancer Control Programme (NCCP), which moved from a position of 33 hospitals delivering

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[26] National Treatment Purchase Fund statistics, published in August, 2016

[27] http://apps.who.int/rhl/effective_practice_and_organizing_care/cd006632_haddadsm_com/en/

care in a fragmented manner to the creation of eight designated centres for cancer care in Ireland, leading to better patient outcomes[28].

LHC recommends the implementation of Care Pathways that detail what to do, when and by whom and in which setting and are gateways to the creation of Centres of Excellence, which take a multi-disciplinary approach to diagnosis, treatment and care in a co-ordinated manner.

Controlling Costs and Addressing Inefficiencies in both Public and Private Hospitals

We believe that quality healthcare and cost effectiveness should not be mutually exclusive. We undertake a programme of Utilisation Review (UR), which is a clinical review of claims to ensure the delivery of high-quality, cost-efficient healthcare for our members is in line with best practice clinical guidelines. It is designed to evaluate the quality and cost of medical services from healthcare providers. UR is now fundamental to our claims management strategy and is a proven safeguard against unnecessary and inappropriate care. Our UR has already led to a number of efficiencies including:

- **Reducing length of stay for medical admissions and surgical procedures**

- **Treating patients in the right setting:** we have identified a significant percentage of medical admissions that could have been treated as outpatients or in an ambulatory / primary care setting.

LHC recommends addressing inefficiencies in the health system through:

- Greater collaboration with key stakeholders, including health insurers who have a significant level of expertise with medical services’ cost control strategies, to review:
    - Evidence of current practice
    - Adherence to best practice guidelines
- As a result of this collaborative review, working with healthcare providers to put in place more efficient and appropriate practices

Universal Application of Diagnostic Related Groupings (DRGs)

A DRG is a patient classification system and the basis for establishing medical reimbursements. Rather than paying the hospital for what it spent caring for a hospitalised patient, the theory is that the insurer pays the hospital a fixed amount based on the patient’s DRG or diagnosis. DRGs incentivise efficiencies and remove the incentive to over-treat or keep patients in hospital unnecessarily. The DRG incentivises the hospital to ensure correct diagnosis from the outset.

From a policy and resource perspective, collecting data on patients through the DRG system facilitates health resource planning. The Minister for Health, Simon Harris TD has stated that using DRG data for a more efficient and fair risk equalisation scheme will require the collection and coding of all hospital activity data for both public and private hospitals[29]. LHC recognises the role private insurers have to play in encouraging the use of DRGs by private hospitals. Equally, we recognise the role DRGs can play in helping to control costs and ensuring best practice in relation to patient care.

LHC recommends that the universal use of DRGs across the healthcare system is a requisite for a more efficient and equitable service.

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[28] http://www.hse.ie/eng/services/list/5/cancer/about/services/

[29] https://www.kildarestreet.com/wrans/?id=2016-06-08a.1075

Health & Wellness in the Workplace

Early intervention and prevention have a significant impact on keeping our populations healthier, for longer. LHC recommends that more is done to keep people well and that Government policy should support the notion that the healthier choice should be the easier choice with the introduction of initiatives to incentivise companies to support the health and wellbeing of staff.

According to the World Health Organisation (WHO), workplace health programmes are one of the best ways to prevent and control chronic disease and support mental health[30]. The impact that the workplace can have on health and wellbeing is increasingly recognised at international level.

A formal Government initiative or statutory instrument would support Healthy Ireland's[31] agenda of taking a preventative approach to health and wellness and could take the form of **a grant or tax incentive** for pre-determined workplace programmes such as:

- Heart screening, diabetes testing and blood pressure testing
- Occupational health programmes
- Workplace programmes on diet, nutrition, physical activity, mental health
- Workplace programmes to address financial health / stress related health

While such a measure would come at a cost, the positive impacts for employers, employees and the State have the potential to render this initiative economically viable given:

- IBEC estimates that workplace absenteeism is costing businesses in Ireland €1.5 billion per year[32]
- The fiscal burden on the State:
  - Almost 59,000 people received State Illness Benefit in 2013 at a direct cost to the Exchequer of around €650m[33]
  - Absenteeism means that the State loses out on payroll deductions (tax, PRSI, USC)

LHC is a strong advocate of initiatives that support health and wellbeing in the workplace. We have the largest health and wellness offering that spans a wide spectrum of health needs; both physical and mental. We also fund SuperTroopers, which is a health homework programme in which 1,000 primary schools across Ireland are taking part in with the aim of embedding healthy attitudes towards nutrition and fitness from an early age to ensure a healthier adult population in the future.

While some companies in Ireland have dedicated health & wellness policies, many more do not have the resources to do so and the need for Government support in this area has never been greater.

<u>LHC recommends that more is done to keep people well and that Government policy should support healthier choices with the introduction of initiatives to incentivise companies to support the health and wellbeing of staff.</u>

Challenges to Achieving a Universal Single Tier Health Service

The WHO has advocated universal healthcare as the best means of improving global health and in principle, LHC supports this view. It takes a patient-focused approach to healthcare with all citizens having equal access to primary, hospital and acute medical care, regardless of income. Achieving it is not without its challenges:

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[30] http://www.who.int/occupational_health/healthy_workplaces/en/ *

[31] http://www.healthyireland.ie/about/

[32] IBEC – A Guide to Managing Absenteeism

[33] DSP (2014) Statistical Information on Social Welfare Services 2013

CHALLENGE	DETAIL / SOLUTION
Affordability of PHI for the consumer	- Risk equalise for a single advanced product and a single non-advanced product - Reduce the Public Beds Re-designation charge - Regarding the Risk Equalisation Scheme, the compensation level for any age group should be maintained at or above a net claims cost of 130% of the market average net claims costs - Increase Tax Relief at Source for insured
Integrating services around the patient	- Open up consultation between key stakeholders including opening up negotiation between public hospitals and insurers to ensure the patient is central to all decisions - Engage with public representatives, citizens and communities to involve them more directly with decisions about the future of healthcare and ensure that any integration of services is fully patient-focused
Encouraging health insurers to provide more extensive primary care cover	- If minimum benefits are to be reviewed as part of a standard product, it is vital that primary care benefits are taken into consideration
Agreeing the *basket of services* to be provided under a universal single tier service	- Collaboration between all stakeholders in health
The cost to the taxpayer / the State, the member, insurers, healthcare providers	- Fully costed proposal to ensure early buy-in is critical
Funding	- Government grants and financial incentives to: o Set up satellite centres of excellence o Additional GP fees / facility fees o Insurance for GPs to cover extended procedures o Train/upskill GPs o Develop existing premises o Develop integrated IT systems
Buy-in from health professionals / negotiating new contracts	- Monitor and re-negotiate contracts for both GPs and consultants - Ensuring manageable workloads for GPs - Ensuring minimal financial impact on health professionals due to supporting primary care solution - Embark on pilot scheme
Buy-in from the general public	- Information and education campaign required so patients are comfortable receiving treatment in a GP setting instead of a hospital
Geographical variances / access to care including urgent care	- Ensuring 24-access to care by creating ‘urgent care networks’ that can be accessed at the right time, in the right place when needed - Review potential telemedicine solutions for non-emergency care

Integrated Primary and Community Care

STEPS NEEDED TO MOVE TO A MODEL OF INTEGRATED PRIMARY, SECONDARY & COMMUNITY CARE	DETAIL
Co-ordination of care	- Sharing information among all healthcare providers involved in a patient's case - Patient has access to their medical notes - Integrated Care Pathways with the patient at the heart of decision-making processes
Integrated health IT systems	- Facilitating (appropriate) access to and management of a patient's health at every level; primary, secondary and community - Mandatory e-claims between provider and insurer to reduce administrative burden and achieve faster reimbursement times
Linking healthcare providers on a formal basis	- Clinical community links help to connect healthcare provider, community organisations and other health stakeholders - Improves patients' access to preventative and chronic care services
Pilot scheme	- See example below

Supporting the Transition towards a Model of Integrated Care - Pilot

While undeniably complex to implement, the integration of health and social care has the potential to provide better, more cost-effective services that put the needs of the patient first to deliver the best possible outcomes.

LHC recommends an introduction of a pilot scheme of integrated primary and community care that upon completion could be rolled out across the country. The pilot scheme, based on an appropriate model in a local population, would allow us test and review a balanced integration of primary, secondary and community services. We propose:

- Select one regional area with a large hospital with key local primary, secondary, community and acute care services (for example CUH and Cork hinterland) to facilitate collaborative working and agree a framework of delivery of integrated services
- Set up a steering group, reporting to key officials in the Department of Health, comprising representative stakeholders at both local and national level to co-ordinate the implementation and assessment of the pilot on a phased basis. This group would be tasked with:
    - Investing and strengthening local primary care centres
    - Reviewing funding system, including incentives for participation for the term of the pilot
    - Installing an integrated ICT system to allow primary and secondary services to share data and operate efficiently
    - Setting up proper assessment and reviewing frameworks involving multi-disciplinary groups to establish key learnings and allow iterative changes to be made throughout the pilot scheme

  - Including the experiences of the patient in the assessment of person-centred care
  - Evaluating the pilot
- The group would present the workings and findings of the pilot to the Department of Health
- Following review the model of integrated care could be rolled out on a phased basis.

Proposed Funding Model

According to the Central Statistics Office (CSO), Ireland's health spending is the second highest in the Organisation for Economic Co-operation and Development (OECD) as a proportion of gross national income (GNI). Ireland's €18.4 billion spend on health represented 12.4 per cent of GNI in 2013, when the OECD average was 9.2%[34].

Despite a recent upturn in the economy and falling unemployment levels, additional healthcare funding will pose a huge challenge for the State and there is no evidence to suggest that investing more money in the healthcare system will improve patient outcomes.

This can only be achieved through a re-modelled health system recalibrated to:

- Drive greater efficiencies in healthcare
- Drive down the cost of services
- Deliver greater collaboration between all stakeholders in health
- Facilitate the universal introduction of a DRG system
- Successful implementation and reporting on the Government's Activity Based Funding (ABF) model, which replaces block funding of hospitals

LHC advocates the Money Follows the Patient (MFTP) or ABF[35] funding model, where hospitals are funded based upon the quantity and quality of the services they deliver to patients. It incentivises hospitals and hospital managers by clearly allowing them to see the link between money and the work they do, with targets set to encourage them to pursue the most cost-effective means of meeting these targets.

Examples of Best Practice

This submission doesn't afford a detailed, in-depth analysis of the many viable international models of integration that could work in Ireland (see the Adelaide Health Foundation paper[36]).

However LHC has experienced the Dutch model and believes that, while not without its flaws, it is one of the world's leading models of one-tier healthcare. The main principles applicable to the Irish healthcare system are:

- It is a fully private system, financed through a 'multi-payer' model of compulsory PHI
- There is a significant culture of collaboration – all the players work together for the good of the patient
- A strong foundation of the Dutch healthcare system is the role GPs play in early intervention – preventing unnecessary use of more expensive secondary care and promoting the co-ordination and consistency of individual care. Other best practice models for consideration include the Canadian model, which is 70% funded through taxation and 30% through private health expenditure. Lloyd's Pharmacy

https://www.layahealthcare.ie/

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[34] http://www.cso.ie/en/releasesandpublications/er/sha/systemofhealthaccounts2013/

[35] http://health.gov.ie/future-health/structural-reform-2/money-follows-the-patient/

[36] https://medicine.tcd.ie/public_health_primary_care/assets/pdf/Integrated-Care-Policy-LR.pdf

Lloyds Pharmacy

Our healthcare system is facing major challenge and undergoing significant change. With our population over 65 expected to double by 2036 and the burden of chronic diseases expected to rise by 40% by 2020, radical reform is needed in our healthcare system.

As a core provider of essential healthcare and public health services, community pharmacists have a central role to play in finding solutions to secure the best possible future for the Irish healthcare system and for the patients. We can learn from international experience and the expanded role that pharmacists play in other advanced countries such as the UK, Australia, New Zealand, Canada and US.

With five years of professional training, community pharmacists are highly skilled, trained healthcare professionals. They are the most accessible primary care service providers, with over 1,800 pharmacies nationally and 85 million individual visits made to pharmacies annually.

LloydsPharmacy proposes that, with Government support, the role of the community pharmacist be expanded to include the following services:

- Minor Ailments Scheme
- Medicines Use Reviews
- Extended Vaccination Service
- Chronic Disease Management
- Health Check Service
- Structured Health Promotion Services
- Anticoagulation Service
- Reclassification of Medicines
- First Care Clinics
- Transfer of Care
- Substance Misuse Support
- Needle Exchange Service

The expansion of services provided by pharmacists must be sustained by increased State supports and investment for community pharmacy. This approach would yield significant savings for the State through reduced patient care costs and lower rates of hospital care interventions, reduced GP visits and A&E attendances. At LloydsPharmacy, we strongly believe, and international experience demonstrates, that pharmacists have the requisite expertise, skillset and accessibility to introduce cost-effective extended services. Extended services will help to improve public health and wellbeing and reduce the burdens on our overstretched healthcare system.

Introduction

People are living longer with complex health issues and science and technology are transforming our ability to predict, diagnose and treat disease. With our population over 65 to double by 2036[1] and the burden of chronic diseases expected to rise by 40% by 2020[2], the Irish healthcare system is not fit for purpose. Our core public health challenges include;

Ageing population
Rising burden of chronic disease
Unsustainable public health expenditure growth
Declining number of healthcare professionals
Changing patients' needs
Poor adherence to medicines

Healthcare policymakers must make radical structural and systematic reforms of the healthcare system to remain sustainable and provide a better patient experience and health outcomes. As our economy recovers and Government can again commit resources to enhancing the provision of health services, investment must deliver clear health benefits and facilitate deep impact reform in line with modern models of care to ensure long term sustainability.

Community Pharmacy has a Central Role to Play

As a core provider of essential healthcare and public health services, community pharmacists have a central role to play in finding solutions that will secure the best possible future for our healthcare system and ultimately, for patients. We believe that our dynamic and progressive pharmacy network can support the high-performing, affordable healthcare system envisioned for Ireland. In this submission, LloydsPharmacy will outline how community pharmacies can deliver on Government healthcare priorities, achieve true value for money and how the existing system of resource allocation within the our health service can be improved to support of the aims of the *Healthy Ireland* health reform programme which are:

Better health for everyone
Fair access
Responsive and appropriate care
High performance
Investing in resources where they can make the greatest impact[3]

About LloydsPharmacy

With 94 branches, LloydsPharmacy is Ireland’s largest pharmacy chain. Our geographic footprint gives us reach into communities across the country. We employ over 1,000 people, caring for over 90,000 prescription customers every month. LloydsPharmacy is part of the McKesson Celesio Group, one of the largest pharmaceutical wholesalers and provider of logistics and services in the healthcare sector worldwide. McKesson’s recent acquisition of United Drug Wholesalers shows our commitment to end to end healthcare in Ireland and jobs provision. Our sister company is McKesson Ireland, the company behind the National Integrated Medical Imaging System (NIMIS) project. Our access to expertise and experience in different healthcare markets has never been so significant, giving us even more opportunity to enhance patient care.

LloydsPharmacy in the Community

At LloydsPharmacy, we appreciate the responsibility of treating our patients to the highest standards and embedding our company and colleagues in the local community. Two aspects of this philosophy are key – high quality training of our colleagues and giving back to community through active corporate social responsibility programmes. LloydsPharmacy colleagues are trained to a very high standard, ranging from our Institute of Leadership and Management-endorsed “Manager Development” and “Leadership in Over the Counter Medicine and Advice” programmes, to our soon to be launched NVQ qualification, Dispensary Assistant Programme created exclusively for LloydsPharmacy in conjunction with Carlow IT. Our high standard of training is driven by the desire to always put patients first and ensure our expertise remains relevant. Equally we give back to communities through our flagship health and wellness programme Change Your Health Direction, and our charity partnerships including our corporate charity partner, the Irish Hospice Foundation.

Expanding the Role of the Community Pharmacist

With an average of five years of professional training, community pharmacists are highly skilled, trained healthcare professionals. They are the most accessible primary care service providers, with over 1,800 pharmacies nationally, with 85 million individual visits to pharmacies annually. For many, pharmacists are the first port of call within the healthcare system, playing a vital role in healthcare delivery. However, they remain one of the most underutilised resources in the health service.

When predicting the role that community pharmacists may play in the future, we can learn from international experience and the expanded role pharmacists play in countries such as the UK, Australia, New Zealand, Canada and the US. These countries utilise evidence-based approaches in the modernisation and enhancement of the cost-effectiveness of their pharmacy services by taking lead roles in primary prevention such as minor ailments and secondary prevention in areas like the management of obesity, smoking cessation, medicine use reviews, immunisation, cardiac assessment and monitoring, and detection of certain systemic disease.

The case for the expanded role of the pharmacist is supported through an independent report for the European Commission which called for: '*a change in the definition of pharmacists, expanding from a "dispenser" to an integrated health care professional offering counselling, advice and new pharmacy services*'[4] and a European Commission-appointed independent Expert Panel on Effective Ways of Investing in Health proposed that '*a greater involvement of a highly-trained, skilled and underutilised workforce of pharmacists across Europe could be a disruptive innovation in health care*".[5] Patients support the expansion of the role of the pharmacist with over 90% agreeing they would like their pharmacist to carry out blood pressure tests, treat minor ailments and offer advice on medicines regimes[6].

At LloydsPharmacy, we strongly believe the community pharmacy network in Ireland can deliver much of what the health system needs. Pharmacy has the potential to be at the heart of the development of the most cost effective interventions when it comes to health promotion, medicines and optimal therapeutic regimes. We believe that:

> *Prevention should play a vital role in enhancing the health and well-being.*
> *When people become ill, their illness should be managed at the lowest possible level of complexity, starting with self-management.*
> *The vast majority of healthcare needs should be addressed by a comprehensive range of primary care services.*
> *More integration of care is needed which should be supported by the transfer of many cases into primary care.*
> *Patient safety and greater choice for service users in their dealings with the health service should underpin planning and delivery of all services.*

Government must develop a clear plan to provide enhanced pharmacy services in the community, with increased State supports and investment for community pharmacy adequately compensating and acknowledging their expanded workload. This would yield significant savings for the State through reduced patient care costs and lower rates of hospital care interventions, reduced GP visits and A&E attendances.

Proposals

LloydsPharmacy proposes that, with Government support, the role of the community pharmacist be expanded to include the provision of the following services, offered in dedicated consultation rooms within the pharmacy:

Minor Ailments Scheme
Medicines Use Reviews
Extended Vaccination Service
Chronic Disease Management
Health Check Service
Structured Health Promotion Services
Anticoagulation Service
Reclassification of Medicines
First Care Clinics
Transfer of Care
Substance Misuse Support
Needle Exchange Service

Minor Ailments Scheme

LloydsPharmacy proposes the expansion of the pilot Minor Ailments Scheme, which would be available to GMS patients at no additional cost to the HSE

Community pharmacists deal routinely with minor ailments, advising patients on how to treat self-limiting conditions and distinguishing between minor illness and major disease. Consultations for minor ailments are a burden on high cost service providers. It is estimated that one in seven GP visits and one in twelve A&E attendances could have been dealt with by a pharmacist.[7]

The Minor Ailment Scheme is an internationally-recognised Extended Pharmacy Service, whose primary aim is to enable medical card patients to receive treatments for common illnesses and minor ailments free of charge direct from their local community pharmacy. A three month pilot Minor Ailment Scheme in four Irish towns, launched on 1st July 2016. LloydsPharmacy supports the implementation of a national pharmacy-based Minor Ailments Scheme, which would be cost neutral to the Exchequer and demonstrate how pharmacists can improve public health access, shape future services and broaden pharmacy roles to deliver quality patient care whilst improving patient health outcomes.

Medicines Use Reviews

LloydsPharmacy proposes the introduction of a Medicines Use Review Service to reduce the cost to the HSE of medicines and GP/hospital resources and improve patient outcomes.

Medicine Use Review is a consultation-based service undertaken by a pharmacist to assist patients to understand and manage their medicines, ensuring they get the greatest benefit from their treatment regime. The *Joint Committee on Health and Children's Report on the Adverse Side Effects of Pharmaceuticals* recommended that the role of the pharmacist be expanded and provision made for regular medication reviews for all patients.[8] International evidence demonstrates that pharmacist interventions, through medicines management initiatives, lead to improved health outcomes, enhanced quality of life for patients and a reduced requirement for hospital care creating quantifiable savings for the health service. The Spanish ADHIERETE study found that pharmacists' intervention improved adherence by 41.2% to 70.6%.[9] In Australia, Government funded Pharmacist Medication Use Reviews yielded a net saving of AS$100 per review per patient. In Scotland, MURs conducted by pharmacists on elderly patients on multiple medications reduced hospital readmission rates by 30%.[10]

Extended Vaccination Service

LloydsPharmacy proposes the expansion of the vaccination service to include additional vaccinations and off-site provision of the service.

The introduction of the pharmacy based Winter Flu Vaccination service in 2011 was welcomed by LloydsPharmacy. LloydsPharmacy, promotes this service and invests significantly each year in training and re-training our pharmacists. Evidence of the benefit of the improved convenience and accessibility with which pharmacists provide this service is seen by the fact that over 50,000 people were vaccinated in community pharmacy in the 2014/15 flu season, 24% of those had never availed of the flu vaccination previously despite the fact that 85% of them were in an 'at risk' category.[11] Recent legislation to allow pharmacists to provide shingles and pneumococcal vaccinations will similarly improve the uptake of these public health interventions.

Internationally, pharmacists routinely offer a wider range of vaccination services. At LloydsPharmacy, we would welcome the expansion of the vaccination service to include vaccinations such as Meningococcal Disease, Hepatitis A and B, Tetanus, Cervical Cancer and Travel vaccines. These vaccinations can easily and cost effectively be added to the list of products and services supplied and administered in Irish pharmacies.

Furthermore, LloydsPharmacy would welcome the opportunity to provide the vaccination service 'off-site'. Pharmacists are currently only permitted to administer vaccinations in pharmacy consultation rooms. Allowing pharmacists to attend off-site locations including nursing homes, prisons and office blocks, would help to maximise the potential for the service, promoting the uptake of this public health intervention.

Chronic Disease Management

LloydsPharmacy proposes the creation of a Chronic Disease Management Service to provide patient education and screen Chronic Diseases.

Chronic diseases such as diabetes and chronic heart disease are a large and growing burden on the health of Irish people and healthcare system. Approximately 38% of Irish people over 50 years have one lifelong chronic disease with 11% having more than one chronic disease.[12] Chronic disease accounts for 78% of Ireland's healthcare spending, 80% of all GP visits, 40% of hospital admissions and 75% of hospital bed days.[12] Due to the doubling of the elderly population over the next 30 years, the burden of chronic disease will have a significant impact on our already overstretched healthcare service.

Chronic diseases currently dictating health service usage are preventable through addressing risk factors and health behaviours. Approximately 60% of the disease burden in Europe is accounted for by seven preventable risk factors including high blood pressure, tobacco, alcohol, high cholesterol, overweight and obesity, poor diet and physical inactivity.[13] Many of the consequences and costs of chronic diseases are avoidable through screening, early intervention, behaviour change and elimination of key risk factors. We propose that chronic disease management be an enhanced service offered by Community Pharmacy throughout Ireland. This service should be a collaborative initiative between GPs, Practice Nurses, Community Pharmacists and other healthcare providers where pharmacists play a key role in monitoring patients for chronic diseases and reviewing and adjusting prescription regimens to ensure better control of symptoms and delivery of better treatment outcomes. Data from the US has shown that Chronic Disease Management Programmes can achieve a 50% reduction in unplanned hospital admissions and a 50% reduction in bed day rates for these conditions.[13] This highlights how a greater orientation towards primary care and more health-promoting services can improve patient health outcomes and ease the burdens on our overstretched healthcare services.

Health Check Service

LloydsPharmacy proposes the development of Health Check Services including Asthma Control and Sexually Transmitted Infection Services.

Early detection of chronic illness, coupled with early intervention and treatment, is a cornerstone of the Government's *Healthy Ireland* strategy.[3] At LloydsPharmacy; we believe that pharmacy-based health checks could effectively identify those at risk of developing chronic diseases such as diabetes, cardiovascular disease, osteoporosis and chronic obstructive pulmonary disease (COPD) and asthma. Due to the continuous availability of expert advice from pharmacists coupled with the fact that community pharmacies open 50% longer than GP clinics, community pharmacy is well-positioned to provide these extended services.

As innovators in the field of healthcare, LloydsPharmacy has developed Patient Support Programmes to provide health checks and enhance patient treatment. The first of these, the LloydsPharmacy Asthma Control Service launched in 2015. Since acute exacerbations of asthma result in over 5,000 hospital admissions, 20,000 A&E attendances and 50,000 out-of-hours visits every year in Ireland,[14] LloydsPharmacy offers an Asthma Control Service to our patients. This service provides adherence support through inhaler technique reviews with pharmacists to ensure that patients effectively manage their condition, reduce exacerbation of symptoms and wastage of medication.

LloydsPharmacy also offers home-based Sexually Transmitted Infection (STI) testing kits, which have been well received in the community. Due to the significant increase in the number of STI notifications and the fact that 80% of STIs are symptomless[15], LloydsPharmacy proposes STI testing be offered in community pharmacy as an Extended Pharmacy Service. This would enable community pharmacy to play a more active role in improving sexual health in line with the Government's Sexual Health Strategy 2015.

Structured Health Promotion Services

In the *Tackling Chronic Disease* Report, it is estimated 80% of cardiovascular disease and Type 2 diabetes and 40% of cancers could be avoided if major risk factors such as obesity and smoking, were eliminated.[12] According to the World Health Organisation, Ireland is set to become the most obese country in the world,[16] while smoking amongst Irish adults remains at approximately 19.5%.[17] LloydsPharmacy, are keen advocates of health promotion, and in response to these concerning statistics, launched our **Change Your Health Direction (CYHD) Campaign** in January 2015. Through this campaign, our customers avail of free weekly consultations with our highly-trained colleagues, gaining ongoing advice and support and receive encouragement and monitoring of weight management and smoking cessation. Since its inception, this successful campaign has had peak sign ups of 850 regular participants and a combined weight loss of 6,000 lbs with 200 customers quitting smoking.

LloydsPharmacy also run additional health promotion campaigns such Healthy Heart, Men's Health and Diabetes Risk Management. The aim of these is to make people aware of risk factors associated with these diseases and to adopt a healthier lifestyle.

Anticoagulation Service

Most patients in Ireland on Warfarin attend a hospital Warfarin clinic for INR checks. LloydsPharmacy, proposes an INR testing service offered in community pharmacy. This service would be convenient, fast and accessible for patients and enable pharmacists, to counsel and educate patients on anticoagulation. At LloydsPharmacy, we believe that this service would reduce the workload in hospitals and improve patient care experience. Similar services exist in New Zealand, Australia, the US and UK.

Reclassification of Medicines

LloydsPharmacy would welcome an increase in the number of medicines available without prescription, as occurs in the UK and New Zealand. This would provide patients with greater access to the treatment of minor ailments whilst freeing up GP time. Evidence of the benefit of pharmacy-led services to patients in terms of efficiency, cost-effectiveness, improved convenience and accessibility can be seen from the success of the reclassification of emergency hormonal contraception in Ireland.[10] Medicines which LloydsPharmacy propose be reclassified from POM to P include Sumatriptan for the treatment of migraine, newer anti-allergy medicines like Fexofenadine and a wider range of analgesics.

First Care Clinics

As part of a wider strategy of services that community pharmacy can provide, LloydsPharmacy proposes that pharmacist-led triage First Care Clinics be carried out in the community and hospital A&E departments across Ireland. A trial of such a scheme was conducted by LloydsPharmacy UK who found that First Care Clinics provide rapid and convenient access to the treatment of minor ailments and injuries without appointment, for low costs, with limited waiting times and freeing up GP time and avoidable A&E visits.

Transfer of Care

LloydsPharmacy collaborate with VHI to deliver VHI Homecare. This is a consultant-led "hospital in the home" clinical service. It enables suitable patients to be discharged from hospital early and continue certain medical treatments at home under the care of VHI Nurses and Doctors. Through this scheme, LloydsPharmacy dispense and deliver medication such as intravenous antibiotics and anti-coagulation therapies to patients' homes. Home treatment of various medical conditions has been safely and successfully provided in the US and Australia. LloydsPharmacy are proud to be part of this initiative which has helped to reduce hospital stays, support care homes, simplify complex medicines regimens and support independent living.

Substance Misuse Support

LloydsPharmacy are pro-active in the care we provide to our methadone treatment patients. Our pharmacists are regularly trained by HSE staff and suppliers on best practice management of patients and we provide advice on health, diseases, hygiene, dental health, sexual health and nutrition to marginalised patients, many of whom have limited access to healthcare services. At LloydsPharmacy we believe that we can play a much more significant role in the care and rehabilitation of this cohort by:

- Development of enhanced pharmacy services for methadone treatment patients
- Provision of pharmacy services and methadone dispensing and supply to HSE methadone treatment clinics
- Partnering with shelters, hostels and homeless organisations.

Needle Exchange Service

In 2011, LloydsPharmacy was amongst the first pharmacies in Ireland to partner with the HSE's Addiction Services on the provision of Needle Exchange Services. We continue to offer this service in as many areas as we can. We would welcome expansion of this service across the country, as well as the opportunity to become more involved in the Dublin region, as this scheme can have a very positive influence on public health by reducing the incidence of infectious diseases.[18]

Conclusion

LloydsPharmacy welcomes this Committee's establishment and strongly supports its remit. The development of a ten year strategy mapping the direction of our health services for the next decade is a goal which must be supported by both healthcare providers and policymakers. It provides a vital roadmap for all to follow and allows for benchmarks to be set and achieved.

At LloydsPharmacy, our **Vision** is a healthier world where more people can live life to the fullest and our **Mission** is to effectively, efficiently and passionately deliver innovative healthcare services that equip and inspire more positive lives. Our healthcare system must focus on providing patient-focused healthcare at the lowest level of complexity. An important part of the future of the Irish healthcare system rests in the recognition and advancement of pharmacists' roles and in the extension of the services that they provide.

At LloydsPharmacy, we strongly believe, and international experience demonstrates, that pharmacists have the requisite expertise, skillset and accessibility to introduce cost-effective extended services. These extended services will improve the health and wellbeing of our citizens and reduce the burdens on our overstretched healthcare system.

We respectfully ask this Committee to fully consider our proposals and to incorporate them in the final strategy document. At LloydsPharmacy we are committed to working with all stakeholders to ensure that these proposals are realised.

http://www.lloydspharmacy.ie/

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Mallow Primary Healthcare Centre

Submission to assist in the preparation of a report to make recommendations on a changed model of health care in the Irish health system in the next 10 Years by moving from the current model of Health towards a model based on Patient centred integrated primary, community and secondary healthcare

Mallow Primary Healthcare Centre (MPHC) is a World Class 70,000 sq ft mid tier healthcare facility which has been specifically designed and developed to provide caring, considerate, patient centred modern primary medical care. There are 3 General Practices located in MPHC with 20 general practitioners and 11 practice nurses working together with the HSE Primary Care Teams and North Cork Community Mental Health Services personnel (Approximately 200 HSE Primary care staff) in the one environment with the aim of providing integrated patient care delivery, to all the community of Mallow, North Cork and beyond. We work in close association with our supporting hospitals, Mallow General Hospital and the Cork City Hospitals.

MPHC also houses "The 4th Practice" which provides specialist enhanced services supported by the GPs and visiting Consultants that are not usually available to general practitioners in Ireland. These extra facilities and enhanced diagnostic procedures are open to all general practices and their patients. A number of nurse led chronic disease management programmes and clinics such as anti-coagulation, cardiac, diabetes, respiratory, travel medicine, phlebotomy and venesection are also provided.

All our activity is IT based and research orientated through our READS centre (Research, Education, Audit, Development & Standards). All GP practices use the same nationally certified IT system CompleteGP which allows all healthcare inputs and outputs across all practices to be measured, researched and audited on an ongoing basis. Through coded IT data, MPHC is producing internationally accepted data, peer reviewed papers and new models of care with national universities UCC, UL, UCD, RCSI.

All of MPHC activities are carried out to international standards (ISO 18001 & The International Primary Care Standard (IPCS).

Politicians, commentators and economists have acknowledged that care is best delivered in a setting closest to the patient in the appropriate primary care setting with general practice integrated with PCTs and community health professionals.

We are well placed to assist the committee in achieving it's objectives and we would welcome an opportunity to present to the committee on how to move services efficiently from the current model towards a model based on patient centred integrated primary, community and secondary healthcare, reducing the cost to the state and dramatically reducing waiting lists in the next 10 years.

MPHC could become the pilot location for further enhanced protocols and pathways between community care and acute care to enhance the range of services that are largely the preserve of the hospital system e.g. minor surgical & diagnostics are two examples of many.

Use MPHC as the "prototype" for demonstration of the benefits of an integrated universal care system.

MPHC allows periodic review of performance of outputs and outcomes (KPI's).
Provide ongoing assessment & validation of value for money health services.

In our opinion we see the following as the key priorities for inclusion in a 10-year plan for the Irish health service.

Develop a patient centered, accessible integrated healthcare system with an emphasis on primary and community care. Services that can be delivered in the community should be delivered there.

General practitioners will always be at the core of primary care delivery providing more than 27 million consultations (more than 90% of all healthcare contacts). This will increase in the next 10 years **due an increasing aging population, we need to plan for multi-morbidity and chronic disease management in Primary care.**

Without adequate full time GP numbers, <u>no system of healthcare will work</u>. At present we are losing a high proportion of our well trained GP's (11-14 years training) to other countries. This can only be addressed by appropriate resourcing of general practice.

Develop funding pathways to support, develop and deliver the desired additional medical services required in primary care. A combined primary and secondary care budget is key to delivering services to PCCs. Currently the money does not follow the patient into primary care. Developed primary care can **ease the unsustainable burden on secondary Care.**

Integrated delivery of services. **Break down barriers between different silos** in healthcare.

Develop IT based, standardised and auditable systems that measures outcomes and outputs. Tracking of the patient to avoid duplication of services and reduce outpatient department consultation and re re-evaluation / tests in primary and secondary care.

At present there is an **absence of reliable data in Irish healthcare. Real world data collection to inform strategic planning. Accurate data leads to better economic healthcare.** We can plan for the expected (demographic change, flu outbreaks Etc.) and have flexibility to deal with the unexpected (new illnesses, new methods of treatment, new drugs, epidemics etc.) Future healthcare planning and delivery has to be based on ongoing **audit, research and training at the point of delivery in the community.**

Education Everyone involved in healthcare delivery will require training in patient centered integrated multi-disciplinary system.

Standards. All primary care patient centred activities should be delivered to an affordable, fit for purpose international standard and be independently audited. Primary care standards which provides verifiable and documented evidence of competent, safe , professional and best practice in primary healthcare. IPCS Standards have been developed and delivered in MPHC since 2010 and are annually certified by EQA, an INAB accredited international auditors.

Governance All stakeholders including patients must have a say in the governance structure. Delivery of good healthcare to the patient must demonstrate accountability & responsibility at all levels both clinical and organisational. MPHC achieves this through it's patient forums, board of governance Ethics committee. Etc. These can be developed and rolled out nationally.

What are the key challenges, in your view, to achieving a "universal, single-tier health service, where patients are treated based on health need, rather than ability to pay"?

General practice at present delivers "universal, single-tier health service, where patients are treated based on health need, rather than ability to pay". This however does not happen anywhere else in the healthcare system in Ireland. HSE Primary care deals with GMS full medical card population only. Non GMS and GP visit card patients do not have access to HSE primary care facilities. 90% of healthcare contacts occur in general practice, the role of the general practitioners has always been gatekeepers to secondary and tertiary Care.

The key challenges to achieving a "universal, single-tier health services" are in our opinion:-

- The **deficit of trust in the Irish healthcare system needs** to be overcome. There must be buy in from all stakeholders.
- **General practice is currently under resourced** following many years of cuts and unless we do something now to build up capacity, infrastructure and services we cannot achieve a "universal, single-tier health service". Appropriate resourcing of general practice and retention of our highly trained junior doctors at all levels is the main challenge over the next ten years.
- **Improved interface between primary and secondary care IT systems**. Hospital IT does not integrate with PCC systems.
- **Taking pressure off the hospitals**: everything that can be done in primary care should be done. Developing and supporting primary care to it's maximum potential with adequate diagnostics, chronic disease management and appropriate treatment facilities.
- **Clinical activity should guide the healthcare Budget and <u>not</u> vice versa**.
- The **government funding planned to support PCCs has not materialised** and as a result the viability of existing PCCs is affected. As a key platform for health reform and given the investments already made, we should work together to secure the future of state of the art PCCs.

The health system in general is undergoing an unprecedented reform programme, while budgets are expected to continue to be restricted. As with the majority of developed health systems around the world we are facing a number of key challenges, including:

- Increasing patient expectations
- Rising demand for services
- Increasing cost of provision
- Governance, leadership development and performance management issues
- Lack of development of primary care and integrated care models
- Workforce restructuring
- Clinical engagement
- Budgetary pressures
- Limited funding to support transformation
- Culture and low morale

The Following actions are needed to plan for, and take account of, future demographic pressures (population growth, ageing population), and their impact on the health system

Accurate, accessible and updated information based on records from real life community based data. This can be provided by MPHC's and similar PCCs IT Database on primary care and chronic disease management statistics gathered over the last 6 years.

Ireland is facing a very predicable health challenge over the coming years. As our population ages there will be an exponential rise in the incidence of chronic disease and it is imperative that we **radically reform the manner in which we deliver services to those suffering from chronic disease**. The Irish medical Organisation (IMO) have already published a very informative booklet on Solving the Chronic Disease Problem through General Practice which was presented to the Minister for Health **Mr Leo Varadkar** in Buswells Hotel, Dublin on 13th January 2016.

Hospitals are organised to supply disease specific specialised care.

We need to plan how to deal with the change of care arising from single care patients becoming multi morbidity patients (suffering from multiple diseases). **Look at the ability to move services from hospitals to primary care and deliver multi morbid care to patients inj the community, as close to their homes as possible.**

A clinical and organisation capacity study is required for Primary, Secondary and Tertiary care.

Integrated Primary and Community Care

We believe the following steps are needed to move from the current model towards a model based on integrated primary, secondary and community health care.

We believe Primary Care Centres (PCCs) can do more to support the Government's health reform programme. "Future Health" with its focus on universal healthcare, a key feature of which is a well-developed primary and community care service and infrastructure to support 90% of people's healthcare. Unfortunately that aim has not been delivered because the necessary infrastructure and pathways to provide this care have not been developed by the State. There are currently 356 Primary Care Teams (PCTs) and a small number of newly built PCCs across the country. These state of the art facilities are not being maximised at present and the planned transfer of any hospital services to the PCCs has not taken place. PCCs can deliver these mid tier services at 30-50% of the cost in a hospital setting. With hospitals under significant pressure it makes sense to transfer these services to PCCs.

We have the opportunity now to maximise the investment already made in PCCs and deliver on the PC strategy easing hospital pressure while at the same time support the health reform's objective of keeping patients out of hospitals and implementing integrated care.

Our proposal is to deliver low complexity hospital services in in existing and future primary care centres.

The Ten key features of our proposal are :

Primary Care centres (PCC's) operating as Ambulatory Hospitals will provide services which are currently delivered in hospitals, but which can be delivered in a less complex and 20-30% lower cost setting in the community.

Transferring services to PCC's will reduce demand on hospitals and provide improved quality of care and outcome for patients at a significantly lower cost to the state. Care would be on an outpatient basis to include

Diagnostics
Observation
Consultation
Treatment
Intervention
Rehabilitation

Services will be based on demographics with an appropriate variance in each place to reflect local needs. Our IT systems can facilitate this customising of services.

Examples of the services proposed include the following:

Anti-Coagulation clinics in primary care
Minor Surgery (see Acute Hospital operational plan 2016 move 10,000 minor procedures from Secondary to Primary care)
Day Cases – for example dermatology, vasectomies, ophthalmology, cutaneous and subcutaneous surgery, venesections; infusions, vasectomies
Outpatients – consultants visiting the patient in the community & preoperative screening
Endoscopy Clinic – for example providing endoscopy, colonoscopy, cystoscopy, hysteroscopy and the forthcoming colon cancer screening programme
Diagnostics – for example x-ray, ultrasound, ECHO, DEXA, laboratory testing, and other potential diagnostics such as MRI are required in PCCs to support the above services.Innovation will drive strategic decision making **with strong links to universities, effective use of IT and shared services**, and a focus on measuring and evaluating outputs and outcomes.

Services will be delivered by staff of the Primary Care Centres/Primary Care Teams and hospital **consultants who will have sessions at the PCC, in accordance with their current public consultant contracts.**

The proposed PCC services will be **governed through existing Clinical Governance arrangements of the PCCs and patients will be referred to the services using existing referral protocols**

Each of the PCC's will partner with the newly established Hospital Trusts, to drive integrated care and decrease hospital referral

The PCC's will be accredited / licensed as outlined in HIQA's Better Safer Healthcare to an international standard

Funding for PCC services will follow the services (transferred) and the patient, as outlined in Future Health leading to more efficient use of current funding.


We consider the key barriers to achieving this, and how might they be addressed are as follows:-

PCCs are committed to supporting the reform programme and facilitating truly integrated care at a lower cost. In our opinion the key roadblocks to Primary care delivery are as follows:

Clinicians buy-in

Consultants are pivotal to our proposal and their championing of in the Exemplar centres will be key.

> **Mitigation:** Over the last few years we have worked with clinicians to understand the practical aspects of transferring services from the hospitals to PCCs. We are confident the clinicians who have worked with us are willing to support its implementation.

PCCs have been particularly hard hit by budget cuts in healthcare

Given the high fixed costs & Loan repayments of the PCCs have remained with reduced incomes, rates increases, lack of funding for services being delivered by these centres.

> **Mitigation**: Funding Model needs to change to enable the transfer of services in primary Care.

Infrastructure required – some PCCs will require investment

> **Mitigation:** While the potential range of services which could be transferred is extensive, Given the shortage of funding available, we have focused on services which will provide an immediate return on investment.

Funding

Funding of services in PCCs is required which is challenging given the Current Healthcare Budget restraints. This needs to be dealt with at a political level.

Momentum and commitment

Given the challenges in the system, an opportunity to work with change leaders should not be missed.

> **Mitigation:** MPHC and some other PCCs have put together a team of enthusiastic individuals who are committed to making change happen and delivering innovative solutions.

How would you ensure buy-in from health care professionals to progress towards an integrated health care model?

Establish an evidence base and identify Exemplar Sites

A demonstration study in PCC's, Mallow Primary Healthcare Centre (MPHC) for example, is required to confirm the benefits case and gain further buy in nationally. We need to demonstrate an evidence based, better model of healthcare using real world data. We need to show success stories by proving that properly funded, open, transparent, patient centred integrated services **measuring output and outcome** are being delivered in primary care and can be rolled out nationally.

Substitution of Services

Ensure that specific hospital services to be transferred to the PCCs are no longer delivered in a hospital setting, achieving substitution not 'additionality', and maximising the cost saving opportunity while freeing up staff, facilities and resources in hospitals. Transferred services need to be properly resourced (funding and Infrastructure) and respectfully introduced.

We need to identify Clinical Champions nationally

Buy-in by health care professionals is dependent on clinicians delivering services at multiple sites. Clinical champions, working with their PCCs colleagues, are required to lead the demonstration study. It is critical that clinicians are on board and support the transfer of the relevant hospital services to PCCs. Some PCCs have already made excellent progress on this front.

Provide funding (see next section)

Ongoing Clinician Training and Research in MPHC

Are there any examples of best practice that the Committee should consider? Please refer to any evidence you have to support this.

MPHC is an example of best practice that the Committee could consider but needs to be supported and enhanced to its full potential. See The Examiner article from 2012 below outlining what we have achieved.

Link to "Primary care yet to come of age"

Some example of best practice audited and accredited studies we have delivered to date are :-

Anti Coagulation Clinic in Primary care to relieve the pressure on Cork University Hospital & Mallow General Hospital. TTR Across the clinic has gone from 56% to >70%

http://completegp.ie/papers/AnticoagulationAuditPC.pdf

We are particularly proud of our EARLI Pilot Study: Blueprint for Primary Care MPHC 2011 which halved "at risk" > 70yo hospital admissions year one and annualised return of 30% reduction in cost.

Retinopathy Screening programme which was developed in MPHC and is now a national HSE programme.

Minor surgery in primary care: A structured dermatological programme in primary care showed a 68.57%. reduction in referrals to a Hospital OPD

MPHC is a literacy friendly centre with Crystal Programme Award 2015 from NALA and striving to be a dementia friendly institution

Dementia Carers course (WONCA) winner 2013 Prague.

MPHC, with its partners are involved in **National e prescribing programme and pioneering seamless electronic connection between GP, Pharmacy, Nursing Homes and Hospital**.

Through the use of a secure **password protected SI Key** allow patient access to their medical records through any internet connected computer worldwide.

Projects we are currently working on include

Treatment of multi-mobidity Patients (with multiple diseases).
care of the elderly in the community vs in nursing home,
Hospital Liaison Clinic (keep care in community),
electronic DMARDS clinical care,
Providing minor operations in Primary care.

Proposed Funding model

Do you have any views on which health service funding model would be best suited to Ireland?

The system we propose is the **National Health Insurance Model** which utilises private-sector providers, but payment comes from a government-run insurance program that every citizen pays into. Since there's no need for marketing, no financial motive to deny claims and no profit, these universal insurance programs tend to be cheaper and much simpler administratively than current for-profit insurance models. The Canadian health system would be a good example of this.

Traditional funding in the Irish healthcare system has not worked**. The funding system should be based on outputs and outcomes and not just patient activity**.

There should be commissioning of services, an example of which is utilised by the NHS in the United Kingdom.

Whichever model is adopted, the current practice of silo funding in the HSE has to cease. The HSE Operational Plans for 2016 for Acute Hospital Services, Mental Health, Social Care and Health & Wellbeing all call for services to be delivered as much as possible in primary care but an appropriate portion of the budget must be transferred from these budgets to the PCCs, There is currently no funding pathway to support this.

Many of these recommendations are made in the **Indecon report on "Analysis of Potential Measures to Encourage the Provision of Primary Care Facilities Autumn 2015".**

We ask that recommendations on funding already made in the Primary Healthcare Care Public Hearings in January and February 2009 and in the cross party **Joint Committee on Health and Children Second Report on Primary Medical Care in the Community – 10th February 2010** be implemented.

"The evidence shows that primary care (in contrast to specialist care) is associated with a more equitable distribution of healthcare in populations, a finding that holds in cross-national and in-nations" Starfield, Shi Makinko 2005

Excellent national and international ttudies already exist demonstrating this, including those hyperlinked below.

Indecon report on Analysis of Potential Measures to Encourage the Provision of Primary Care Facilities in the IRISH HEALTH SYSTEM Autumn 2015.
Rhode Island Department of Health:- Impact of Primary Care on Healthcare Cost and Population Health A Literature Review AMERICAN SYSTEM Feb 2012
Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report 2012
Contribution of Primary Care to Health Systems and Health, Barbara Starfield 2005

Please outline the specifics of the financing, payment methods and service delivery (purchaser and provider) of the model you are advocating?

- There must be a separation between the purchaser and provider of services.
- Service provision to patients must be the priority.
- The cost of infrastructure should be included in payments by public and private purchasers.
- There needs to be transparency in payment methods for service delivery.

What are the main entitlements that patients will be provided under your funding model?

Whichever funding model is adopted, there should be open access and patient's entitlements should be free at the point of delivery in the community. The emphasis should be on the provision of all care including multi-morbidity (patients with multiple diseases) and chronic disease management in primary care. Patients should only be referred to hospitals for specific investigations.

Examples of Best Practice

Audit report of the HSE Midland Diabetes Structured Care Programme, May 2010

Heartwatch — the National Programme in General Practice for the Secondary Prevention of Cardiovascular Disease in Ireland. This is a very successful Cardiac programme but participation has been limited to 20% of GP practices, this should be rolled out nationally.

There is sufficient money in the healthcare budget already but it needs to move more freely between secondary care and primary care to generate savings and reduced OPD Visits.

PCCs create environment where more could be done, but there is no resource for public patients for diagnostics and minor procedures. Patients are entitled to free access in public hospitals and, as a result, the hospitals are under severe pressure with large waiting lists. If public patients had cover for diagnostics and minor procedures in PCCs, hospital waiting lists can be dramatically reduced.

Similarly, while Private Health Insurers will cover the Doctor Fee of some limited procedures in PCCs, they won't pay a facility fee. These are paid by insurers to hospitals to cover the cost of the rooms and facilities used. If procedures are to move to PCCs, then the infrastructure must be resourced.

Thank you for taking the time to consider this submission. We would welcome an opportunity to present to your committee and would suggest a visit to MPHC, an Integrated functioning PCC.

http://www.mphc.ie/

Meath Special Hands Group, Kells, Co. Meath

We wish to outline our suggestions & recommendations in the areas which the committee should consider by way of a long term view & strategy for the future of healthcare & healthcare policy in Ireland for the coming decade.

Our submission, specifically, will outline our key priorities, identify the challenges we face & show our perceived view of how a 'universal single tier health service' could better meet the needs of people with a physical & intellectual disability & their individual, specific needs.

We will propose actions to be taken that will allow for population growth, the transition of adults with disabilities from children services and the fact that these adults will become a new ageing demographic.

We will suggest steps that should be taken to transition our current healthcare model to a fully functioning & truly holistic 'Integrated primary, secondary & community healthcare system' which specific emphasis on 'Community'.

We will give you a little insight into the world of 'disability', the barriers & challenges faced on a daily basis will also recommend a funding model based on the Danish model which we believe works well, which if tweaked would be worth consideration to be adopted by the HSE.

Based on the Committee's objectives, we have identified the following topics to be discussed as part of our submission, namely….

How to achieve cross-party consensus on a ten year vision for the health service with an emphasis on quality of patient care, supported by strong managerial and organisational accountability.

In order to achieve cross party consensus for a future 10 year healthcare model, we must first accept that the existing model is redundant and does not meet the needs of the current population. In particular, the needs of children with physical & intellectual disabilities and those transitioning into 'Adult' services.

This is an area fraught with huge difficulties and also highlights the poor interpretation of what constitutes a legal **'Adult'**. The department of Social Protection consider a person at aged 16 yrs to qualify and subsequently deliver disability allowances to children from this age.
Additionally, at the age of 16yrs, a child with a physical &/or intellectual disability who has attended the same children's clinics & hospitals is expected to transition to an adult hospital such as the Mater or Beaumont where the staff & consultants are ill equipped to deal with a cognitive age of a child who presents in a young adults body. Yet, technically & legally the person does not become an adult until they reach 18 yrs of age.

The true definition of a legal **'Adult'** in relation to a person with a physical&/or intellectual disability must first & foremost be clearly defined in relation to their **citizenship & rights.** It must also be agreed that from aged 18 yrs onwards, the person will transition into adulthood via different tiers.

Establishing & then maintaining a consistent quality of patient care could be better achieved & maintained in these tiered aged groups. It would follow on that a tiered HSE management structure should mirror these age tiers in order for this to work. i.e.; Instead of having the existing groups of

- Early intervention (from babies – 6yrs old)
- 6-18yr olds
- Adults

We suggest;

- Babies & early intervention
    - Therapy Supports and equipment, HSE liaison, home support, respite, easier access to specialists/consultants , medical cards, better diagnosis services , counselling/family support at time of diagnosis. Pre-school support & crèche facilities.
- 6-16yrs old
    - Therapy, equipment, home support, respite, HSE liaison, medical cards, annual assessments, pre-school leaving preparation. Independent living skills training, career guidance Family Centred approach to the delivery of services where family's are listened to, as they are the caregivers
- 16-18yrs old
    - Therapy, Adult home support, Adult age appropriate respite, medical cards, Transitional officer to allow for easier transition post leaving school.
    - We suggest that the HSE start transitioning children from aged 16 out of child services and onto adult further education/service providers.
    - This way the services would get a year's advanced notice of the person and start preparing for the person joining the service.
    - The Stress on the families of young people going into adult services has to be better managed and not crisis managed.
    - Career guidance, Home support, Respite, Employment & Job search support, Community Social & Recreational Facilities & Services

- 18-30yrs old
    - Age appropriate Respite, and home support to assist young adults to access social & recreational facilities. Training Centres for the young adults who cannot access employment in the community. Here they can be taught independent living skills.
    - Educational and Recreational courses to give their day a sense of purpose and achievement. The Service Providers should be properly trained in performing continual assessments & transparent audit process of the adults. The Intellectual Disabled young people should have Key support workers to help them access Apprenticeship schemes and follow up that they are being treated fairly. There should be more employment creation for the Intellectual disabled young people.
- 30-65 yrs old
    - Same as above supports and key workers should follow our Intellectual disabled community into middle years and old age. Day services, annual assessments, 'Long term care' services/community facilities accountability in these services.
- 65yrs +
    - Day services, annual assessments, 'Long term care' services/community services…'for all age groups Proper Contract of Care to be provided to the family and signed by the Service provider and family. This is annually updated.
    - Proper communication between service providers and families with regard to responsibility of the adult when he /she enter long term care. Proper hospital passports updated yearly.
    - Proper communication with family when the person in long/short term care goes into hospital. Ensuring that the person has a support care person with them at all times. This also to be discussed in a timely manner not crisis managed.
    - Disability money and accounts opened by the person in long term care requires strict supervision of this by family and service providers. Upon death of person in long-term care their financial affairs and access to their estate is explained in a timely manner.

You can clearly see that the needs of each group, although at times would overlap say in the areas of personal needs (incontinence wear etc.), access to primary & community healthcare services etc, they would be different in the areas listed and resources & funding could be clearly targeted & delivered more successfully.

As the age range would be more specific, health professionals with expertise in these areas could be better employed to generate age appropriate programs/services and deliver them in a more targeted manner.

There is also the fundamental question of 'When is a person with a physical disability and/or intellectual disability deemed to be an adult' - Is it 16yrs or 18 yrs?

As **adulthood** is a bewildering & frightening stage in the life of a person with a physical &/or intellectual disability when colossal changes occur i.e. leaving school, exiting children's respite, change in home support where fundamental future decisions are being made.

To include an implementation plan as part of the Committee's reporting process, setting out achievable targets with appropriate milestones and resources needed for implementation.

If we work on the assumption that the HSE accepts the new six 'age tiers', as shown above, it would be easier to identify real numbers of people who fall into these categories, identify their specific needs and to account for their requirements. It would also be easier to plan for the delivery of appropriate services, healthcare professionals, medical & other professionals, HSE management structures & funding.

To establish what healthcare entitlements should be covered under an agreed definition of 'Universal' Healthcare.

As per the 'New Directions' programme, we as a society are moving away from the old idea of providing institutional or residential care, in the main, for people with physical &/or intellectual disabilities and moving to a more community based 'Inclusive society' model. Whilst in theory, this is a more humane & morally correct approach for our **vulnerable citizens;** it requires a great deal of planning & community supports for it to be a successful & sustainable approach.

For a person with a disability to live happily and meaningfully within a community the following must be in place;

- Home support, Respite for families where the disabled person remains living with their family
- Independent living facilities & community housing for the person who is capable & wishes to live within their community but in a more independent way. Support worker to assist in this transition to independent living, and to oversee that the person is safe and not vulnerable.
- Social/Recreational facilities so that the person can interact with all members of their community. I.e. disability friendly leisure centres, swimming pools, youth/adult clubs, accessible cafes/bars/restaurants, mentoring/buddy schemes.
- 'Real' Employment services & opportunities, Government legislated Employer/company supported' employment opportunities where companies/employers are financially enticed to create & support employment opportunities & vacancies for disabled persons, appropriate 'Job Creation', Career/job support workers, appropriate legal job protection & employee rights & entitlements.
- Community based medical /healthcare services where all community based GP/primary care centres are fully wheelchair accessible, have hoists/facilities to support non-ambulatory persons, community based OT & Physio services, community based 'nursing' services for minor medical requirements, whereby **ALL** rudimentary medical requirements are treated

locally within community sparing the person unnecessary trips to a hospital for routine type procedures are reducing the strain on already over burdened hospitals.

- Introduction of ‘Cottage Hospital’ type services where long term residents with physical & intellectual disability can continue living in a ‘Nursing/Medical’ led environment. A home with medical benefits.
- It is currently under consideration that all citizens of Ireland might one day carry a ‘Full Medical History Swipe Card’ with all the relevant medical data recorded.
- **Funding**, **Funding**, **Funding**.... for all 'ad hoc' 'Miscellaneous' community based service requirements such as community transport, friendship programs etc.
- Support & easily accessible funding available for community based groups such as 'Special Hands Activity' group whereby local community group initiatives could be supported such as Art classes, music groups, cookery classes etc. All independently operated by parents/friends who are experts in the field of their loved ones/disability but supported by government.

To outline the steps required over time to implement Universal Healthcare, including an appropriate funding model.

In my opinion, the Danish model for healthcare is worth considering.

In order for all people with a physical &/or intellectual disability to have continued access to high quality healthcare, the correct funding must be in place from day one. Considering if a child presents to ‘Early Intervention’ within the HSE, they are known & in the system from an early stage, therefore funding could be set aside and ‘Ring Fenced’ for each year which would accumulate during the person’s life & stay with them from birth to their demise. Thereby eliminating the ongoing challenge of sourcing funding when it is required.

The following is a little insight into the Danish model;

The quality of Denmark’s health system is extremely high.

The Danish health system is divided into two sectors:

Primary health care: Primary health care deals with general health problems and is usually the first point of contact if you require general medical treatment. Services in this sector are available to everyone, and include treatments from general practitioners, dentists, physiotherapists, etc.

Hospital sector: Hospitals are responsible for patients who require more specialised medical treatment, for example intensive care or the need for specialist equipment.

The ‘cornerstones’ of the Danish healthcare system is that it is a public healthcare system predominantly financed through general taxes

Healthcare is organised in such a way that responsibility for services provided lies within the lowest possible administrative level, usually the county councils

There should be universal, free and equal access for all 5.4 Million citizens.

Since 1970, most decisions regarding the form and content of health care activity have been made at county and municipal level.

The Ministry of Health has a coordinating and supervisory role, but no operational responsibilities for health services. Working in close cooperation with the government and municipalities, the five regions are responsible for hospitals and primary care. Regions have wide powers to organise the health services for their citizens, according to regional wishes and possibilities and can adjust services and staff, etc., according to needs at the different levels. County council elections held every four years usually focus on local issues.

There are important channels for co-ordination and negotiation between the state and the regions and municipalities and between the regions and the municipalities. In recent years, the political focus on controlling health care costs has encouraged a greater degree of formal co-operation.

Special educational needs;

A number of acts in Denmark regulate the teaching of children, young people and adults. General provisions are, laid down in the acts applying to the relevant areas, except for the Act on Special Education for Adults.

Since 1980, the Act on Special Education for Adults has formed the legal basis for compensatory special education for adults with functional difficulties of a physical or psychological nature. Furthermore, there is a ministerial order on special educational support in vocational education and training, etc. Apart from these, no specific legislation applies to learners with special needs.

General legislation, pertaining to the individual levels of education, more or less outlines directly that teaching is accessible to all and should be organised and performed in due consideration of pupils' different prerequisites and needs. Various provisions apply to special considerations in connection with examinations and the like.

According to the *Folkeskolen* Act, special needs education is still a possibility for learners, but only if supplementary education is failing to give them sufficient and efficient education. Children with a need for a special class or a special school or learners who need more than nine hours' support per week can be transferred to special needs education. This requires individual assessment through pedagogical psychological services and parental involvement in the decision process.

This legislation was approved by the Danish parliament and has been in place since May 2012.

The concept of special needs education in Denmark is restricted to very specialised education, with the emphasis on schools finding ways to deal with educational challenges without transferring learners to special needs education.

Municipalities run *Folkeskolen*, including mainstream schools, schools with special classes and special schools. Municipalities can transfer learners with special needs to other municipalities, but most communities create their own school system including special education. Very few specialised schools for blind, deaf and blind/deaf students are run by regional authorities, but the costs are paid by municipalities and they decide on the transfer of learners to and from these institutions. The state runs VISO and ViHS, national institutions for knowledge and specialised counselling to municipalities regarding learners with disabilities in special needs education.

Please see below the link for more information.....

http://international.ucl.dk/files/2012/08/the_danish_healtcare_system.pdf

To develop a model of integrated healthcare with an emphasis on primary and community care.

It is clear that 'Universal Healthcare' is the correct approach for the future, with the emphasis being placed on the majority of services being provided at a 'local/community' level. Where local GP/Primary medical centres with a full knowledge & understanding & history of their patients are best placed to provide a full & comprehensive range of services.

This in turn eliminates the need to place additional burdens on hospitals for what would be deemed as routine/minor medical procedures. A more 'Robust' & effective doctor on call & local A&E service would keep the standard & qualities of care provided in the community at a very high level and dramatically reduce both hospital waiting times & financial cost.

If local GPs & local community hospitals were properly funded, fully trained & supported to offer a more comprehensive list of services/facilities/procedures to all residents & in particular adults with physical &/or intellectual disabilities.

It would allow for minor medical procedures/services to be performed in a timely & efficient manner thereby reducing overall waiting times, reduce delays, reduce medical negligence, eliminate minor ailments from escalating into more serious problems, thereby requiring more expensive/invasive treatments etc.

This will require INTELLIGENCE, FUNDING, GOVERNMENT SUPPORT, APPROPRIATE HSE INITIATIVES.

Challenges faced by parents

To give the committee an idea of the challenges we as parents face, please see below for an honest a true account of one of our parents who has firsthand knowledge of the challenges faced with dealing with adult services.....

“As a parent of an adult daughter with a disability, I would like to see a healthcare system that promotes and supports disability awareness. Many parents are frustrated when their child with an intellectual disability turns 18 and is placed in a day service where they are now given all these choices! Sometimes these choices are not always in their best interests. When difficulties arise, parents are often met with “he/she is 18 now they have a choice”.

When a child *without* a disability turns 18, the parents have to learn to accept that these young people are now at a stage in life where they can navigate their own futures. Parents will invariably learn to let their sons or daughters make their own choices in life. When there’s been a good relationship, these parents are still there for advice and support.

However where there is an intellectual disability, the goal posts change somewhat. Invariably the child remains the same, in that generally their intellect is not going to change. This does not mean that they should be treated like children. They should be given every opportunity to grow and develop further.

Care givers and service providers must insure that these young people are getting the best stimulation possible in the same way you would with young children in pre-school, primary, secondary…and that means parental involvement! They must be encouraged to reach their full potential and lead full and rewarding lives. The HSE need to understand that parents should and must continue to play a significant role in the children/young people's lives when they turn 18. Who knows their children best – parents!

Clinical care of children and adults with disability in residential settings.

Residential services will take children and adults to see GPs but it often stops at that. There is often no follow up where referrals are made to consultants and no onus on anyone to do so. We have personal experience of this. We were continually told by the HSE Children's Disability Services and residential service, which included many professionals that it was not on their remit to progress a clinical matter.

After a referral was made, no body followed up to see what was happening. Some appointments were not received, others were either overlooked and put on a very long waiting list with no one except very distressed parents left to do all the work. We had to coordinate everything ourselves as we were being continually told it was on the remit of the HSE to coordinate services between residential care settings and GPs, acute hospitals, etc.

The question is, what if the parents are not present or have not got the capacity to do what we did, what happens to the child or young person? Are they allowed to suffer on? We consider ourselves lucky in that after a long and hard battle, we finally pushed our daughter's clinical care to the level where she finally got a diagnosis and is now getting the proper healthcare which was actually denied to her for so long.

What if an adult in a residential centre has to go to hospital and the parent is not available, are they treated like adults then? A hospital can be frightening places for young children so equally this applies to adults with an intellectual disability. Should they be left alone in a strange environment? Can they make their own decisions about medical procedures just because they are over 18? This is a major concern to parents as they get older themselves. Who will be the voice for their "children"? There is a huge need for more advocacy services for vulnerable people with medical/health issues.

There should be meticulous ongoing liaison and coordination between healthcare professionals involved in the care of children and adults with disability in residential services and it ultimately lies with the HSE to ensure this".

http://www.meathsports.ie/directory/special-hands-group/

Medical Research Charities Group (MRCG)

The **Medical Research Charities Group (MRCG)** is an umbrella group of medical research charities that seeks to generate dynamic health research in Ireland, driving a greater understanding of how illness can be prevented, how it can be diagnosed earlier and treated more effectively with the ultimate goal of improving the nation's health.

The MRCG believe that patient organisations should lead and stimulate medical research driven by patient need.

We work to identify and remove any barriers to medical research are work collaboratively with the patient community, the research community and policy makers to improve the research infrastructure.

The MRCG's key priority is to build research capacity amongst its members. We work with our member to help them identify suitable research opportunities.

The MRCG want to ensure there is a dynamic medical research environment in Ireland. In 2014 we established the ***Irish Health Research Forum (IHRF)*** on foot of our report ***The Health Research Landscape: What Researchers*** *Say.* The Forum is a partnership of stakeholders whose aim is to influence an environment which enables high quality research, supports researcher careers and promotes the involvement of service users.

Ensuring priority investment for medical research will help to deliver patient care, public health service transformation and economic and enterprise development. A well-functioning medical research infrastructure will ultimately help patients, the health system and the economy.

In this document we present the key priority areas for the members of the MRCG that we are asking the Oireachtas Committee on the Future of Healthcare to take on board when it is developing a ten year strategy for health care and health care policy in Ireland.

List of Recommendations the MRCG would like considered by the Committee
The priority areas for the MRCG members are as follows:

- ✓ **A commitment to increased investment for medical research.**
- ✓ **Appointment of a Director of Research in the HSE and the appointment of a HSE Working Group on access to new and innovative therapies.**
- ✓ **Development and maintenance of patient registries.**
- ✓ **Passing of the Human Tissue Bill and the Health Information & Patient Safety Bill.**
- ✓ **Implementation and resourcing plan, and oversight group for the National Rare Disease Plan.**
- ✓ **Appointment of dedicated Minister for Research**

Priority 1: Increasing Investment for Medical Research

Background: Facilitating and nurturing research in the health system is undoubtedly challenging, especially in a resource-limited environment, but there is a valid case to be made that this is the very time when investment in research can reap dividends. In addition to driving better health outcomes for individuals, communities and populations, investment in health research results in direct cost savings, improved reallocation of resources, objective and concrete data on access, quality, cost and outcomes, improved cost effectiveness and innovative models for the delivery and financing of healthcare.

Ask: The MRCG believes that health research in Ireland should be a key area of on-going investment, especially during a time of economic constraints, as it assists patients, while also benefitting the economy through the creation of jobs and expertise.

We are a critical player in health research in Ireland. Currently €800,000 in funding is provided annually for health research through the Joint Funding Scheme run by the Health Research Board (HRB). This €800,000 is matched euro for euro in funding from MRCG member charities ensuring huge value for money. This funding allows charities to carry out health research that they would not be able to fund on their own. It also provides valuable opportunities for researchers to gain experience, thereby contributing to the economy. The Joint Funding Scheme has contributed approximately €18 million of research since its inception in 2006.

There needs to be **on-going investment by the State in health research**, in order to improve the care of Irish patients and contribute to the wider economic gain. The Government must not only recognise the importance of investment in this area but also maintain investment in medical research.

Appointment of a Director of Research in the Health Service Executive

Background: Research must be embedded in the health system, likewise the health system must be a good place to carry out clinical research and there must be excellent practices and policies to support this.

Ask: The lack of leadership within the health service for the medical research agenda must be urgently addressed. The appointment of a full time Director of Research within the Health Service is particularly needed now for a number of reasons:

To deliver Government policy on health research.
To take a leadership role in incentivising and supporting clinicians and hospitals to carry out more medical research and raising awareness of the impact of health research among health practitioners.
To promote positive health research case studies to enhance our reputation in this area and to ensure Ireland retains the highest calibre of health researchers going forward.

Increasing numbers of researchers and academics are choosing to leave Ireland because of the **lack of investment in research** and the **loss of protected time for research**. These researchers, once they leave Ireland, will bring their expertise, their international research funding and graduate research opportunities with them. This is an extremely worrying situation for us as a small country, the loss of these researchers will have a huge impact on medical research in general, and on patients in particular.

Research and innovation in a primed health system have a vital role in **supporting enterprise development in Ireland**, creating jobs and delivering significant economic benefits to the exchequer through direct and indirect savings. Developing and maintaining a high quality health research system provides opportunities to engage with private enterprises in areas such as pharmaceuticals, medical devices, diagnostics, services science, e-health and assisted living technologies and thereby benefitting the economy.

Priority: Improved Support Structures for Medical Research

Background: It is vital that there is a **strategy on patient data** and its role in terms of patient research. **Patient Registries** are vital for medical/health research, yet there is no national policy or adequate recognition of the role of patient registries in Ireland. **The work of many patient registries remains undervalued and underfunded.**

Ask: A coherent policy approach for the development and support of patient registries in Ireland. Patient registries provide vital information on issues such as the number of people suffering from a disease; where treatment centres should be located and whether the survival ages of patients are increasing or decreasing (a key indicator of quality of patient care). Patient registries are recognised internationally as a **vital prerequisite for good quality health research**.

Priority : Improved Legislative Framework for Medical Research

Background: For there to be a well-functioning **medical research infrastructure** which will benefit patients, the health system and the economy it must be underpinned by an appropriate and proper **legislative framework**. Two key pieces of legislation, the **Human Tissue Bill** and the **Health Information & Patient Safety Bill**, have not received the appropriate attention from successive Governments. The Human Tissue Bill is still a Category C bill while the Health Information & Patient Safety Bill has been a Category B bill since 2009.

Ask: The measures contained in these bills will impact the health research environment in Ireland and contain initiatives which will have major impacts on the areas of population health, registers, the structure and regulation of research ethics approval and regulations for the removal, retention, storage, use and disposal of human tissue.

Priority: Effective Resourcing of The National Rare Disease Plan for Ireland 2014-2018 (NRDP)

Background: In the European Union, a disease is defined as rare when it affects fewer than 5 in 10,000 people. In the EU it is estimated that 6-8% of the population has a rare disease (in Ireland that's around 280-370,000 people.) In other words, up to 1 person in 12 in Ireland may have a rare disease at some stage in their life. **The National Rare Disease Plan for Ireland 2014-2018** (NRDP) was launched by the Minister for Health in July 2014. It was planned to be the first generic policy framework for rare diseases in Ireland. It is broad and it applies to all rare diseases.

Ask: Clearer commitments on implementing the NRPD and removing uncertainties in key aspects of health policy that impact on rare diseases, in particular:

- The urgent need for an **Oversight Implementation Group** for the NRDP to be established. This group needs to be formalised and have clear terms of reference.
- The inclusion of the NRDP in the **HSE Service Plan for 2016**. The lack of visibility and commitment to rare diseases in the HSE Service Plan for 2015 is a major deficit. The

Department of Health is mandated to set out health policy in Ireland, yet it is frustrating and unacceptable that a national plan endorsed by the Minister for Health is not reflected in key HSE planning processes.

- The need for a **Government policy on the future of genetic services in Ireland**. The recent downgrading of the National Centre for Medical Genetics to a Department of Crumlin Hospital has caused considerable uncertainty for patients. The HSE have indicated that a new plan for national genetic services in Ireland will be drawn up in the near future. MRCG calls on this draft plan to be published as soon as possible along with adequate consultation with key stake holders, including MRCG.
- There is considerable uncertainty in relation to **access to new and innovative drugs** for people with rare diseases in Ireland. The NRDP could play a key role in helping to inform how we approach this complex and sensitive issue in future.

Priority: Appointment of dedicated Minister for Research

Background : In the current government, there is no dedicated Minister for Research and no ultimate ownership of the research agenda

Ask : MRCG proposes that a Minister of State for Research is appointed by Government who will -

- Advance government policy on research i.e. the priorities set in the research policy document Innovation2020
- Support adequate funding for research as a driver for improving health provision in Ireland and finding new and innovative therapies

http://www.mrcg.ie/

Medtronic

The proposals in this submission reflect Medtronic's position both as the world's premier medical technology company

The establishment of this Committee is a welcome recognition that Ireland faces significant healthcare system challenges. As many Western countries have acknowledged and responded to these challenges earlier than Ireland, this allows an opportunity to learn from mistakes and successes of other geographies and build a healthcare system which prioritises efficiency, capacity and patient outcomes. The need for system change can no longer be the focus of discussion - it must become the focus for action.

The proposals in this submission reflect Medtronic's position both as the world's premier medical technology company, and as Ireland's largest company; and our readiness to be a partner in the transformation of Irish healthcare. We have successfully worked with many healthcare systems to tackle healthcare delivery challenges and realise the goal of improved population health whilst addressing escalating cost pressures.

As a mission-driven company dedicated to expanding access to healthcare for the underserved worldwide, Medtronic commends the Irish Government's aspiration to introduce Universal Healthcare in Ireland. However, we believe that the healthcare provided should be focused on patient outcomes and value relative to cost. There are fundamental changes required to the Irish system both to realise and prepare for this quality Universal Healthcare.

One way to address the new requirements is to radically rethink how and where Ireland provides and pays for care. We believe that adapting to a Value Based Healthcare (VBHC) system is critical for Ireland. Aligning with a value-based model means restructuring a transactional system in which payments are made for every consultation or treatment and adopting a new approach of payments tied to quality and outcomes.

In order to achieve this, our recommendations include:

Focusing on outcomes and measurements
Cost of care, in its totality, must be known and agreed by all
Procurement must be based on value
Payment to all stakeholders must be contingent on improved outcomes
Encouraging benchmarking and cross-learning
Reducing the organisational barriers and bureaucracy delaying new partnerships and needed changes

Furthermore, Medical Technology as an enabler to achieving population health outcomes is recognised worldwide. Unfortunately, a methodical and strategic approach to their use is absent within the Irish Health Service despite the presence of a global medical technology hub in the country. We further recommend that assessment of medical technology is improved to be at least equivalent to pharmaceuticals to ensure its value is captured and purchasing decisions can be made on value, not the up-front cost alone.

The health system, without the structure to handle the well-documented burgeoning challenges facing Ireland, has been forced to focus most of its resources on reacting to population illness and depending on supplementary budgets to fund this care. Yet, health systems play a central role in modern society in helping people maintain and improve their health. Medtronic wishes to work with Irish stakeholders in partnerships where we share the rewards and risks for outcomes and costs to achieve universal, value-based healthcare.

VALUE BASED HEALTHCARE

Medtronic, together with a host of clinical, academic and third-party thinkers, are strong advocates of the Value Based Healthcare (VBHC) model which offers fundamental change, with a shift away from systems that are silo-ed by medical speciality to integrated systems treating patients holistically. We believe this should be at the heart of the ten-year plan for the Irish health service.

Michael Porter, a Harvard Business School professor and leading expert on Value Based Healthcare, describes what this shift means: “This ideological shift means moving from a long-established system that rewards volume of visits, hospitalizations, procedures, and tests to a system that focuses on improving patient outcomes while lowering costs. Value, versus cost-shifting or restricting services, is a solution that can unite the interests of all system participants — and improve care.”

At Medtronic, we see VBHC as an effort to develop and deploy products, services, and integrated solutions that improve patient outcomes per Euro spent by the healthcare system by improving the quality of care and/or reducing the associated expense. Solutions that fit into value-based care typically are characterised by business models in which payment is based on the value created by the solution (e.g., gain-sharing arrangements), or in which payment is contingent upon improved outcomes (e.g., services provided with a guarantee or reduced payment for poor quality).

VBHC follows outcomes taking into account therapy, risk stratification, disease, multi-morbidity, and population levels. It moves away from systems rewarding volumes (e.g. the total number of operations in a hospital) to systems rewarding value for money spent.

VBHC is more, however, than a shift based on measuring outcomes alone. VBHC promotes innovations that add real value in better patient outcomes while maintaining or reducing costs, it can lead to enhanced quality of life, it can reduce health waste and can be validated by clinical and economic evidence. Founded on VBHC thinking, improved performance and efficiency is in evidence across Europe in a growing number of projects and case studies *(for examples please see appendix 2).*

It also implies sharing risk within the healthcare system across payers, providers and industry. “Value Based Healthcare: A Global Assessment”, a forthcoming study undertaken the Economist Intelligence Unit report identifies that European governments have started to implement a number of ways of sharing both risks and rewards. In the case of healthcare providers, individual countries and regions have experimented with a range of pay-for-performance (P4P) models.

Examples include a contract between Stockholm’s Karolinska Institute and an imaging-equipment manufacturer, under which Karolinska agrees to pay the company an additional 10% of its total fee if it is able to help the hospital to achieve certain results among defined patient groups; or the partnership between Maastricht University Medical centre and Medtronic, which helped the centre become one of the top ranked cardiovascular institutes in Europe by implementing the optimisation of clinical pathways, designed together with Europe's leading clinicians. The five-year partnership started in 2014 and delivered $2.5M in cost savings.

The Diabeter Clinic, acquired by Medtronic in 2015, is a Dutch diabetes clinic and research centre dedicated to providing comprehensive and individualised care for children and young adults with diabetes. Diabeter has delivered best in class outcomes for paediatric Type 1 patients by achieving lowest HbA1c levels, a key measurement used to assess blood glucose control. Near normal blood glucose control has been shown to reduce long-term complications of diabetes and can reduce healthcare costs over the long term. Diabeter has shown the lowest number of admissions for complications, the highest volume of patients and the lowest overall cost for this care in the Netherlands.

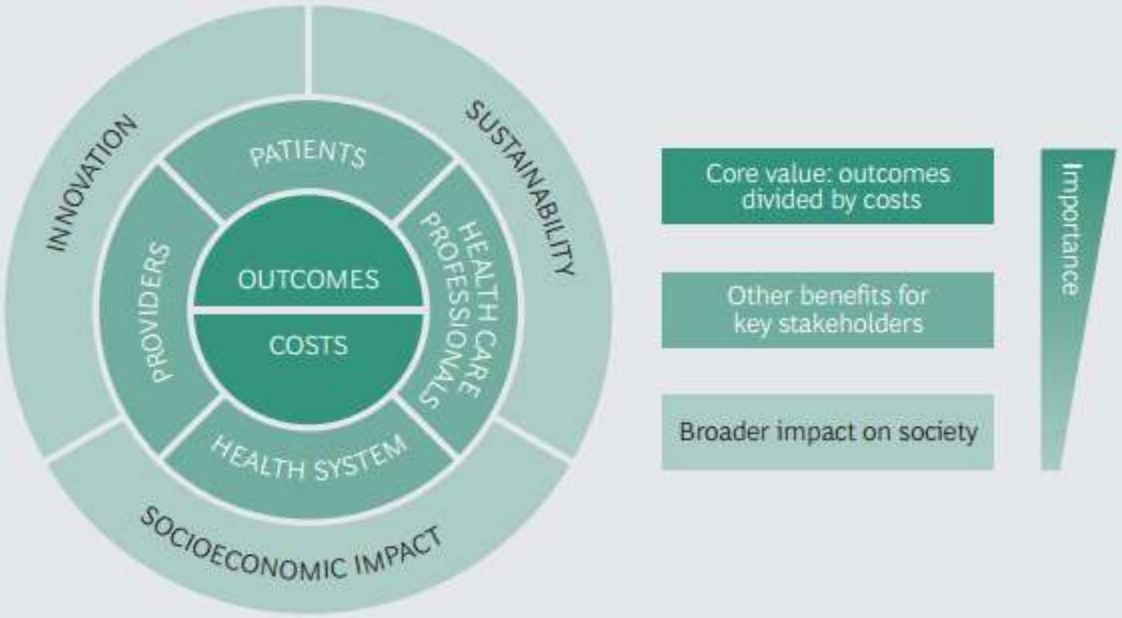
As Michael Porter summarises, healthcare can be fixed if we listen to our patients, define the outcomes they wish to achieve, measure them globally on the same standardised scales and calculate the costs of attaining these outcomes, disease by disease, so we can calculate value. When formulating the ten year health strategy, understanding the expectations of Irish patients is the key to prioritising and refocusing healthcare spending in a way that the public will visibly benefit from.

VALUE BASED PROCUREMENT

A value-based system requires new thinking and participation from all stakeholders in the healthcare ecosystem, but the most significant force is procurement practices. In 2014, the European Union sought to address price-only-based procurement through the Public Procurement Directive, 2014/24/EU, which puts far more emphasis on the concept of the best price-quality ratio in procurement. The directive aims to improve procurement by promoting quality and innovation while considering longer-term costs and other elements such as environmental and social factors. Specifically, it allows greater freedom to contracting authorities by encouraging the use of flexible procedures and allows greater interaction with the market.

In assessing VBHC the Boston Consulting Group and MedTech Europe produced a report entitled Procurement: the Unexpected Driver of Value Based Healthcare in which they developed a new framework for value-based procurement, as a guide for contracting authorities building a tender:

EXHIBIT 3 | A Value-Based Public-Procurement Framework



Source: BCG analysis.
Note: Costs include the costs of care delivery.

At the core of the framework is the value-based health-care equation — patient outcomes relative to the cost of delivering these outcomes. There are also second-tier benefits that BCG suggests could include relative convenience and comfort for patients; the safety and the ease of use for healthcare professionals and reduced overall costs for the health system. Finally, the Framework allows for considerations that reflect the broader impact on society and are of direct interest to policymakers: innovation, sustainability, and socioeconomic impact.

Though this Framework is not a prescriptive algorithm for every tender, it helps to develop a common language between healthcare providers and companies in the industry to improve value, and moves away from price as the primary consideration.

BCG further outlines that tenders have thus far not given much weight to patient outcomes, at most setting minimal performance requirements. However if purchasing authorities factor outcomes—including patient-reported outcomes—into relevant aspects of the tender evaluation process, this could be a transformative step in moving to a VBHC system.

Most Economically Advantageous Tendering (MEAT) value-based procurement approaches can incorporate outcomes as a central part of the process, and proposes pragmatic ways for innovative products, services and solutions to demonstrate their value when used in the health service. The MEAT criterion enables the contracting authority to take account of criteria that reflect qualitative, technical and sustainable aspects of the tender submission as well as price when reaching an award decision.

The MEAT principles have been used successfully across Europe to incentivise a broader way of measuring value; they offer a stepping stone for the Irish Government towards a VBHC system. Procurement can efficiently include patient outcomes during the tender process and reward innovation that leads to better value.

In order to enable a VBHC model, the role of procurement must adapt and change; procurement departments have the potential to be seen as a strategic resource within organisations but this evolution is not without its challenges. In March 2016, MedTech Europe facilitated a discussion between European procurement officials and industry representatives on this matter, a summary can be found here. The main challenges discussed are worthy of the Committee's consideration:

Engaging finance and procurement officials

As procurement professionals take their seat at the management table in hospitals and the health service, there is an opportunity to lead change but this is not without its challenges. There is work to be done to convince finance officials to embrace MEAT value-based procurement, which is difficult as budget-holders often operate in silos. Hospital procurement officials may be unwilling to spend more this year if the benefits show up on someone else's balance sheet at some point in the future.

Concerns over legal disputes

Choosing the lowest-cost option often appeals because it is seen as less likely to be the subject of criticism. There may be a perception of subjectivity with unsuccessful bidders feeling aggrieved at not winning a contract, particularly where they view the criteria as opaque and subjective. To overcome this, MedTech Europe suggests that pilots and case studies, endorsed by respected experts, could play a powerful role.

Timeframe

The timeframe over which value would be measured offers further challenges to the status quo. Assessing impact on infection rates, complications and readmissions is relatively easier than trying to weigh more long-term benefits or broader socio-economic factors.

Training in new procurement models

As the role of procurement grows in importance and complexity, practitioners will need new skills and competences. National and European institutions have an important role to play in convening officials and facilitating knowledge sharing.

A relatively new approach of procuring includes negotiated procedures and competitive dialogue. It is seen that negotiated procedures are well suited to situations where the authority knows what they want to buy and can describe it in a tender whilst competitive dialogue is more appropriate if the authority can describe its problem but is not yet clear on the precise solution.

Objective data

Measurable outcomes are necessary but some procurement officials share concern that competing suppliers may present conflicting studies in support of their products, services and solutions; which highlights that objective data is needed.

Strong data analytics can also address challenges caused by healthcare system inefficiencies and suboptimal clinical outcomes. Harnessing “big data” can lead to actionable insights, clearer vision for future strategy, improved outcomes and reduced time to realisation of value.

Strong political leadership together with hospital level commitment is required to address this selection of challenges. The recommendations of the Ten Year Health Strategy can be a real opportunity to overcome short-term and price-only thinking and to reap the benefits of a more outcomes-focused funding system. We offer any of our expertise that might be helpful to the Committee in building the foundations for such a system.

RECOMMENDATIONS FOR ACTION

Focusing on outcomes

The key challenges in creating the shift from payment based on activity, regardless of whether the activity was high quality, to getting paid based on results is the necessity for measurement of outcomes. VBHC is founded on standardising outcomes measurement and developing measures of patients’ reported experiences.

The standardisation of outcomes measurement has to begin with collaboration amongst providers, suppliers, physicians, payers and patients on disease-specific outcomes. The lack of adequate data on existing products is a key challenge and there are not enough programmes that track real-world outcomes involving patients and healthcare professionals.

Collectively, we have to agree on how to systematically measure outcomes for specific disease states and medical conditions. Some efforts in these areas are already taking place by institutions like the OECD and the International Consortium for Health Outcomes Measurement (ICHOM).

Total cost of care must be known and agreed by all

Activity-based funding is an important step which brings understanding of the total cost of care - we advocate for its accelerated implementation. However, where costings illustrate that the delivery of care is greater than the current budget allocated, this should be seen as a sign that outcomes focused, VBHC models should be considered.

Total cost of care needs to include each of the component parts that aggregate to the total cost. Failure to do so will lead back to the current situation that inevitably drives dated procurement practices, that focus on the ‘high’ cost elements and then seeks to achieve cheaper price. When the total care cost is known, this may lead to investment in practices and technologies leading to pathway improvement and or delivery of care outside of the traditional secondary care settings.

Payment and procurement are based on value

We strongly propose that the Most Economic Advantageous Tender (MEAT) becomes the default criteria for assignment of tenders. To achieve value, procuring authorities should focus on spending well, rather than just on spending less.

The realisation that the solution with the lowest single acquisition cost may not be the best value overall. For example, the cost of pacemakers vary dramatically but a cheaper version which includes a shorter battery life or requires more frequent hospital visits may offer less value long term than a more expensive pacemaker upfront. In this example there is a cost to both the hospital for increased procedures and to the patient in time out of work and their personal life.

Economic Value encapsulates cost-related factors which go beyond the initial purchase price. These cost factors are life-cycle costs and costs relating to ownership and include: direct medical costs e.g. laboratory or diagnostic tests, provider services as well as hospitalization and sub-acute care; costs of maintaining, cleaning, and storing the device; other ongoing operating costs, including efficiencies achieved in other areas due to introduction of the device; upgrade costs; staff training and other employment costs; disposal costs

Payment to all stakeholders is contingent upon improved outcomes being realised

This includes but is not exclusive to Suppliers, Hospitals, GPs, Consultants, Social Care within the public sector. Activity based funding for example seeks to reimburse upon activity, this is in line with international DRG based systems. Development of these international payments system introduces mechanism to prevent escalating activity as a way to prevent provider income generation. For example, in the US, insurers will only pay for hospital stays for the days where patients receive treatment. If a patient is admitted on a Tuesday but does not receive treatment until the following day, the payment begins on the Wednesday. This helps to change the behaviour of the health service to focus on what’s best for the patient - speedy and effective interventions.

Ireland now has the opportunity to lead the world, given the learnings that can be observed. This should at a minimum be the payment of procedures only on achievement of the outcomes desired on a patient and aggregate population level. These outcomes should be predefined within any contract, and systems such as clinical registries should be established to audit. Where outcomes have not been demonstrated or re-intervention is required a provider would not be paid and where provisional payment made for the primary intervention has taken place, there should be a mechanism for cost retrieval from the provider. This can ensure that the costs incurred to the system are redistributed to ensure the desired clinical outcome is achieved.

Encouraging benchmarking and cross-learning

Clinical audit, national registries and outcomes datasets are a necessity to establish the paradigm shift in Irish healthcare delivery. The ability to benchmark in public allows for the necessary scrutiny and discussion on where services should be delivered and on whom. This transparent benchmarking will allow us to more specifically understand the priorities and expectation of the public.

More importantly where the anticipated success is being delivered, the ability to benchmark and share this success across the Irish Healthcare system will lead to standard practices, efficient cost utilisation and population health. This methodical evidence based approach has the opportunity to place Ireland at the centre of outcomes based commissioning and VBHC.

Reduce the organisational barriers and bureaucracy to the uptake to new partnerships and other changes

The premise of the 10year health strategy acknowledges that the current structures of the Irish healthcare system needs to be refreshed. As a keen partner in healthcare transformation, we have witnessed bureaucracy that can prevent the new entrants and partnerships from being established.

When embarking upon a VBHC, the business model is required to be tailored to the service or clinical outcomes desired by the payer and population. Without dexterity and speed of will to undertake such forward thinking business models, partnerships will not be realised and results will never be achieved. The Committee is an excellent vehicle to drive out old world thinking and entrenchment in historical payment methods.

Whilst workforce skills and flexibility may be addressed under a separate workforce planning initiative, we respectfully acknowledge that adaptations to the some existing working arrangements will allow for new and innovative deliveries of healthcare.

Medical Technologies

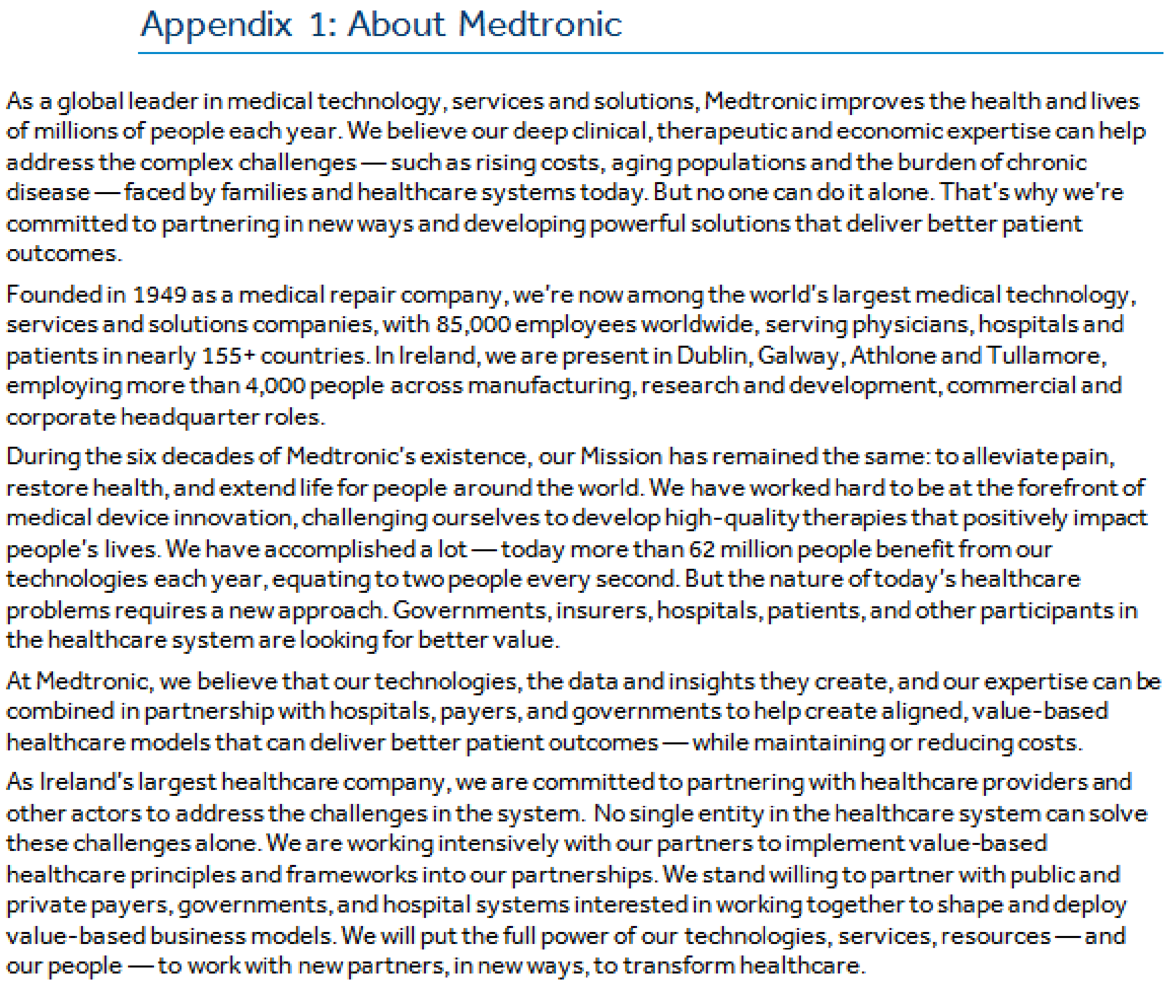
Medical technologies within the Irish healthcare system are often seen as cost drivers rather than an enabler to deliver unmatched patient outcomes, even though Ireland is home to an established and growing Medical Technology cluster. The country boasts both a vibrant SME landscape together with 15 of the top 20 global MedTech companies manufacturing and undertaking R&D. If the Committee members have the opportunity to visit MedTech companies within their constituencies, they will more than likely witness Irish tax payers developing, producing and exporting lifesaving medical equipment that they would have no access to under their own national healthcare system, even when the technologies are proven to deliver greater health outcomes than the current standard of care. Ireland is well placed to benefit from medical technologies, we recommend that:

Assessment of medical devices should be formalised and prioritised

The total Irish healthcare spend on Medical Technologies is significantly less that the European average and comparable healthcare systems. This is largely due to the absence of a functioning and methodical approach to Health Technology Assessment (HTA) in Ireland, or the use of overseas jurisdictions’ recommendations such as The Scottish Health Technologies Group (SHTG) and The National Institute for Health and Care Excellence (NICE). The National Centre for Pharmacoeconomics (NCPE) is exclusively for pharmaceutical assessment, while the HIQA is limited to a very narrow scope.

The recommendation therefore is to establish a ‘horizon scanning and health technology assessment’ programme for medical devices. This will lead to earlier identification of technologies that can demonstrate value for tax payers’ money as they relate to population outcomes and also accelerate of the adoption of technologies at a pace that would dramatically change healthcare delivery in Ireland.

Linkage to the Most Economically Advantageous Tendering process is critical, as with this combination of detailed assessment with tendering considerations beyond the point of purchase cost, we are likely to encourage a more widespread adoption of live saving, restorative technologies that will ultimately deliver improved population health.



Appendix 1: About Medtronic

As a global leader in medical technology, services and solutions, Medtronic improves the health and lives of millions of people each year. We believe our deep clinical, therapeutic and economic expertise can help address the complex challenges — such as rising costs, aging populations and the burden of chronic disease — faced by families and healthcare systems today. But no one can do it alone. That's why we're committed to partnering in new ways and developing powerful solutions that deliver better patient outcomes.

Founded in 1949 as a medical repair company, we're now among the world's largest medical technology, services and solutions companies, with 85,000 employees worldwide, serving physicians, hospitals and patients in nearly 155+ countries. In Ireland, we are present in Dublin, Galway, Athlone and Tullamore, employing more than 4,000 people across manufacturing, research and development, commercial and corporate headquarter roles.

During the six decades of Medtronic's existence, our Mission has remained the same: to alleviate pain, restore health, and extend life for people around the world. We have worked hard to be at the forefront of medical device innovation, challenging ourselves to develop high-quality therapies that positively impact people's lives. We have accomplished a lot — today more than 62 million people benefit from our technologies each year, equating to two people every second. But the nature of today's healthcare problems requires a new approach. Governments, insurers, hospitals, patients, and other participants in the healthcare system are looking for better value.

At Medtronic, we believe that our technologies, the data and insights they create, and our expertise can be combined in partnership with hospitals, payers, and governments to help create aligned, value-based healthcare models that can deliver better patient outcomes — while maintaining or reducing costs.

As Ireland's largest healthcare company, we are committed to partnering with healthcare providers and other actors to address the challenges in the system. No single entity in the healthcare system can solve these challenges alone. We are working intensively with our partners to implement value-based healthcare principles and frameworks into our partnerships. We stand willing to partner with public and private payers, governments, and hospital systems interested in working together to shape and deploy value-based business models. We will put the full power of our technologies, services, resources — and our people — to work with new partners, in new ways, to transform healthcare.

University Hospital of South Manchester – NHS Trust, UK

The Challenge	University Hospital of South Manchester NHS Trust is a major teaching hospital recognised as a centre of excellence in cardiology and cardiothoracic surgery, heart and lung transplantation, respiratory conditions, burns and plastics, cancer and breast care services. With 950 beds, it draws patients from the North of England and beyond. Dealing with growing demand driven by changing demographics, the hospital needed to do more with the same budget to minimise a funding gap. Short-term cuts were not going to address this challenge. In that context, the Trust was eager to renew ageing CathLab equipment, optimise daily operations whilst improving capacity and reducing waiting lists, and treat more patients with the same resources.
The Solution	To address the University Hospital of South Manchester's requirements, Integrated Health Solutions entered into a partnership with the organisation in June 2013 to create a tailored solution: to provide funding and access to latest cardiac technologies; to improve operational efficiency, resulting in savings; to increase operational capacity, resulting in incremental revenue.
The Process	Medtronic supported state-of-the-art CathLab refurbishment and equipment maintenance, determining appropriate equipment needs and coverage levels as well as developing a Quality Framework for CathLab operations management. Supply chain management was optimised by developing and implementing a Quality Framework to standardise and maintain best practices. Medtronic facilitated operational excellence by introducing a patented framework which helped hospital staff prioritise important issues and data analytics tools. Lean Academy training also helped empower staff by embedding a culture of continuous improvement and driving efficiency gains.

The Impact	One year into the partnership, a 25% improvement in start-time efficiency and a reduced underrun by 72% (time difference between last patient out and planned end time) had been achieved. Lab activity increased by 15% for the period of June 2013 - June 2014. Based on average tariff, this is worth about £2 million revenue to the Trust. There was a reduction in expired stock from circa 13% to 0.4%, which based on a stock turn of 1 year, is worth £200,000 to the Trust. The two CathLabs also enabled tremendous savings by leveraging buying power.

Canada – A Risk Sharing Arrangement

The Challenge	A Canadian provincial health authority issued a tender in 2014 for approximately 22,000 pacemakers, implantable cardioverter defibrillators, and cardiac resynchronization therapy over a four-year period. The health authority was eager to secure devices which had a median life span, including normal battery depletion, so as to avoid patient surgery to replace batteries which would subsequently lead to increased cost in healthcare.
The Solution	To address the health authority's needs, the tendering process involved suppliers indicating the expected longevity of their devices under various usage scenarios. In most cases, the clinical data required to back up supplier claims was not available to the health authority. e.g. some newer devices described as having a seven-year life span had not been in patients long enough to confirm this claim. The health authority needed to overcome the lack of reliable data. To overcome the lack of data, the health authority required suppliers to share some of the risk.
The Process	If a device needed replacement before the end of the promised seven-year time period, the supplier would be obliged to pay the cost of the patient's replacement surgery. The commitment served as a powerful incentive for suppliers to provide realistic life-span information and eliminated the need for them to provide clinical proof of expected longevity at the time of the tender.
The Impact	Risk sharing obviated the manufacturers' burden of clinical proof while ensuring that the health authority would get products that met its technical requirements for better patient outcomes.

Imperial College – Healthcare NHS Trust, UK

The Challenge	Imperial College Healthcare NHS Trust is a major teaching hospital recognised as a centre of excellence in cardiology and cardiothoracic surgery, treating more than 20,000 patients with a variety of heart conditions annually. Dealing with growing demand driven by changing demographics, the hospital faced the stark reality that it needed to accomplish more with the same resources to minimise a funding gap. In that context, the Trust was eager to renew ageing CathLab equipment, optimise daily operations whilst improving capacity and reducing waiting lists, and increase their appeal against the competition.
The Solution	To address Imperial College's needs, Integrated Health Solutions created a tailored solution to bring them the latest in cardiac technologies and to optimise non-clinical operations, aimed at closing the gap between cost and patient access. The seven-year partnership with the Imperial team started in November 2013 and included a cardiology transformation programme identifying £1.5 million in efficiency savings.
The Process	Medtronic took over the responsibility for the capital equipment in CathLabs, determining appropriate equipment needs and coverage levels as well as developing a Quality Framework for CathLab operations management. Optimised supply chain management was achieved by developing and implementing a Quality Framework to standardise and maintain best practices. Medtronic was able to increase the operational excellence of the Trust by implementing structured procedures for advance preparation and scheduling. Through Lean Academy training, the staff was empowered by embedding a culture of continuous improvement and training. Closer collaboration and teamwork was established by organising regular meetings amongst all parties involved to drive the partnership forward.

Maastricht University – Medical Center (Mumc+), The Netherlands

The Challenge	Maastricht University Medical Center (MUMC+) is an academic hospital in the southern part of the Netherlands and the main provider of health services for its region. MUMC+ was facing an increase in both patient volume and the complexity of cases. They were also under continuous pressure from the health system to maintain a high quality of care for more patients without increasing costs. The hospital set out the goals to become a truly patient-centric organisation and improve quality and care outcomes. In addition, they wanted to increase employee engagement and become an employer of choice, whilst optimising processes and instilling a culture of continuous improvement.
The Solution	Integrated Health Solutions created a tailored plan to optimise operational processes and clinical pathways and to fully manage the CathLabs. The solution also made it possible to engage MUMC+ staff for successful change management. The five-year partnership started in 2014 and delivered $2.5M in cost savings.
The Process	To help MUMC+ become one of the top ranked cardiovascular centres in Europe, Medtronic implemented the optimisation of clinical pathways, designed together with Europe's leading clinicians. For Heart Failure and Cardiac Resynchronisation Therapy (CRT), consensus of standard of care was established together with multi-disciplinary team training on patient identification. For Bypass Surgery (CABG), using a Lean analysis approach, Medtronic radically changed planning schedules and improved on-time starts to optimise OR utilize (??). Subsequently, intensive care for specific groups was avoided and planned discharges on admission day maximised bed availability, whilst patient communication also improved. The Integrated Health Solutions also took over the management of CathLabs, managing daily operations and optimising planning and scheduling. Lean Academy training was deployed hospital-wide, involving all levels of staff, establishing Project Management Office and over 40 improvement boards to reduce variability in processes.

REFERENCES

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Medtronic, Transforming Healthcare, Aligning Value view here

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http://www.medtronic.com/ir

Mental Health Reform

Mental Health Reform (MHR) welcomes this opportunity to participate in the Oireachtas Committee on Future Healthcare' consultation on future models of health care in Ireland. As the national coalition promoting improved mental health services and implementation of the mental health policy *A Vision for Change*, MHR makes this submission with particular reference to the need to prioritise mental health in any future health care vision. Specifically Mental Health Reform recommends the following:

1. **Mental health should be prioritised in any future health care vision and integrated with physical health care throughout the health system**
2. **The principles of human rights, autonomy and recovery should underpin all service delivery, including in mental health, the wider health services and other social and community services**
3. **A Mental Health in All Policies (MHiAP) approach should be adopted to take account of the broad impact of mental health on a range of social and economic policy areas**
4. **Government should invest in mental health in primary care to ensure that the mental health needs of the population are addressed at the lowest possible level of the mental health system. This should be supported through investment in mental health resources in primary care and implementation of the shared approach between primary and secondary mental health services. Furthermore, individuals with long term mental health needs should be afforded access to free primary health care.**
5. **Evidenced based supported employment services should be provided to all individuals with mental health difficulties who want to work across the country to support their recovery. Interventions to promote mental health and well-being in the workplace should also be delivered to improve the mental health outcomes of the wider population.**
6. **Government should provide tenancy sustainment supports for individuals with severe mental health difficulties, where necessary, to prevent homelessness and promote recovery.**
7. **Government should implement a nationwide schools programme on mental health and well-being in order to build resilience among the younger population and improve mental health outcomes.**
8. **A national electronic mental health information system should be implemented in 2017 that will report on the extent of service resources, provision, quality and outcomes for community based mental health service delivery according to key performance indicators aligned to mental health policy**

Background

Mental health is a cross cutting issue that is deeply entrenched in every aspect of Irish society. In 2015 the European Joint Action on Mental Health and Wellbeing stated that "mental health is more crucial today than it has ever been… " due in part to its impact on every domain of life.[37] This is compounded by the growing prevalence of mental health difficulties and, as a consequence, an increasing demand on a service that is already under-resourced and overstretched.

- Currently, mental health difficulties constitute one third of the disease burden in Europe and according to the World Health Organisation (WHO), by 2030 depression is expected to be the largest contributor to disease burden
- The Healthy Ireland survey reports that 9% of the Irish population over age 15 has a 'probable mental health problem' (PMHP) at any one time.[38] This equates to approximately 325,000 people based on Census 2011 population data
- Almost 20% of young people aged 19-24 years and 15% of children aged 11-13 years have had a mental health disorder[39]

The high level of demand for mental health supports is clearly demonstrated in the number of individuals accessing existing services. Between 2014 and 2015 the number of referrals for the Counselling in Primary Care Service increased by 18% from 14,407 to 17,000.[40] In child and adolescent mental health services the number of referrals has grown from 8,663 in 2011 to 13,062 in 2014, i.e. by more than 50%.

In addition, a significant proportion of need that could be met within primary care is not being addressed at this level, further increasing pressure on the system. This is due to a lack of integration of mental health in primary care and the absence of a national approach to shared care between primary and secondary mental health services.

Many individuals experience difficulties in accessing timely and appropriate mental health supports. By the end of 2015 almost 3,000 children and adolescents were waiting to be seen by Child and Adolescent Mental Health Services (CAMHS), of which almost 200 were waiting over 12 months.[41] Particular groups of individuals, including people who are homeless, those with a co-morbid diagnosis

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[37] Joint Action on Mental Health and Well-being (2015) Mental Health In All Policies: Situation analysis and recommendations for action. Available at http://www.mentalhealthandwellbeing.eu/publications

[38] Department of Health (2015) Healthy Ireland survey 2015: summary of findings. Dublin: Department of Health.

[39] Cannon M, Coughlan H, Clarke M, Harley M & Kelleher I (2013) The Mental Health of Young People in Ireland: a report of the Psychiatric Epidemiology Research across the Lifespan (PERL) Group Dublin: Royal College of Surgeons in Ireland.

[40] Information provided by HSE.

[41] HSE Performance Assurance Report December 2015.

of mental health in intellectual disability (MHID) and people with a dual diagnosis of mental health and substance misuse experience
significant challenges in accessing appropriate care. Recovery and social inclusion supports for people with long-term, severe mental health difficulties also remain largely under-developed, while the new forensic mental health services envisaged in *A Vision for Change* have not yet been delivered.

Inequity remains throughout the mental health system with wide variation in the resources available in different services across the country. Despite developments in the number of multi-disciplinary staff there are still mental health teams that do not have the full complement of MDT staff. This situation is exacerbated by continued difficulties in the recruitment of staff to services across the country. The mental health services are under-staffed by approximately 20% and during the last Government the number of staff in post increased by only 7.2% (or 644 staff), from 8,909 at the end of 2012[42] to 9,553 in April 2016.[43] In 2008, there were almost 10,500 staff in post.[44]

Of particular concern is that mental health services are still not uniformly providing the basic model of care that includes 24/7 crisis intervention with crisis houses, as the norm in all areas of the country. The requirement for crisis services can be demonstrated by the prevalence of individuals engaging in suicidal behaviours. The number of people who presented to emergency departments nationally following self-harm was close to 10,000 in 2014[45] and the number of people who died by suicide in 2013 was almost 500.[46] Ireland continues to have one of the highest rates of suicide among young people in Europe.

People with mental health difficulties continue to experience significant social exclusion in Ireland, facing prejudice and discrimination, high levels of unemployment, low levels in income, and a growing risk of homelessness. The absence of a dedicated mental health information system has contributed to the absence of any real data on the outcomes for people engaged in the mental health services. Overall, the absence of an information system based on key performance indicators has led to a lack of full transparency and accountability in the evaluation, planning, funding and delivery of mental health services.

In this context Mental Health Reform calls on Government to make mental health a priority within its vision on the future of Irish healthcare. More specifically, mental health should be considered in the context of a range of social and economic policy areas.

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[42] HSE Performance Assurance Report December 2014.
[43] HSE Performance Assurance Report April 2016.
[44] HSE, Vision for Change Implementation Plan, 2009-2013.
[45] Griffin, E, Arensman, E, Dillon, CB, Corcoran, P, Williamson, E and Perry, IJ (2014). National Self-Harm Registry Ireland Annual Report 2014. Cork: National Suicide Research Foundation, p. 29.
[46] Information provided by the National Research Foundation.

The WHO recognises that mental health influences a wide range of outcomes for individuals and communities. It is both a cause and a consequence of social and economic status.

The WHO further identifies that in order to improve the mental health outcomes of the population, Government must focus on facilitating a Mental Health in All Policies approach in which “policy makers across all sectors think in terms of mental health impact”.[47] The social, cultural and economic determinants of mental health must be addressed through a whole of Government approach in which mental health is considered in areas such as the wider health environment, primary care, housing, employment, education, justice and social protection.

Mental Health in All Policies (MHiAP)

The EU Joint Action for Mental Health and Wellbeing has recently identified the MHiPA approach as one of its key priorities.
It defines MHiAP as follows:

“Mental health in all policies (MHiAP) is an approach to promote population mental health and wellbeing by initiating and facilitating action within different non-health public policy areas. MHiAP emphasises the impacts of public policies on mental health determinants, strives to reduce mental health inequalities, aims to highlight the opportunities offered by mental health to different policy areas, and reinforces the accountability of policy-makers for mental health impact”.[48]

Of fundamental importance is that the MHiAP approach promotes:

- positive mental health and wellbeing
- the prevention of mental health difficulties
- early intervention and
- supports the recovery of individuals with existing mental health difficulties

This approach is further endorsed in the European Framework for Action on Mental Health and Well-being 2016. A key objective of the framework is to:

“Develop mental health promotion and prevention and early intervention programmes, through integration of mental health in all policies and multi-sectoral cooperation”.

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[47] Friedli,L. (2009), p. iv.
[48] Joint Action on Mental Health and Well-being (2015).

In line with the WHO, the Joint Action Group has concluded that in order to improve the mental health outcomes of the population "mental health needs to be incorporated in all [Government] policies and at all levels".[49] This is clearly reflected in the Together for Mental Health - A Strategy for Mental Health and Well-being in Wales. This strategy identifies a range of protective factors for mental health and well-being, in addition to a number of risk factors for mental health difficulties. In the UK, work is being developed on the MHiAP approach following on from the Government's report *No Health Without Mental Health*.

A number of measures have been recommended at European level to support the implementation of the MHiAP approach. These include the development of tools for implementation of MHiAP, such as mental health impact assessments. For the purposes of this submission Mental Health Reform will reflect on specific areas and identify how mental health should be considered in the context of each. These areas are: the wider health environment, primary care, employment, housing and education.

Specifically Mental Health Reform recommends:

1. **Mental health should be prioritised in any future health care vision and integrated with physical health care throughout the health system**
2. **A Mental Health in All Policies approach should be adopted to take account of the broad impact of mental health on a range of social and economic policy areas**
3. **Mental Health Reform's specific recommendations on addressing mental health in the context of the wider health environment, primary care, employment, housing, and education, as set out below, should be considered in any future healthcare vision**
4. **The principles of human rights, autonomy and recovery should underpin all service delivery, including in mental health, the wider health services and other social and community services**

Guiding principles

Mental Health Reform strongly recommends that the principles of recovery and autonomy, in addition to a human rights based approach should be recognised and embedded in the delivery of all public services (including mental health and the wider health and social system).

There is a range of human rights which have particular relevance to people with mental health difficulties, including the right to the highest attainable standard to mental health. Other legally binding human rights that extend to the underlying determinants of [mental] health include the right to adequate housing, the right to work and the right to be free from all forms of discrimination. The human rights based approach reflected in the Convention on the Rights of Persons with Disabilities

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[49] Ibid.

(CRPD) views people with disabilities as the subjects of rights or rights holders rather than as the passive recipients of benefits, and places an obligation on the State to respect, protect and fulfil the human rights of people with disabilities. This shift towards a more human rights based approach is reflected in the Expert Group Review of the Mental Health Act, 2001, which recognises the need for service delivery that is underpinned by rights to autonomy and choice.

To date, people with experience of a mental health difficulty as a group are one of the least protected in terms of their rights. They are also one of the most socially excluded, experiencing prejudice and discrimination in all areas of their life in the community.
With respect to the principles of recovery, *A Vision for Change* encapsulates the meaning of recovery stating that [it] ... "should inform every level of service provision".[50] Mental Health Reform is of the view that a cross Departmental approach is required to ensure the recovery of people with mental health difficulties. The associated principles of recovery recognise that services should operate from a hopeful orientation that supports recovery; listen to and work in partnership with people who use services; offer choice and the opportunity for individuals to exercise their autonomy, and support the social inclusion of people with mental health difficulties. The recovery ethos is further endorsed by the Mental Health Commission in its Quality Framework for mental health services and in its report on a recovery approach within Irish mental health services. Mental Health Reform's full briefing paper on recovery can be found at this link https://www.mentalhealthreform.ie/resources/.

Recent efforts have been made to instil the recovery ethos in a number of mental health services across the country. However, such organizational change requires continued action and commitment, including through a wider health agenda.

Health

Recommendation: Mental health is afforded priority within the wider health agenda and is integrated with physical health care throughout the health system

MHR strongly recommends that mental health is recognised and afforded appropriate priority within the wider health agenda to reflect its significance in contributing to the burden of disease in Ireland. It is evident that mental health is both a cause and consequence of physical health problems. A recently published report by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the US found that adults aged 18 or older with any "mental disorder" or major depressive episode in the past year, were more likely than adults without these conditions, to have high blood pressure, asthma, diabetes, heart disease, and stroke. In terms of health service utilisation, adults with any

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[50] AVFC (2006) p. 5.

“mental disorder” used both emergency departments and hospitals more than those without a mental disorder, leading to higher health care costs.[51]

The ongoing gaps in achieving integrated access to mental health care within the health system fall short of international human rights which recognise the rights of people with mental health difficulties to the highest attainable standard of health, on par with those of people with physical health difficulties.

A measure of the lack of priority of mental health within the health system currently is the significant underfunding of mental health relative to its scale and impact. The national mental health policy recommended that the proportion of the total health budget allocated to mental health should be progressively realised to 8.24%. However in 2016 this reached only 6.4%. While this represents a similar pattern on recent years, it also constitutes a reduction from the 13% spent in the 1980s.[52] Internationally, the percentage of mental health funding as a proportion of the overall health budget is significantly higher at 13% in both Britain and Canada and 11% in New Zealand.[53]

International evidence suggests that investing in mental health services will reduce the healthcare costs in other areas of the health sector. Mental health difficulties can result in physical health problems and can also exacerbate existing issues. Altogether, the extra physical healthcare caused by mental health difficulties was estimated in 2012 to cost the NHS at least £10 billion.[54] However, when people with physical symptoms receive mental health care, the average improvement in physical symptoms is so great that the resulting savings on NHS physical care outweigh the cost of mental health care. By investing in mental health services, the Government will ensure savings in a number of areas of expenditure, including physical healthcare. Savings will also be gained in the areas of social protection, education, employment and the criminal justice system.

Primary care/ integrated care

Recommendation: Government should invest in mental health in primary care to ensure that the mental health needs of the population are addressed at the lowest possible level of the mental health system. This should be supported through investment in mental health resources in primary care and implementation of the shared approach between primary and

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[51] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality (April 5, 2012) The NSDUH Report: Physical Health Conditions among Adults with Mental Illnesses., Rockville, MD: SAMHSA.

[52] College of Psychiatrists Ireland (2015) Press Statement: 9th October 2015:Budget Submission 2016, available at http://www.irishpsychiatry.ie/Libraries/External_Affairs/Budget_Submission_2016.sflb.ashx

[53] Evelyn Ring. Low spend on mental health is criticized. Irish Examiner (Dublin) 10th October 2015,available at http://www.irishexaminer.com/ireland/low-spend-on-mental health-is-criticised-358584.html.

[54] Centre for Economic Performance (2012) How Mental Illness Loses Out in the NHS, p. 1.

secondary mental health services. Furthermore, individuals with long term mental health needs should be afforded access to free primary health care.

The WHO has recognised that mental health in primary care is “fundamental”.[55] Primary care services are the first level of care within the formal health system and are generally the most accessible, affordable and acceptable for communities. Where mental health is integrated as part of these services, access is improved, mental health difficulties are more likely to be identified and treated, and co-morbid physical and mental health difficulties managed in a seamless way.

Internationally, there is consensus that primary care workers should be appropriately trained to ensure mental health integration at primary care level.[56],[57] In Ireland, the guidance document issued by the Vision for Change Working Group on Mental Health in Primary Care notes that there is a need to “ensure that sufficient numbers of professionals within primary care teams have the required skills and knowledge to work effectively with patients with mental health related difficulties of a mild to moderate nature that do not require referral to secondary mental health services.”[58]

Despite the development of a range of materials and training programmes to support GPs and General Practice in mental health care, there is a lack of evidence as to how such training is implemented in practice. There are concerns that individuals are often not getting appropriate support, whether it be assessment, treatment and/or referral from their GPs, where they present with a mental health difficulty. This issue has consistently been raised to Mental Health Reform by service users, family members and carers.

The development of a shared care approach is fundamental to improving mental health in primary care and integration between primary and secondary mental health services. This is recognised in national policy, including in *A Vision for Change*[59] and is further endorsed by the Mental Health Commission[60] and the World Health Organisation.[61]

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[55] Mental health is central to the values and principles of the Alma Ata Declaration; holistic care will never be achieved until mental health is integrated into primary care.

[56] WHO (2008), p.8.

[57] Professor Chris van Weel, World President of the World Organisation of Family Doctors (WONCA) states: “We need education and training on mental health care for all students and health professionals training to work in family medicine and other areas of primary health care”.

[58] HSE National Vision for Change Working Group (2012). Advancing the Shared Care Approach between Primary Care and Specialist Mental Health Services: A Guidance Paper. Health Services Executive, Dublin.

[59] AVFC (2006), p.6.

[60] Byrne, M. & Onyett, S. (2010), Teamwork within Mental Health Services in Ireland: Resource paper, Dublin: Mental Health Commission, p.15.

[61] WHO (2005) Mental Health Policy, Plans and Programmes (updated version 2), Geneva: WHO.

The benefits to ‘shared care’ have been clearly identified and include:

1. Enabling GPs to learn about mental health from specialists
2. Creating a clear pathway between primary and secondary care
3. Reducing referrals to secondary care for mild mental health difficulties

Despite this common understanding, and the fact that in a study of Irish psychiatrists, 35% ranked shared care as the primary area for improvement in delivering mental health services in primary care,[62] there continues to be a fundamental gap in care between the two divisions of primary care and mental health.

While the HSE’s Guidance Paper on a ‘shared care approach to primary care and mental health services’ falls short of being a national, binding policy, it provides valuable support for a shared care approach. There is a need to build on and drive national implementation of this guidance through a specific action plan.

Finally, in the context of primary care, access to free healthcare is an important issue for individuals with long-term mental health difficulties who may require long-term treatment for both their physical and mental health. In line with Government policy that supports people being de-institutionalised and living in the community, lack of a medical card can undermine an individual’s ability to access mainstream primary care and continue their treatment. Furthermore, people who have been receiving mental health treatment free of charge from mental health services, may hesitate to be discharged to their GP if they think their costs will increase.

Irish research has found that those with low incomes but without a medical card are less likely to visit a GP.[63] The costs of a GP visit, plus the ongoing costs of multiple prescriptions for psychotropic medication, could deter someone from taking medication that helps to maintain their mental health. A sudden stoppage of medication due to financial concerns, without adequate preparation or medical support, could easily result in an individual having a relapse and requiring hospitalisation which is much more expensive than providing ongoing health services.

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[62] Copty, M. (2004) Mental Health in Primary Care, Dublin: Health Service Executive/Irish College of General Practitioners, p.22.

[63] Nolan, A. & Nolan B. (2004) Ireland’s Healthcare System: Some issues and challenges, Dublin: ESRI.

Employment

Recommendation: Evidenced based supported employment services should be provided to all individuals with mental health difficulties who want to work across the country to support their recovery. Interventions to promote mental health and well-being in the workplace should also be delivered to improve the mental health outcomes of the wider population.

In an analysis of the costs of mental health care in Ireland it was identified that the main economic costs of mental health difficulties are associated with the labour market as a result of lost employment, absenteeism, lost productivity and premature retirement.[64]

There is an opportunity to promote positive mental health and wellbeing among the working age population through targeted interventions in the workplace. In accordance with the WHO, such interventions must, however, be complemented by improved working conditions across the work force, in addition to work place based supports.[65]

Of fundamental importance is the provision of supported employment services for individuals with severe and enduring mental health difficulties who experience challenges in accessing and sustaining employment.

Employment has been identified as increasingly important as a route to social inclusion and recovery from a mental health difficulty. However, people with a mental health disability are nine times more likely to be out of the labour force than those of working age without a disability, the highest rate for any disability group in Ireland.[66] Furthermore, half of adults with a mental health disability who are not at work say they would be interested in starting employment if the circumstances were right.[67] It is clear that the current system of employment supports for people with mental health disabilities, throughout the country, has not been successful in facilitating access to employment.

There is strong evidence that the internationally evidence based approach to supported employment (Individual Placement Support) is the most effective method of supporting people with severe mental health difficulties to achieve sustainable, competitive employment.[68] It has also been shown to be

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[64] O Shea, E. & Kenelly, B.(2008).
[65] Friedli,L. (2009).
[66] Watson, D., Kingston, G. and McGinnity, F. (2012) Disability in the Irish Labour Market: Evidence from the QNHS Equal- ity Module, Dublin: Equality Authority/Economic and Social Research Institute, p.19.
[67] CSO National Disability Survey 2006 Volume 2,Dublin: The Stationery Office, p.86.
[68] Sixteen randomised controlled trials have demonstrated that Individual Placement and Support achieves far superior outcomes across varying social, political, economic and welfare contexts. These show that 61% of people with serious mental health conditions can gain open competitive employment using Individual Placement and Support as compared with 23% for vocational rehabilitation. Randomised controlled trials in the United States have also shown that IPS participants have much better employment outcomes than people

both cost effective and less costly than traditional vocational approaches.[69] This approach includes seven key essential principles including integrated mental health and employment supports, intensive, individual support, rapid job search followed by placement in paid employment, and time-unlimited in-work support for both the employee and the employer.[70]

In 2015, the Department of Social Protection invested in a pilot of evidenced-based supported employment by partnering with the HSE and Mental Health Reform on this approach in four sites across the country. Early indications are that the sites are able to provide a more integrated supported employment service than has been the case previously through Employability services. There is the potential for improved employment outcomes for people with mental health difficulties through this approach and in effect improved mental health outcomes.

Housing

Recommendation: Government should provide tenancy sustainment supports for individuals with severe mental health difficulties, where necessary, to prevent homelessness and promote recovery.

In 2006, *A Vision for Change* identified that homelessness is both a cause and a consequence of mental health difficulties. A study published by Dublin Simon Community in 2014, found that 71% of a representative sample of individuals accessing their services reported having mental health difficulties. Furthermore, a study carried out in an acute unit in Tallaght Hospital between 2012 and 2013 found that 98% of the long stay/delayed discharge inpatients had accommodation related need and there was a discharge to homeless services every 9.4 days.[71]

Housing need has also been identified among people with mental health difficulties residing in HSE supported accommodation. A number of recent reports have shown that some people living in community residences are being over provided for in terms of care and could live independently with the appropriate supports.[72]

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supported by more traditional approaches of providing vocational training and job preparation before undertaking the search for competitive employment.

[69] Researchers conclude that "compared to standard vocational rehabilitation services, IPS is, therefore, probably cost-saving and almost certainly more cost-effective as a way to help people with severe mental health difficulties into competitive employment."In a report for the UK Department of Work and Pensions, the authors calculated that for every pound invested in the supported employment approach there was an expected saving of £1.51.The OECD has also identified that IPS produced better outcomes than alternative vocational services at a lower cost overall to the health and social care systems.

[70] Perkins, R Farmer, P and Litchfield, P, Realising ambitions: Better employment support for people with a mental health condition, 2009, London: The Stationery Office Ltd, p.63-64.

[71] John Cowman (2013) Prevalence of housing needs among inpatients: An audit of housing needs, over one year, in the acute mental health unit in Tallaght Hospital, unpublished report, p.1.

[72] Such findings were found in a review of the Galway/Roscommon community mental health services published by the HSE in 2014. Similar findings were identified in earlier reports including the HSE's own Value

The identified housing need among people with mental health difficulties, including those in homelessness, illustrates the pressing need for the development of long-term dedicated housing supports for this group of individuals.

More specially, Mental Health Reform has consistently advocated that:

1. The Department of Housing and the Department of Health should jointly provide a sustainable funding stream for tenancy sustainment supports where required for individuals with severe and enduring mental health difficulties in order to prevent homelessness. Mental Health Reform welcomes the commitments in the Programme for Government and Rebuilding Ireland on tenancy sustainment supports and urges the relevant Departments to reach agreement on this issue as a matter of priority

2. Government should allocate dedicated funding for the capital costs of providing social housing for people with a mental health difficulty transitioning from HSE supported accommodation and/or acute care

It is important that the issue of housing is addressed in any future vision of health care so that the Government's policy of de-institutionalisation is not hindered by a gap in housing support in the community. Fundamentally, it is necessary for promoting the recovery of people with mental health difficulties and in ensuring their social inclusion within the community. The Australian Human Rights and Equal Opportunities Commission found that one of the biggest obstacles in the lives of people with mental health difficulties is the absence of adequate, affordable and secure accommodation.

Education

Recommendation: Government should implement a nationwide schools programme on mental health and well-being in order to build resilience among the younger population and improve mental health outcomes

In its report on effective interventions for the prevention of mental health difficulties, the WHO identified ample evidence that the education system can influence positive mental health and reduce risk factors for mental health difficulties.[73] International evidence demonstrates that school-based mental health promotion programmes, when implemented effectively, can lead to long term benefits

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for Money Review of the efficiency and effectiveness of long-stay residential care for adults within the mental health services in Ireland and the Mental Health Commission's Happy Living Here Study.

[73] WHO (2004) Prevention of mental disorders : effective interventions and policy options, Geneva: WHO.

for young people by improving social and emotional functioning, reduce the risk of anxiety and depression and improve academic performance.[74]

Furthermore, there is compelling evidence on the value of a 'whole school' approach to social and emotional learning, which every level of education would benefit from.[75] In the context of mental health, the whole school approach builds the capacity of the school community to promote a sense of wellbeing, address the common emotional needs of young people and prevent the development of mental health difficulties. It seeks to make changes to the schools' social and learning environments, strengthen the structures within each school for addressing mental health promotion and promote links between the school and its community.[76]

Schools can also act as an early identification and referral point for students experiencing mental health difficulties. Where timely and appropriate supports are provided for young people with mental health difficulties, there is clear evidence that many will recover, or at least develop coping strategies to manage their difficulties more effectively.[77] There are also obvious economic benefits to addressing the issue of mental health in education.[78] Mental health difficulties in childhood not only negatively affect a child's ability to learn, but can lead to more serious mental health difficulties in adulthood, particularly if the child is not supported to recover.

Mental Health Reform has consistently advocated for the implementation of a nationwide schools programme to build good mental health at both primary and post primary level. As most mental health difficulties begin in childhood, it is of fundamental importance to promote mental health and well-being at this early stage and equip children and young people with the resilience and skills to reduce the likelihood of mental health difficulties in later life.

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[74] Clarke, A., O'Sullivan, M. & Barry, M., (2010). Context matters in programme implementation Health Education, Vol 110 (4), pp.273-293.

[75] Elias, M.J., Zins, J.E., Weissberg, R.P., & Greenberg, M.T., (2003) Promoting social and emotional learning: Guidelines for educators. Alexandria, VA: AFSP.

[76] The implementation of the Incredible Years Programme in Ballymun has shown the benefits of implementing a whole school approach to social and emotional learning. Pre and post test monitoring data demonstrates significant improvements in children's social and emotional well-being (as measured by the Strengths and Difficulties Questionnaire) associated with participation in the programme. Such outcomes were also reflected in the parenting programme. Parents who participated in the programme reported significantly reduced levels of stress (measured by Parental Stress Index) and depression (measured by the Beck Depression Index).

[77] D. Evans, E. Foa, R. Gur (Eds.) et al., (2005) Treating and preventing adolescent mental health disorders: what we know and what we don't know, Oxford University Press, New York.

[78] Ibid.

Mental health information system

Recommendation: A national electronic mental health information system should be implemented in 2017 that will report on the extent of service resources, provision, quality and outcomes for community based mental health service delivery according to key performance indicators aligned to mental health policy

A national mental health information system is essential to ensuring the effective planning, delivery, monitoring and evaluation of the mental health services. Mental Health Reform has consistently called for such a system, however, its specification is yet to be developed.

In 2009, Indecon completed a review of Government's progress on implementation of *A Vision for Change.* Among the key findings of the report, was that there was a lack of available detailed data and information that would be required to facilitate the ongoing monitoring of funding, expenditure and human resource allocation across the mental health services and the assessment of progress on implementation of AVFC.

The report recommended that new performance indicators and up-to-date data should be "developed and published" to progress implementation and monitoring of the national mental health policy. Indecon reported that effective performance indicators would help prioritise resources and increase value for money, enabling the State to progressively improve services and thereby realise the right to health over time in accordance with its obligations under international human rights law.
While, the governance of mental health systems relies on accurate and timely information for effective service planning, implementation and monitoring, in Ireland, information on community mental health services is not routinely collected at the national level. There is no information on the numbers of people resident, admitted and discharged from HSE community residences, or the number of people using mental health day services such as day hospitals, clinics and day centres. Moreover there is a complete absence of data collection on the number of people accessing particular mental health treatments, for example, psychological therapies, and the numbers of individuals on waiting lists for such supports.

The development of an appropriate mental health information system based on key performance indicators will assist in the full transparency and accountability for the evaluation, planning, funding and effective and efficient delivery of mental health services. It also has the potential to provide real data on the outcomes for people engaged in mental health services, including in areas such as housing, employment and education.

Kate Mitchell, Policy and Research Officer, Mental Health Reform

https://www.mentalhealthreform.ie/

MSD Ireland (Human Health)

To make a difference in the lives of people globally through our innovative medicines, vaccines, biological therapies and animal health products.

Ireland’s health service is at a crossroads. This is an opportunity to reframe how better value and quality of care can be achieved in the national interest.

People are living longer, healthier lives thanks to an increasing focus on disease prevention and the breakthrough of new and innovative medicines. But Ireland is also facing challenges. An increase in chronic and manageable disease, long waiting lists and demands on acute services, as well as an ageing population, means that creating and maintaining a cost-effective, world-class health service is imperative.

Future healthcare delivery should be driven by outcomes. Ireland requires a significant rethink on how it funds, not only the overall health service, but the new and existing therapies that provide value for money beyond the cost of the medicine.

MSD is a significant partner in the Irish health service. We interact with the service each and every day and understand the needs of Irish patients. Our medicines make a significant contribution to keeping people well. But we see a health environment that is failing to cope under severe pressure – pressure on outcomes, pressure on resources, and most importantly, pressure on funding.

Ireland is facing similar funding challenges to many other countries in Europe and around the World. Unique factors in Ireland’s favour offer an opportunity to be in the frontline of developing innovative world class solutions to address these funding challenges.

We not only recognise that MSD has a role to play but embraces it. The recent agreement between the Government and IPHA which will inevitably lead to savings in the drugs budget is to be welcomed. However the long term sustainability of this model and healthcare more broadly must be questioned. Now is the time to think beyond this pricing agreement and to begin a conversation about how to create a more sustainable pathway for healthcare in Ireland and how new and existing medicines are funded in the wider context of a ten-year strategy.

This submission is divided into four themes where we believe MSD can contribute to the agreed ten-year strategy for healthcare:

- Value
- Access
- Innovation

- Partnership

Executive Summary

- MSD recognises the need to put the patient at the centre of the ten-year strategy for the Irish health service.
- We recommend the creation of a Medicines Policy for Ireland.
- A Medicines Policy would create a sustainable funding plan, recognising the long-term value of therapies beyond the cost of the treatment.
- Patients are suffering as a result of delays in accessing new medicine and deserve a good assessment process characterised by very clear rules, transparency, consideration of sound evidence and decisions taken in reasonable time.
- Early/expedited access to medicines is imperative for patients. International models should be examined to identify best practice and how new approaches can coexist with current processes which are not optimal for patients or clinicians.
- MSD calls on the Committee to create a Clinical Research Strategy that can provide a framework for world-leading clinical research to take place in Ireland. This should include:
  - Promoting participation in clinical trials
  - Allocated time for clinicians to research
  - Establishment of a Chief Research Officer for the health service
  - Ring-fenced research funding
  - Securing additional EU funding in the aftermath of Brexit.
- To achieve the most efficient use of resources in our health service, healthcare partners should be encouraged to work collectively and collaboratively; in particular public-private collaboration can garner significant success. A systemic cultural shift amongst government and key healthcare influencers and a sense of openness to new and dynamic partnerships should be considered.

Value

In healthcare, the overarching goal for providers and stakeholders must be to improve value for patients, where value is defined as the health outcomes achieved that matter to patients relative to the cost of achieving those outcomes.

A ten-year vision for healthcare in Ireland should recognise the value of medicines and the contribution such therapies make to keeping Irish people healthy. Innovative medicines have contributed significantly in increasing the life expectancy of patients in recent years; indeed approximately 73% of the increase in life expectancy between 2000 and 2009 is attributable to innovation in treatment. Moreover, the value of having the right treatments early in the patient pathway is key in ensuring a more sustainable healthcare system, leading to less hospitalisation and the better management of chronic disease which results in a healthier, more active, and more productive society.

MSD recognises that new and innovative medicines present an affordability challenge at a time when there is public scrutiny of how the HSE spends its funding.

Fig. 1: Additional life expectancy attributed to innovative medicines

We believe it would be in the interest of both government and the industry to develop a Medicines Policy for Ireland which would include a long-term sustainable funding plan for new and existing medicines.

We welcome the agreement between the Government and IPHA signed in July 2016 which will inevitably lead to savings in the Irish drugs bill whilst delivering a transparent process for reimbursement.

With an ageing population, MSD encourages the Committee to consider how the State funds medicines.

More flexible, value and outcomes based reimbursement models offer a way forward because they set the right incentives. Multi-year funding is required to enable such a model and the Programme for Government commits to move HSE beyond merely annual planning.

We in MSD believe that future healthcare delivery should be driven by a focus on outcomes.

Since 1988, the World Health Organisation has disseminated guidelines on National Medicines Policies (NMP), encouraging governments in all countries to develop NMPs to ensure that essential medicines of assured quality, safety and efficacy are available at affordable prices to those who need them at the right moment and at the right place and are used appropriately.

For example, Australia has had an NMP in place since 1999 under four pillars :

Timely access to the medicines that Australians need, at a cost individuals and the community can afford;

Medicines meeting appropriate standards of quality, safety and efficacy;

Quality use of medicines; and

Maintaining a responsible and viable medicines industry.

The Australian NMP, while accepting the relative cost of some new medicine, has allowed patients access to these innovative therapies. Across the 1990s, the share of the market accounted for by new medicines rose in Australia to a greater extent than in comparable countries including the United States, the United Kingdom, Spain, Switzerland, Germany, France, Japan and Italy.

The inclusion of a new Medicines Policy in Ireland would allow input from all sides – manufacturers, healthcare professionals, politicians and, crucially, patients. It would allow for agreement on a sustainable model of funding, for the reinforcement of quality and standards and for a clear pathway to the betterment of patients.

MSD recommends:

- A Medicines Policy for Ireland which would create a sustainable funding plan, recognising the value of therapies beyond the cost of the treatment.

Access

The problems of our two-tier system can be summed up in the question of access. Access to care is a primary reason people choose private healthcare in Ireland. The time taken to reimburse a new therapy can lead to patients being diagnosed later, being treated later and leading to worse health outcomes. It also leads to increased cost to the State and increased pressure on an already stretched system.

MSD commissioned the research company Ipsos MRBI to carry out a major piece of research that examines patient perspectives of current and future healthcare in Ireland. This initiative, My Healthcare, My Future, involved interviews with focus groups, a telephone poll of 1,000 people and interviews with key opinion leaders in healthcare. The research (which will be published in autumn 2016) shows that 89% of people believe that being able to access healthcare services in a timely manner in the future is very important.

Delays in the reimbursement of new and innovative medicines can have an adverse effect on patient outcomes.

While the agreement between the Government and IPHA signed in July 2016 endeavours to commit all parties to a timeline for the reimbursement process, MSD would like to see Irish patients have the fastest possible access to EMA-approved innovative therapies, similar to fast-track systems in other European countries.

This requires a good process characterised by very clear rules, transparency, consideration of sound evidence and decisions taken in reasonable time.

It also requires a degree of flexibility in terms of process. The current system of requiring a Health Technology Assessment (HTA) on multiple indications is time-consuming for all concerned, including the National Centre for Pharmacoeconomics (NCPE).

Innovative thinking is required on new models that will allow patients access to the right medicine at the right time.

In the UK, the Early Access to Medicines Scheme (EAMS) aims to give patients with life threatening or seriously debilitating conditions access to medicines that do not yet have a marketing authorisation where there is a clear unmet medical need. It was launched on 7 April 2014 as a key part of the Government’s Strategy for Life Sciences and is expected to help the UK compete internationally in terms of early access to medicines arrangements.

Under this scheme, the UK regulatory body – the Medicines and Healthcare products Regulatory Agency (MHRA) – provides a scientific opinion on the benefit/risk balance of the medicine, based on the data available at the time of the EAMS submission. The opinion lasts for a year and can be renewed. Following this, EAMS medicines will be commissioned by the NHS to ensure that there is equity of access to eligible patients across the country. It does not replace the normal licensing procedure.

As per current MHRA guidance, the drug is provided free of charge by the pharmaceutical company for EAMS patients and associated delivery costs are covered by the NHS.

Fig. 2: Overview of the UK Early Access to Medicines Scheme

In an independent review of the scheme, published in 2016, PriceWaterhouseCoopers said:

The EAMS is an important mechanism in securing early patient access to innovative medicines in areas of clear unmet medical need […] Between launching in April 2014 and November 2015, the UK’s Early Access to Medicines Scheme (EAMS) received 18 applications, approved 4 products, and provided early access to innovative medicines for over 500 patients across the UK.

From an industry perspective, the EAMS has offered a valuable opportunity for early dialogue with government and arm’s length bodies about product uptake within the NHS. Further, applicants we interviewed also praised the introduction of the Promising Innovative Medicines designation, the support offered by the MHRA, and the role of the EAMS task group as key strengths of the current EAMS process.

In the United States, the Food and Drug Administration (FDA) has four ‘Expedited Programs for Serious Conditions’. These programmes are intended to ensure that therapies for serious conditions are approved and available to patients as soon as it can be confirmed that a therapy’s benefits justify its risks .

These expedited programmes represent efforts to address an unmet medical need in the treatment of a serious condition.

The challenge for the Department of Health and the Department of Public Expenditure and Reform in Ireland is to identify an early access model that marries the best of such international schemes and that is appropriate for an Irish setting.

Recent delays in patient access to medicines have resulted in significant media scrutiny and emotional testimonies from patients, their families and clinicians. Question marks have been raised about the nature of the process and the complexity involved in several different stakeholders including politicians making decisions on these new medicines.

While we recognise the need to have a full and rigorous analysis of new medicines based on cost-effectiveness, all parties must consider that lengthy delays in this process hit the patient hardest. A scheme that would allow patients access to these potentially life-changing medicines at an early stage will ultimately have a net benefit to the overall health service.

MSD recommends:

- International models of early/expedited access to medicine should be examined and introduced to coexist with a current process which causes unnecessary delays and distress for patients.

Innovation

There is significant potential to expand access to clinical trials for Irish patients.

The Irish Government has openly stated its ambition to make the pharmaceutical sector a cornerstone of economic policy and one of the main priorities for Irish economic growth going forward.

R&D is integral to this, and while we acknowledge the commitment to increased investment in R&D structures in Ireland, a centralised research process that can allow for clinical trials to get off the ground early and progress efficiently, will certainly contribute to enhancing Ireland’s standing in the field of clinical trials.

Indeed, with a clinical trial being such a complex process, having a dedicated research expert at national level, ideally at government level, could encourage pharma and other companies to consider Ireland as a location to carry out research in the future.

Innovative medicines have been at the centre of our ability to drive changes in survival and cost effectiveness of treatments. MSD would like to see research included as a key aim of the ten-year strategy.

According to research commissioned by Cancer Trials Ireland (formerly ICORG) in 2016, cancer trials can add 6 to 15 quality adjusted years of life collectively for trial participants with a related economic benefit to the health service ranging from €0.28m to €0.65m per trial.

While huge strides have been made in recent years to enhance Ireland's capabilities to take on oncology clinical trials, such research can be difficult to undertake given the resourcing and budgetary constraints within the current health system. In fact, Ireland is an under-performer globally in this domain despite our prime position to create Ireland as a hub for clinical research in Europe. Nine of the top ten global Biopharma companies are located in Ireland. The Biopharma industry exported products to the value of €30.2bn in 2015 and contributed €1.7bn in payroll. Yet only 3% of cancer patients in Ireland participate in a clinical trial despite well publicised success stories. This is mainly due to the lack of an integrated administrative approach.

As an initial step, we call upon the Committee to consider a re-focus on research at cabinet level. In the past the responsibility for research was clear at ministerial level whereas now it falls between two Departments - the Department of Jobs, Enterprise and Innovation and the Department of Education. We believe the healthcare agenda would benefit greatly for a new government role for Research.

The creation of a Clinical Research Strategy that allows the continued development of exciting, innovative drugs that can address many unmet needs would be welcomed. Such a strategy should include:

- Promoting participation in clinical trials
- Allocated time for clinicians to research
- Establishment of a Chief Research Officer for the health service
- Ring-fenced research funding
- Securing additional EU funding in the aftermath of Brexit

Sweden is a good example of what's been done to date and could be replicated here, in an effort to prioritise R&D. In 2001, recognising the need to coordinate a strategic plan on research, the Swedish Research Council was established by the Swedish government as an authority within the Ministry of Education and Research. The Council has a leading role in developing Swedish research of the highest scientific quality, thereby contributing to the development of society.

Besides research funding, the agency advises the government on research-related issues and participates actively in the discussions to create understanding of the long-term benefits of research, including clinical research. In 2016, the Committee for Clinical Therapy Research has €15.8 million (of which the public health authorities contribute with €7.9 million) at its disposal to fund clinical therapy research.

Providing a similar framework that encourages Ireland to become a world-leading clinical research hub would allow Ireland not only to promote itself as a destination for increased investment, but also allow new innovations to get to Irish patients quicker.

MSD recommends:

- A Clinical Research Strategy which should include:
  - Promoting participation in clinical trials
  - Allocated time for clinicians to research
  - Establishment of a Chief Research Officer for the health service
  - Ring-fenced research funding
  - Secure EU funding following Brexit

Partnership

MSD recognises that innovation does not come without its challenges.

Driving collaboration and encouraging a multi-stakeholder, solution-oriented approach is important to identify new ways of thinking and we in MSD believe that a strategy to stimulate public-private partnerships can reap huge benefits for healthcare. One area where public private partnerships could be beneficial is in technology.

There are many demands on the health budget; however there is still a concentration of funding on the acute hospital sector. Even in countries with a well-developed primary care system like the UK, €1 in every €2 is invested in hospitals. Now more than ever, a more holistic approach and a focus on disease prevention can prevent complications further in life.

The Ipsos MRBI research, My Healthcare, My Future, commissioned by MSD, shows four in five (80%) people surveyed believe it is very important that technology will be used where possible to make healthcare services better in the future. What may be somewhat more surprising is that it is the 55+ age cohort who place greater importance on this, rather than those that are younger.

At MSD, innovative thinking is part of our DNA. The pioneering work undertaken by MSD employees, both in Ireland and around the world, improves health and well-being globally.

In the UK, MSD is working in partnership with Verily (formerly Google Life Sciences) to help healthcare professionals better identify and support for patients at risk of long term conditions using the most advanced new predictive techniques. This involves analysing trends and patterns related to conditions like heart failure and some lung diseases such as Chronic Obstructive Pulmonary Disease in addition to other public health and environmental data, to help identify at risk patients who would most benefit from earlier preventative and actual treatment options, and including the use of tele-health technology. These patients will benefit from a more personalised service, in particular being proactively offered additional physician support and access to relevant technology. The partnership is being trialled by the NHS in Heywood, Middleton and Rochdale as part of the NHS's test bed programme.

Also in the UK, MSD operates CloserCare - a remote monitoring service designed to support improved self-care for patients with long term conditions.

Following an initial trial for the NHS, an analysis of CloserCare by the University of Hull suggested that the CloserCare service is "extremely popular with the large majority of users. The key benefits would seem to be reassurance, feelings of enhanced safety, and support for carers. In addition, the service appears to be assisting some patients to gain a greater understanding of their condition, increase their awareness of the significance of vital sign changes and become more proactive in supporting their own wellbeing."

MSD is ready to offer such innovative, cost-saving initiatives as part of an overall strategy for healthcare. To do so requires a collaborative approach and openness on the part of government to new public-private partnerships within the health service.

MSD recommends that:

- To achieve the most efficient use of resources in our health service, all partners must work collectively and collaboratively. In order for a greater public-private collaboration to happen openness within government is needed which requires a systemic cultural shift in thinking and approach taken.

Recommendations

In the final report of the Committee on the Future of Healthcare, MSD recommends:

- The inclusion of a new Medicines Policy for Ireland as part of any future planning, which includes:
  - creating a sustainable funding plan, recognising the value of therapies beyond the cost of the pill;
  - a reimbursement process that minimises the delay from regulatory approval to patient access for new medicines.
- The Committee should recommend the development of a Clinical Research Strategy which should include:
  - Promoting participation in clinical trials

- Allocated time for clinicians to research
- Establishment of a Chief Research Officer for the health service
- Ring-fenced research funding.

- To achieve the most efficient use of resources in our health service, all partners must work collectively and collaboratively. In order for a greater public-private collaboration to happen openness within government is needed which requires a systemic cultural shift in thinking and approach taken.

About MSD

- Known as MSD worldwide, and as Merck in the United States and Canada, MSD has operations in more than 140 countries.
- MSD is a leader in healthcare, dedicated to helping the world be well through a wide range of innovative health solutions. This includes the development, production and distribution of prescription medicines, vaccines and biologic therapies as well as animal health products.
- From developing new therapies that treat and prevent disease to helping people in need, we're committed to improving health and wellbeing around the world.
- Our products cover a range of areas including heart and lung health, care for women's health, cancer treatment, infectious diseases and many more disease areas. We are proud to be one of Ireland's leading exporters, manufacturing and packaging many of our leading products in Ireland for the world's markets.
- In Ireland, MSD employs approximately. 2,000 people across its five sites in Dublin, Carlow, Cork, Tipperary and Wicklow. Its extensive Irish operations encompass manufacturing, commercial and marketing facilities
- We have a strong legacy in Ireland that stretches back over the last 50 years, and many of our leading products globally are now manufactured or packaged in Ireland. In fact, over 60% of MSD's global top 20 products are manufactured here.
- In the past five decades MSD has invested over €2.2bn in Ireland, contributing significantly towards making the pharmaceutical industry the country's leading export sector.

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http://msd-ireland.com/

Mundipharma Pharmaceuticals Ltd

Mundipharma Pharmaceuticals is part of a worldwide network of privately-owned independent associated healthcare companies

The demands on healthcare resources and services are set to escalate as demographics shift to an ageing population. This increased pressure will be manifest in the State's drugs bill, as new and more effective treatments will be required for more complex conditions.

Biological medicines will play a major role in delivering these new treatments. However, these drugs will place a significant burden on the State’s resources as they are significantly more expensive to develop and manufacture compared to traditional chemical medicines.

Biosimilars offer an opportunity to deliver real savings while securing biological medicines for patients. Biosimilars are biological medicines developed to be similar to an existing biologic medicine (‘reference product’). Like biologics themselves, which show a degree of natural variation due to their complex structure, biosimilars are not identical to the reference product but have the same active substance(s) and are similar in terms of quality, structural characteristics, biological activity, safety and efficacy.

Since the introduction of biosimilars to the EU in 2006, they have delivered tangible savings in healthcare costs and with a number of high-cost biologic drugs coming off-patent in the coming years, the opportunity exists to capitalise on the adoption of biosimilars to achieve significant savings for the State. However, current legislation prohibits the substitution of biological medicines in Ireland, limiting the potential of biosimilars for the Exchequer and patients alike. This is despite the fact that a number of clinical crossover studies conducted have given no evidence of adverse effects from a switch to a biosimilar, and that a number of EU States are operating pro-switching policies to achieve optimum value for money for drugs. As a relatively small market, Ireland must shape its policies to be open to new entrants, facilitating competition in the market and the efficiencies that follow. This is not solely limited to biopharmaceutical policy, but also Irish legislation that is often written in such a prescriptive manner that inadvertently creates barriers to entry for new, innovative products, stifling competition and reducing patient options.

Mundipharma Pharmaceuticals therefore recommends that:

- **Ireland adopt a pro-switching policy, by amending the Health Act 2013 to allow for the interchangeability of biosimilars, to reduce the cost of biologic and high tech drugs and secure savings for the State and hospitals; and**

- **A more strategic approach be taken to drugs policy legislation; not to set specific dosages and conditions of administration, to allow for greater scope for the benefits of enhance competition and encourage innovation.**

Mundipharma Pharmaceuticals welcomes the Committee's 10 Year Strategy on the Future of Healthcare in Ireland and is happy to provide any further information on any of the points outlined in this submission.

Biosimilar Drugs

As people live longer lives, the demands on all forms of healthcare increase. Such demands have, in recent years, placed considerable pressure on the State's drugs' budget, and will require innovative policies and further collaboration with industry to sustain.

One of the fastest-growing sectors within the pharmaceutical industry, and one that will place significant resourcing pressures on the State if not addressed, is the use of biological drugs.

Biological drugs, or "biologics", are made from living organisms of a variety of sources, including humans, animals and microorganisms such as bacteria or yeast. They are manufactured through biotechnology, derived from natural sources or, occasionally, produced synthetically.

The use of biologics is increasing rapidly and will play a major role in delivering new and effective treatments for patients across a growing number of disease areas in Ireland, especially chronic and complex conditions. By 2020, biologics are predicted to rise to 28% of the entire global pharmaceutical market.[79] These, and High-Tech drugs, will likely place the largest burden on the health budget, due to their high-cost of development and manufacturing compared to conventional medicines, resulting in higher medicines purchase costs.

Similar to the rise of generic drugs for conventional medicines, "biosimilar" products have emerged for biological products, that are deemed as highly similar to a licensed biologic, with no clinically meaningful difference from the reference product.

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[79] "Delivering on the Potential of Biosimilar Medicines: The Role of Functioning Competitive Markets", IMS Institute, March 2016
https://www.imshealth.com/files/web/IMSH%20Institute/Healthcare%20Briefs/Documents/IMS_Institute_Biosimilar_Brief_March_2016.pdf

It has been recently estimated that the use of biosimilars across the EU and the US could yield total savings of €50 billion to €100 billion over the next five years, due to the fact that, by 2020, eight major biologic medications are expected to lose exclusivity protection.[80]

Biosimilars offer an opportunity to bring more affordable options to the market that are safe and effective, thus freeing up resources for greater investment in new areas and relieving pressure on healthcare budgets.

Biosimilars and Interchangeability in Ireland

Biologic medicines are derived from living cells or organisms and consist of large highly complex molecular entities. The active substances of biological medicines are larger and more complex than those of non-biological medicines. Due to the variability of the biological system and the manufacturing process, biologics may show a degree of variation, even among batches of the same product.[81]

As such, Biosimilars are not the same as generics, which have simpler chemical structures and are considered to be identical to their reference medicines. [82] It is not possible for Biosimilars to be identical to their reference medicines, considering the reference medicine biologic can vary across different batches.

Biosimilars receive centralised approval by the European Medicines Agency, after which each country can adopt its own policy on pricing, reimbursement and substitution of biosimilars. In Ireland the Health (Pricing and Supply of Medical Goods) Act 2013 specifically excludes biological medicines from being added the interchangeable medicine lists (i.e. they cannot be subjected to pharmacy substitution as exists for small chemical molecules), while the Health Product Regulatory Authority (HPRA) does not recommend that patients are switched back and forth between a biosimilar and the reference biological product. As a result, biosimilars will only be used in Ireland where a prescriber commences treatment using a biosimilar medicine. By blocking the switching of drugs, the savings of biosimilars in Ireland are minimal, given treatment for chronic conditions are often life-long.

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[80] "Delivering on the Potential of Biosimilar Medicines: The Role of Functioning Competitive Markets", IMS Institute, March 2016

[81] Martina Weise, et al. Biosimilars: what clinicians should know? *American Society of Haematology*, 120, pp 5111-5117. http://www.bloodjournal.org/content/120/26/5111?sso-checked=true

[82] European Medicines Agency: Questions and answers on biosimilar medicines (similar biological medicinal products). http://www.ema.europa.eu/docs/en_GB/document_library/Medicine_QA/2009/12/WC500020062.pdf

A biosimilar product, in order to receive marketing authorisation in the EU, must have no clinically significant difference in terms of safety, purity and potency to the original, already approved biological product. The robust approval process carried out by the EMA must prove quality comparability (physicochemical and biological), pre-clinical comparability (in vitro and in vivo studies) and clinical comparability (pharmacokinetics, pharmacodynamics, safety and efficacy).[83]

EUROPEAN MEDICINES AGENCY COMPARABILITY TEST FOR BIOSIMILARS

Quality Comparability: Quality comparability must demonstrate that the medicine is highly similar to the reference medicine. The Quality Target Product Profile (QTPP) is a prospective summary of the quality characteristics of a drug product that ideally will be achieved and provide assurance of the desired quality, taking into account safety and efficacy of the drug product. The level of data needed to confirm biosimilarity is higher than that is needed for demonstration of similarity for generic products.

Pre-Clinical Comparability: Pre-clinical testing is aimed at understanding functional aspects of the biosimilar medicine and how the molecule behaves in terms of its impact on cellular function. Generic medicines do not require pre-clinical testing.

Clinical Comparability: Clinical comparability demonstrate that there is no clinical difference between the biosimilar and the reference medicine and that there is no differences in the benefit/risk profile.

Mundipharma disagrees with this ban on substitution which effectively blocks the State from achieving the same savings as secured from the adoption of generic medicines. Biosimilars are not identical to their reference product, as is the case with generic medicines, however the nature of biologic drugs means that reference products themselves are biosimilar variants of the original product, given the nature of their production.

No data has yet emerged to suggest any negative effect on treatment safety or efficacy of switching from a reference biologic to a biosimilar, while a number of EU Member States currently permit switching. Most recently, a May 2015 position paper published by the Finnish Medicines Agency on the interchangeability of biosimilars noted that switching biological products is common in some EU hospitals and usually not problematic. It further noted that clinical crossover studies conducted have given no evidence of adverse

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[83] National Medicines Information Centre bulletin. Update on Biosimilar Medicines. Volume 21, V5. 2015

effects, and that the theoretical basis of such adverse effects is weak. Finally, it pointed to the lack of any recorded serious adverse effects of switching in the European EudraVigilance database.[84]

Should a biosimilar pass the rigorous EMA approval process, it should therefore be deemed suitable for substitution in Ireland.

Mundipharma recommends Ireland adopt a pro-switching policy, by amending the Health Act 2013 to allow for the interchangeability of biosimilars in Ireland, to reduce the cost of biologic and high tech drugs and secure savings for the State and hospitals.

SNAPSHOT OF EU MEMBERS WITH PRO-SWITCHING POLICIES FOR BIOSIMILARS

The Netherlands (Medicines Evaluation Board): Exchange between biological medicines (regardless of whether they are innovator products or biosimilar medicinal products) is permitted if adequate clinical monitoring is performed and the patient is properly informed.

Germany (Paul Ehrlich Institute): Biosimilars can be used in the same way as the reference products to which they have shown equivalence. This implicitly covers both patients who have not yet received biological therapy as well as patients who previously received the originator molecule

Finland (Finnish Medicines Agency): Biosimilars are interchangeable with their reference products under the supervision of a health care professional. As with any biological products, the switch should be documented.

Potential Cost Savings

The introduction of biosimilar medicines, offers the opportunity to reduce costs of these expensive agents both in primary care through the High Tech Drug (HTD) scheme and for hospital budgets. This potential for savings will allow for more treatment with new medicines and therefore getting the best possible value for the medicines budget without impacting on patient safety.[85]

- ***HSE Position Papers, Biosimilar Medicines in the Irish Healthcare setting***

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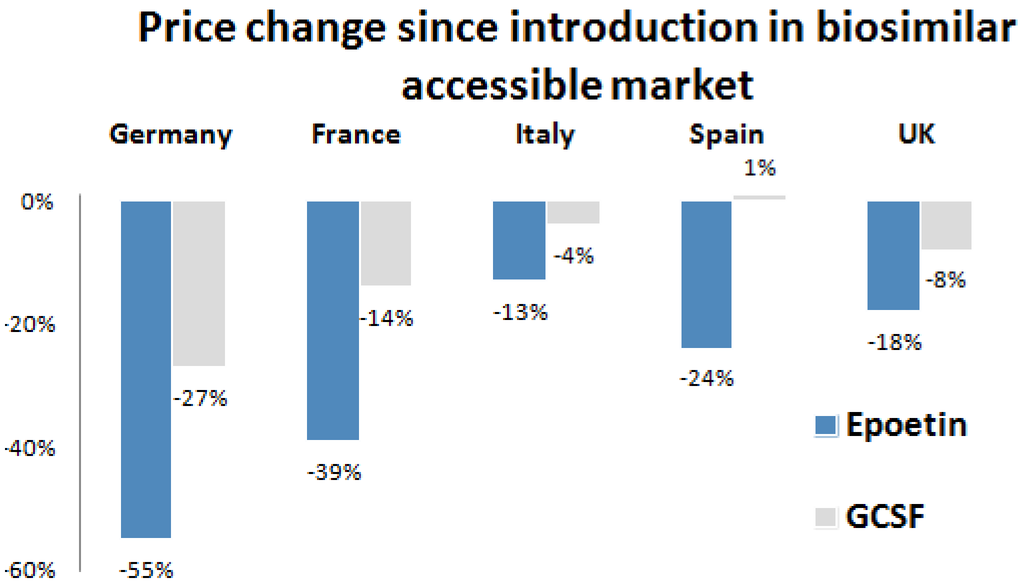
[84] Interchangeability of biosimilars – Position of Finish Medicines Agency (Fimea) https://www.fimea.fi/documents/542809/838272/29197_Biosimilaarien_vaihtokelpoisuus_EN.pdf

[85] Health Service Executive: Biosimilar Medicines in the Irish Healthcare setting. https://www.hse.ie/eng/about/Who/clinical/natclinprog/medicinemanagementprogramme/yourmedicines/positionpapers/biosimilarmedicines.pdf

Competition between originator biologic medicines and biosimilar alternatives offers increased treatment options for patients and clinicians and cost savings for biological treatments. Biosimilars have the potential to free up resources for additional investment in new medicines and relieve pressure on healthcare budgets.

Globally, eight top-selling biologic medicines are due to lose exclusivity protection from patents or other measures by 2020. While the cost of these medicines to Ireland is not available, their combined value in the EU5 (France, Germany, Italy and the UK) and the US in 2015 totalled €42.3 billion.[86] Almost 50 distinct biosimilars are currently in development and will likely result in a highly competitive marketplace over the next five years.[87]

In markets where biosimilars are introduced, price reductions on the drugs have ranged as high as 55% in some circumstances, in the case of Epoetin for example. Likewise, entry of the drug GCSF resulted in reductions as high as 27% across Europe:



In Ireland, the use of biosimilars has shown reductions in terms of cost and provided patients with better outcomes:[88]

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[86] "Delivering on the Potential of Biosimilar Medicines: The Role of Functioning Competitive Markets", IMS Institute, March 2016

[87] IMS Institute for Healthcare Informatics: Delivering on the potential of Biosimilar Medicines: The Role of functioning competitive markets. https://www.imshealth.com/files/web/IMSH%20Institute/Healthcare%20Briefs/Documents/IMS_Institute_Biosimilar_Brief_March_2016.pdf

[88] Health Service Executive: Biosimilar Medicines in the Irish Healthcare setting

Biologics vs Biosimilars – Filgastim

Reference Product	Biosimilar
Neupogen®	Zarzio®
€85.23	€74.63

The use of the biosimilar Zarzio currently offers a **12% reduction** in costs compared with the originator. In 2013, €2.36 million was spent on filgrastim. the use of Zarzio therefore, could result in a saving of approximately **€280,000 per annum**.

Similarly, Irish expenditure on erythropoietin was c. €5.16m in 2016 on the High Tech Drugs scheme, with almost 10,000 items dispensed that year (the 13th most frequently prescribed drug on the HTD scheme). The use of a biosimilar to erythropoietin "offers the potential for cost savings in the acute hospital setting as well as in the community", while the expected introduction of biosimilars for adalimumaab and etanercept (€67.36million and €47.16million in reimbursement by the State, respectively) could result in "significant savings", according to the HSE.[89]

Ultimately the potential for savings for biosimilars is limited at present, given the current legislation only allows for their use in the initiation of treatment. The most significant savings therefore, exist in allowing for and promoting substitution, whereby better value for money can be achieved for every patient currently taking higher-cost drugs also.

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[89] Health Service Executive: Biosimilar Medicines in the Irish Healthcare setting

Case Study: Remsima - UK

Remsima$^{®}$ (infliximab) is an anti-inflammatory biological medicine (biologic), licensed for the treatment of a range of conditions including Crohn's disease, ulcerative colitis (UC), rheumatoid arthritis (RA), ankylosing spondylitis (AS) and psoriasis.

Following the loss of exclusivity by the existing biologic medicine (or originator medicine), the anti-tumour necrosis factor (anti-TNF) medicine Remicade$^{®}$ (infliximab), and subsequent authorisation by the European Medicines Agency (EMA) after undergoing a comprehensive comparability assessment, Remsima was launched in the UK in February 2015.

Infliximab was one of the top 10 medicines in the UK by cost, with **sales of almost £184 million in 2014**.

At list prices alone (as of September 2015), biosimilar infliximab is estimated to **save the NHS around £18.4 million per year (or £50k/day).**

Through its competitive regional tendering process, **discounts are currently being offered to the NHS of around 40-50%** below the NHS list price of the existing 'originator' infliximab, which could equate to a saving of up to **£92 million (£252k/day)**.

Savings achieved have allowed hospitals to reinvest in services, such as the case of University Hospital Southampton, whereby almost **£300,000 was saved over four months** by the usage of Biosimilar Infliximab for all Inflammatory Bowel Disease patients. Of this, **£103,000 was reinvested** in new local services per year.

The British Society of Gastroenterology advises that, provided they are fully informed, patients with a stable clinical response / remission on Remicade can be switched to biosimilar infliximab.

In an Irish setting, the HSE has stated "*In the acute hospital setting there is significant expenditure on the TNF-α Inhibitor infliximab. The availability of infliximab biosimilars Remsima® and Inflectra® have the potential to reduce hospital expenditure by up to 50% for this high cost product*."

Further information:

- European Medicines Agency. Committee for Medicinal Products for Human Use (CHMP). Assessment report: ***Remsima*** (infliximab); June 2013. http://www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Public_assessment_report/human/002576/WC500151486.pdf
- Association of the British Pharmaceutical Industry. Top products in the UK, 2014. [Accessed September 2015] http://www.abpi.org.uk/industry-info/knowledge-hub/uk-economy/Pages/products.aspx
- UK Medicines Information. Prescribing outlook. New medicines. September 2015 [Accessed September 2015] http://www.ukmi.nhs.uk/filestore/ukmianp/2015PrescribingOutlook-NewMedicines-FINAL.pdf
- BSG. BSG Guidance on the Use of Biosimilar Infliximab CT-P13 in Inflammatory Bowel Disease. - http://www.bsg.org.uk/images/stories/docs/clinical/guidance/bsg_infliximab_guidance_16.pdf
- Health Service Executive: Biosimilar Medicines in the Irish Healthcare setting. https://www.hse.ie/eng/about/Who/clinical/natclinprog/medicinemanagementprogramme/yourmedicines/positionpapers/biosimilarmedicines.pdf

Drug Policy Legislation

Given the relatively small market Ireland presents to the pharmaceutical industry, harmonisation with other EU member states, through mechanisms such as the EMA's authorisation procedure and the Single Market are imperative in removing any barriers to entry that may result in innovative and cost-effective products not coming to Ireland.

One such barrier to entry exists in the usage of overly prescriptive terms in Irish primary and (more commonly), secondary legislation. When the usage of drugs is permitted in certain circumstances, often the legislation will establish set dosages, routes of administration and formulations that must be adhered to. In doing so, the legislation captures the description of the drug currently in use, but leaves no scope for advancement in treatments or sets no challenge to market incumbents to optimise their products.

Thus new entrants with potentially different and more innovative formulations for the same indication are blocked from the market, left with the choice of ignoring the Irish market or awaiting amendment to the legislation. Given the size of the Irish market, these potential entrants often choose to ignore the Irish market, resulting in the State missing out on the benefits of competition - namely in product quality and value for money. Therefore, Ireland does not avail of the most innovative and effective medicines in the market, thus maintaining high costs and hindering efficiencies. Equally, Ireland will fall behind other jurisdictions in the availability of better treatments.

http://www.mundipharma.ie/

A case study in this regard is the text and implications of the Medicinal Products (Prescription and Control of Supply) (Amendment) (No. 2) Regulations 2015:

Case Study: Medicinal Products Regulations 2015

The Medicinal Products (Prescription and Control of Supply) (Amendment) (No. 2) Regulations 2015, allows for the supply and provision of Naloxone treatments in emergency circumstances to treat opioid overdose.

The regulation only allows for Naloxone hydrochloride 1 mg/ml pre-filled injection via intramuscular to be administered. Similar products that treat the same indications are not permitted.

Legally restricting the prescribed forms of dosages and administration, means that newer, more innovative and safer products are blocked from entering the market, resulting in Ireland falling behind other jurisdictions in its approach to drug addiction and overdose.

In the case of Naloxone, a pre-filed injection of set concentration is the only product permitted, despite the growing usage across the EU of intranasal Naloxone – Identified by the European Union's European Monitoring Centre for Drugs and Drug Addiction as more user-friendly and safer to administer.

The legislation blocks the entry of a safer, more innovative product. Manufacturers of injectable Naloxone are not encouraged to develop the product, given there is no scope for different compositions.

In both scenarios, the State and patients lose out by inhibiting innovation and competition.

Regulations that do not specify certain dosages and conditions of administration allows for new and

Ireland needs to develop a more comprehensive, market-friendly and future-proofed approach to drug policy legislation, involving industry, clinicians and patients to ensure that legislation is developed to maximise patient options and minimise medicine costs.

A more strategic approach to legislation will encourage innovation and deliver better patient outcomes, drive efficiencies across the health sector and alleviate pressure on acute resources.

It is important to note that more open-ended legislation to allow for future innovation would not entitle any product to enter the market without due diligence - any new product would still require full authorisation from the HPRA or EMA, nor would it impact on the HSE's decision to reimburse any drug on the community drugs scheme.

Mundipharma recommends that drugs policy legislation do not set specific dosages and conditions of administration, leaving that for the bodies already tasked with controlling the pharmaceutical market, allowing for greater scope for the benefits of enhance competition and encouraging innovation.

NALA, National Adult Literacy Agency

The National Adult Literacy Agency (NALA) welcomes the opportunity to input to the Oireachtas Committee on the Future of Healthcare. We also welcome the commitment to health literacy in the ‘Healthy Ireland Framework’ and current HSE Implementation Plan.

NALA believe that health literacy is essential to maintaining health and wellbeing and building a better health service. We seek to make the Irish health service a place where the health provider communicates clearly and the individual has the knowledge, understanding, skills and confidence to take an active role in their health and wellbeing.

With **40%** of Irish people having “limited health literacy”, this means that **four out of ten** Irish adults who use health services have difficulties understanding and acting on health information. This impacts their ability to maintain their health and wellbeing and to participate as an informed partner in health care decisions. This presents huge implications for the health service and practitioners and makes health literacy a key issue to delivering a quality and effective service.

Good health literacy means the health provider communicates clearly and the individual has the knowledge, understanding, skills and confidence to take an active role in their health and wellbeing. With better health literacy, you have better understanding of your health issue and what to do resulting in better health outcomes for everyone.

NALA believes health literacy should be named in the 10-year plan as a strategy for delivering good health services. Also all health programmes and services should identify, integrate and evaluate health literacy from planning through to implementation.

Health literacy is essential to maintaining health and well-being and building a better health service. NALA seeks to make the Irish health service a place where the health provider communicates clearly and the individual has the knowledge, understanding, skills and confidence to take an active role in their health and wellbeing.

Context

40% of Irish people have “limited health literacy” according to the European Health Literacy Study 2012.[90] This means that **four out of ten** Irish adults who use health services have difficulties understanding and acting on health information, such as medication labels, instructions and consent. This impacts their ability to maintain their health and wellbeing and to participate as an informed partner in health care decisions. This presents huge implications for the health service and practitioners and makes health literacy a key issue to delivering a quality and effective service.

Definition of health literacy

Health literacy has two elements:

1. “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”[91]
2. The effectiveness of services provided by health and social care system.

When we deal with health services we often have to find health information, analyse risks and benefits, calculate dosages and communicate. To do this, we may need to be able to:

- understand graphs or other visual information (visual literacy)
- obtain and apply relevant information (information literacy)
- operate a computer (digital literacy)
- calculate numbers (numeracy)
- communicate effectively with healthcare providers (Oral literacy)

Good health literacy means the health provider communicates clearly and the individual has the knowledge, understanding, skills and confidence to take an active role in their health and wellbeing. With better health literacy, you have better understanding of your health issue and what to do resulting in better health outcomes for everyone.

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[90] Report available here: http://bit.ly/2blUyEo

[91] Institute of Medicine. Health Literacy: A Prescription to End Confusion. Washington, DC: 2004.

Healthy Ireland

The national policy **Healthy Ireland - A Framework for Improved Health and Wellbeing 2013 - 2025** includes a commitment to

> “address and prioritise health literacy in developing future policy, educational and information interventions” (Section 3.8, page 25).

In addition the HSE have recently published their **Healthy Ireland Implementation Plan 2015-17** which commits under health literacy to:

> Action 45 – Promote and provide national tools for training, resource development, and health literacy audits in services to raise standards of health literacy among patients, service users, and carers.

Irish research

New Irish Health Literacy research (2015) shows that Irish people want healthcare professionals to use less medical jargon:

- Two in five (39%) Irish people are calling for doctors, nurses and pharmacists to use more understandable language and less medical jargon. This was followed by speaking less formally (22%) and taking more time to explain things (18%).
- 17% of people surveyed said they had taken the wrong amount of medication on at least one occasion.

Why is this so important?

International research has shown that patients who are better informed about their health have more effective consultations with their health care provider, are more likely to comply with their medication and as a result have improved health outcomes.

So how can we address these issues?

NALA seeks to make the Irish health service more literacy friendly. This means providing a service where you take into account the health literacy and numeracy needs of the public and your staff in everything you do. You ensure that literacy is not a barrier to treatment and that people can fully access, understand and make appropriate health decisions. This leads to a higher level of service overall. This is good for everybody.

The National Adult Literacy Agency (NALA) is working with a number of health bodies and settings to help them become more literacy friendly. These include pharmacists and general practices (through the Crystal Clear programme www.nala.ie/crystalclear), hospitals, patient organisations, healthcare professional bodies and local health services.

Recommendations

NALA believes that key priorities for inclusion in a ten year plan would be that:

1. Health literacy is named as a strategy for delivering good health services.
2. In all health programmes and services health literacy should be identified, integrated and evaluated from planning through to implementation.

Some **health literacy initiatives** that may be identified in a programme/service includes:

- Using plain English in all health communications and materials
- Making health literacy part of health training agenda and become a core competency for all healthcare professionals and support staff
- Including health literacy in all surveys and evaluations

Conclusions

There is a need to recognise the importance of developing health literacy both for individuals and health services. NALA believes that by identifying, integrating and evaluating health literacy throughout all health programmes and services, we can deliver a better health services for a healthier Ireland.

https://www.nala.ie/

NAGP, National Association of General Practitioners

This submission conforms to the terms of reference of the committee. The NAGP recognises the immense challenge faced by everyone concerned with reforming our health service. It is our opinion that an integrated care model will best serve the public with regards to clinical outcome, cost and sustainability. We believe that a decisive shift of resources and activity to Primary Care (PC) is possible and will create a better health service. The existing system is failing because it is orientated overwhelmingly towards expensive and frequently ineffective engagement with episodic illness but fails to manage the co-morbid patient, whose numbers are rapidly increasing. The relocation to community care will improve this situation dramatically.

To begin this, we must improve the productive capacity of General Practice. The Irish College of General Practitioners (ICGP) states that only one-third of GP trainees intend to work in Ireland, less than half of these as full-time GPs. Rural and deprived inner city areas and single handed practices will bear the brunt of the resulting shortage of GPs, but no constituency will be unaffected. Next, we must improve the working conditions of GPs to improve on retention of trainees and make Ireland attractive to GPs currently working overseas as it as a competitive global market.

The NAGP represents over 1,600 general practitioners. It is our mission to seek solutions to the problems not only of our members but society in general. Effective leadership and teamwork between senior clinical decision makers, management and Government, will be the key to success.

Background

The Euro Health Consumer Index (EHCI), the most comprehensive measurement of healthcare systems internationally, ranks the Irish health service 21st out of 35 countries[92] and 29th for value. Irish hospitals are working at nearly full capacity – 93.8% compared to 84.3% in the UK and 77.3%[93], the OECD average. Ireland spends at least 45% of our budget on inpatient care, placing us 5th from the bottom for efficiency.

International studies show that the strength of a country's primary care system is associated with improved population health outcomes, regardless of per capita health spend and percentage of elderly. The World Health Organization (WHO) has reported that increased availability of primary health care improves patient satisfaction and reduces aggregate healthcare spending. The majority of studies that compare services delivered from primary care where possible reduces costs, and increases patient satisfaction, with no adverse effects on quality of outcomes[94]. The evidence base for this is now beyond dispute.

GP-led teamwork

The acute care sector cannot deal efficiently with the fastest growing and most resource-hungry demographic, those patients with general fragility and multiple morbidities. A 2014 paper from the US

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[92] http://www.healthpowerhouse.com/files/EHCI_2015/EHCI_2015_report.pdf
[93] http://www.oecd.org/health/health-data.htm
[94] http://www.modernhealthcare.com/article/20141008/NEWS/310089966

Agency for Healthcare Research found that the costliest 1% of patients account for 22.7% of total expenditure[95]. Therefore, it is critical that we identify and manage this cohort of patients if we are to contain healthcare spending. The NAGP's proposals can achieve this, as borne out by international experience of comprehensive, GP-led primary care systems. Within the best of these systems, primary care acts as a 'hub', leading a clinical-community partnership between general practice, specialists, hospitals, home health, long-term care and other clinical providers. These networks focus on the needs of the individual patient, as well as those of populations and communities. GPs, provided with the resources and supports, can manage the majority of such patients by facilitating coordination between the other branches of the system, including crisis prevention in addition to acute and chronic medical care.

The evidence for integrated care

The best example of the success of integrated healthcare comes from an actual scenario. The healthcare system in Canterbury, New Zealand, suffered a very significant loss of infrastructure and capacity following an earthquake in 2011. Health outcomes and resource utilisation were analysed pre- and post-earthquake using advanced statistical methods. The analysis, published in the British Medical Journal in May 2016, found the following[96]:

"Canterbury's integrated health systems transformations have resulted in a dramatic and sustained reduction in ED attendances and acute hospital admissions. This natural intervention experiment, triggered by an earthquake, demonstrated that integrated health systems with high-quality out-of-hospital care models are likely to curb growth successfully in acute hospital demand, nationally and internationally."

The interpreted time series analysis demonstrated that the rapidly-accelerated integrated Canterbury health system transformation strategy after the earthquake significantly lowered the level and the growth rate of acute admissions. These important shifts have significant resource implications. The most dramatic reduction in acute admissions growth after the earthquake occurred among those aged 65+ years. Canterbury's integrated health system model, which embodies community interventions including Acute Demand Management Services (ADMS), Community Rehabilitation Enablement and Support Team (CREST), the Medication Management Service (engaging community pharmacists to review medications actively) and the Community Falls Prevention programme, targeted older adults. Unlike hospital avoidance programs elsewhere, this targeting has been successful. ED attendance rates were also significantly influenced by the Canterbury health system's whole-system community-focused approach.

Understanding the implications of this research is crucial. The NAGP, through its Primary Care Partnership, also has direct access to the people who achieved this.

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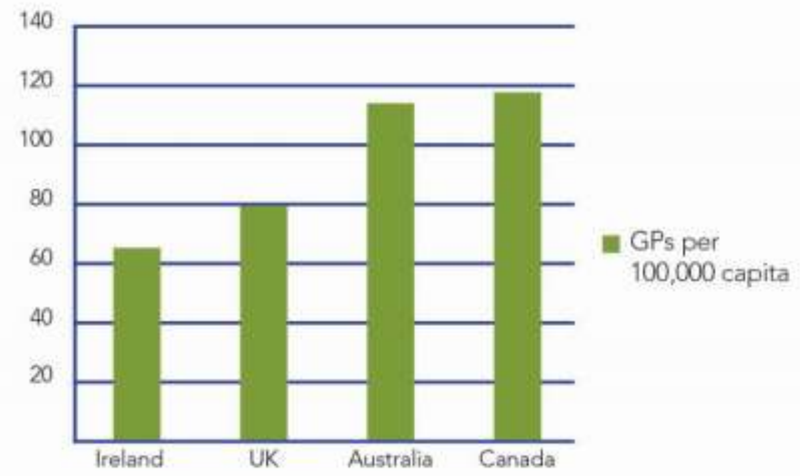
[95] https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality-annual-review-evidence-2013-2014
[96] http://bmjopen.bmj.com/content/6/5/e010709.full

Challenges and solutions



1. CSO (August 26, 2014). Population and migration estimates.
2. CSO (December 12, 2013). Regional Population Projections: 2016-2031.
3. OECD (June 2014). Health Statistics 2014. How does Ireland compare?
4. Department of Health (2013). Healthy Ireland: A framework for improved health and wellbeing 2013-2025.
5. HSE (2014). Primary Care Reimbursement Services: Statistical Analysis of Claims and Payments 2013.
6. Teljeur C, Tyrrell E, Kelly A, O'Dowd T, Thomas S (July 2013). Getting a handle on the general practice workforce in Ireland. Irish Journal of Medical Science, ePublished.
7. OECD statistics database: http://stats.oecd.org/

The number of GPs in Ireland per head of population already falls significantly short of international norms.

Table 1: GPs per 100,000 capita population. Source: LHM Casey McGrath 2015.[97]General practice delivers 22 million consultations every year, projected to increase to 33 million within five years. The number of contacts provided by GPs is ten times that of hospitals. The expansion in demand for GP services is due to facts: the increase in the number of Medical Card Patients, now approaching 50% of the population since the introduction of the under-6s and over 70's schemes and the remorseless increase in the number of elderly frail and co-morbid patients. The table below shows the projected number of GPs needed to meet this demand:

Table 2: Projected number of GPs required. Source: LHM Casey McGrath 2015.

Year	Number of GPs	Annual consultations	Annual consultations per GP
Current	2954	23308910	7891
2021	4264	33644400	7891
2026	4411	34803600	7891

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[97] LHM Casey McGrath Report 2015

During this period of rising Medical Card numbers, Financial Emergency Measures in the Public Interest (FEMPI) has reduced the price paid per consultation from an average of €42 to €29, against an ever increasing cost base. GPs have disproportionately borne the burden of FEMPI, at enormous personal cost. This, however, is no longer sustainable, as the number of doctors leaving Ireland shows. Cash flow and poor working and contractual conditions make general practice an impossible choice for new graduates, many with large educational loans. The Department of Health must seek to address this urgently to stabilise and sustain general practice. If the Department of Health fails to do this, it will make the task of the NAGP in promoting advantageous reform all but impossible.

Manpower: Retaining GP talent

It is the stated intention of 915 Irish GPs – almost one-third of the workforce – to retire or emigrate within the next three to five years, i.e. within the lifetime of this Government. Such a drastic cut in available capacity in itself may be a significant challenge to creating a GP-led primary care system if immediate and meaningful improvement in the lives and prospects of GPs is not forthcoming.

Skilled generalists such as GPs are the cornerstone of medical care. With the increasing subspecialisation of consultants and an ageing population with multiple illnesses this generalist role is crucial. The loss of a large proportion of such doctors will create a void that will be very difficult to fill and planning to fill this imminent loss of GPs must begin quickly to avoid disaster.

There is a huge deficit in the resourcing of general practice. It is not possible for the secondary care sector to make up for this, and even if it were the cost would be crippling. According to the Economic and Social Research Institute (ESRI), by 2021, five years from now, it is projected Meath will have only 27 GPs per 100,000 population. Cork will have 63/100,000, Kildare and Laois will have little more than 30. Such a situation is just unconscionable, but on our current trajectory, inevitable.

Role of the NAGP

The NAGP wishes to discuss viable solutions to create the system we all envision, but it must be acknowledged that it will be impossible for our members to increase their daily workload unless the effects of FEMPI be recognised and to some extent reversed. The morale and well-being of GPs have never been lower. Practices are now in constant financial strain and are unable to refit and invest. It is all but impossible to begin a new practice or take over an old one, such are the insurmountable costs of doing so. The result of this has been a mass exodus from the sector, mostly to the benefit of the UK, Australia, New Zealand and Canada. To be able to find a locum in Ireland is now almost unheard of, such has been the scale of this migration, about which the denial of the Department of Health must change.

Priorities for a GP Led System of Primary Care

SUPPORT THE UTILISATION OF PRIMARY CARE TEAMS

Priority 1

Create a functioning primary care network. The NAGP supports the ICGP sponsored Local Integrated Care Committee (LICC) structure (based on the Carlow-Kilkenny model) which has been adapted by the IEHG and adopted by the Primary Care Division. The LICC initiative proposes the creation of local clinical networks, comprising hospital consultants, primary care physicians and hospital/community management. We also recommend a re-designation of planned and existing Primary care centres into Primary Care Resource Centres (PCRC); to provide the infrastructure to house and expand the capabilities of the networks. For Primary Care and Primary Care Teams (PCTs) to deliver there is a need for human, as well as, physical infrastructure to be developed. This means greater clinical staffing working in PCTs. Clinician-led projects drive hospital innovation. Similarly, GP-led Primary Care will do the same to integrated services in the community and at the interface with hospitals. There is now a choice to be made: do we continue to focus primarily on buildings or do we develop the human and professional engagements of Primary Care Teams in a way that allows all health practitioners and GPs to engage equally and efficiently? The NAGP is confident that there is little or no desire amongst its members to use these new centres as currently intended.

Primary Care Resource Centres

We, therefore, recommend a re-designation of planned and existing Primary care centres into Primary Care Resource Centres (PCRC); to provide the infrastructure to house and expand the capabilities of the networks. Over the last year, the NAGP has engaged in wide-ranging consultations with clinicians and HSE management. The current Primary Care Centres only benefit a small number of GPs and patients. If re-designated as “resource centres” they can serve as diagnostic and service hubs that support patient-focussed care with full engagement of all local GPs. This model would mean that Primary Care Resources Centres (PCRCs) in themselves may not always serve as locations for particular practices, but rather for all GPs/patients in a designated catchment area. If all GPs in a locality buy into the concept of one Primary Care Resource Centre (PCRC), this allows all to refer equally through one agreed pathway to podiatrists, dieticians, physiotherapy, OT, Public Health Nurses, etc., expanding the clinical network and providing for oversight and budgetary control. While the NAGP recognises that this approach may not suit all locations, this is how controlled transfer of resources can happen in a planned way in most locations. Local and regional liaison among practices can be formalised. This would enable innovation and economies of scale for new developments. Supports for local integrated care would be accelerated, and patient outcomes improved. New PCRCs could have a significant role in developing social inclusion in healthcare, attracting engagement from Mental Health and Addiction services, Counselling (SHIP/CIPC), Traveller Health and other voluntary services that are active in Primary Care. PCRCs could also be a focal point for local engagement with other State Agencies – e.g. TULSA, Depts. of Education and Rural Affairs, etc.

A shared GP-HSE Governance and Development Committee could provide oversight and develop local and regional care pathways with access to diagnostics at the PCRC in an agreed manner. This would energise PCTs and transform PCCs into fully functional Primary Care Resource Centres. The presence or absence of GPs on some sites would not impede the development of PCTs or patient services.

Benefits of PCRCs:

- Puts the patient first
- Changes the culture towards engagement
- Solves the impasse on PCT development
- Supports PCTs to deliver their full potential

- Allows all GPs and health providers to engage with new PCRC buildings
- Allows all GPs and patients equal access to PCRC facilities
- Allows shared Governance and Development of PCRCs
- Creates a service hub for all patients
- Creates an agreed access point to develop local diagnostics
- Builds community-based centres that can develop new services
- Develops and houses new integrated services with Secondary Care
- Supports social inclusion in healthcare through community participation
- Assists PC to reach its potential for more care in the community
- Assists PC to be more self-sufficient with less reliance on Hospitals

Practice Manager Subsidy

GPs operating in a single-handed practice are struggling to manage their increasing clinical demands along with the current level of administrative work required. Single-handed practices would benefit from a subsidy payment to finance a Practice Manager for administrative support.

The addition of a competent practice manager would allow GPs to focus on their clinical work, seeing more patients and ensuring adequate time for each appointment. We must ensure that GPs' time is managed well. Supporting the work of GPs with the necessary administrative staff will ensure better outcomes for the patient and allow GPs to focus on the important work of patient care.

INCENTIVISE INWARD INVESTMENT

Priority 2

GPs, as independent contractors, have traditionally invested in their own practices and infrastructure. Since the financial crash, this has largely ceased, and there is a lack of economic confidence about inward investment. The NAGP would urge the Oireachtas Committee on the Future of Healthcare to explore the use of tax credits as a means of encouraging GPs to invest in their practices. Exploring the use of tax credits and reliefs, we believe, would create more financial certainty and contribute substantially to retaining doctors in Ireland.

SUPPORT INTEGRATED CARE

Priority3

The NAGP supports the development of GP-led Primary Care and the shift of focus from our hospital-centric model to a community-based service. This requires a cultural as well as structural change. For Primary Care to engage as equals with Secondary Care, it needs a forum for local and regional engagement. The NAGP Local Integrated Care Committee (LICC) structure can provide this within a relatively short timeframe.

SUPPORT DIGITAL HEALTH SOLUTIONS

Priority 4

Integrated health means patient-centred health. The cultural emphasis on medical practice must move away from institutions and employees and towards the needs of the patient. The creation of a human and digital network that allows universal, real-time access to relevant information is vital to achieving this, with I.T. playing a key role.

Within the professional sphere of services surrounding the patient, communication and coordination can then begin. Problems can be better identified and appropriate action taken at the most practical level. Video technology, data and calendar sharing will enable clinical networks to react quickly, increase productivity, reduce duplication, and avoid missed appointments. The NAGP will have such a platform in operation by the end of 2016, and would be willing to work with the Department of Health to use the platform as a model for expansion. A unique patient identifier system is essential, and we welcome its introduction later this year.

BUILD THE NURSING INFRASTRUCTURE WITHIN GP LED PRIMARY CARE

Priority 5

As we move towards less hospital-centric care there is a need to develop the nursing capacity in general practice to assist in new models of care for chronic disease. An aging, multi-morbid population, with complex socio-medical needs requires greater levels of anticipatory, predictive and preventive care that can only be delivered by “generalists” in the community. This is where GP-led care can provide better care and cost savings to the state. The move from specialism to generalist will take time, but should be resourced by the recruitment of extra nursing staff within general practice. We are seeking for the current number of practice nurses to at least double in order to reach the level that is in keeping with ratios of GPs per practice nurses in other successful GP-led primary care systems. Some of these additional nursing posts can support chronic disease management in the community using existing agreed Clinical Care Programmes. The addition of extra primary care nurses would assist, to some extent, the difficulty this country will face in enticing GPs back to our shores.

Existing GP practice nurses will need training in delivering the new services necessary in a GP-led primary care system. Nurses should be trained to work independently with the support of a GP, to reduce demand on the GP workforce and allow doctors to focus on the intensive management of individuals and population groups.

DEVELOP COMMUNITY-BASED DIAGNOSTICS

Priority 6

For Primary Care to deliver its full potential, it must learn to work seamlessly with Secondary Care through new structures such as LICCs, CHOs and HGs, and also develop its own autonomous diagnostic services that are based in the community and not in the hospital.

The beneficial synergies for Primary Care and hospitals are evident from diagnostics delivered at PCRCs. Having a diagnostic hub at the local level would break the dependence on hospitals and make Secondary Care and Primary Care more efficient.

SUPPORT CHRONIC DISEASE MANAGEMENT IN THE COMMUNITY – NOT IN HOSPITALS

Priority 7

The new GP contract must provide for chronic illness and multi-morbidity management, on an agreed and not ad hoc basis. Flexible care pathways can be delivered by GP-led Primary Care that works through LICCs with its partners in hospitals, HGs and CHOs. A decisive shift to Primary Care can only happen by agreement and adequate resourcing. Clarity of responsibility must be central to any new GP contract. The NAGP will play its full part in the negotiation and implementation of effective chronic disease management.

SUPPORT DIRECT GP ACCESS TO HOSPITAL SERVICES

Priority 8

As we move towards more seamless care between Primary Care and Secondary Care there is a need for GPs (who are the senior decision makers in the community) to have direct access to some agreed hospital services. Direct GP access to Medical Assessment Units, Acute Surgical Assessment Units, Gynaecology, frail elderly and Paediatrics services are critical in chronic care management but are not universally accessible to GPs. Rapid access clinics for frail elderly are a top priority especially as we head towards another winter of predictable respiratory illness in this cohort, many of whom will end up needlessly in Emergency Departments.

Swift discharge of patients from hospital should be facilitated by Primary Care to avoid delayed discharges – a major cause for rising trolley counts. Home-Care Packages should be prioritised by Primary Care. LICCs should be active in improving access to our acute hospitals and facilitating early discharge.

https://nagp.ie/

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4. https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality-annual-review-evidence-2013-2014

5. http://bmjopen.bmj.com/content/6/5/e010709.full

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Additional resources

- The quest for integrated health and social care: A case study in Canterbury, New Zealand (http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/quest-integrated-care-new-zealand-timmins-ham-sept13.pdf)

- Mrs Andrews' Story – what went wrong? Health Service Journal (https://www.youtube.com/watch?v=I0TVbhHdg4A&feature=youtu.be)

National Rehabilitation Hospital

There is strong international evidence to support the cost effectiveness of rehabilitation yet is remains one of the most under resourced areas of health care in Ireland. The National Policy and Strategy for the Provision of Neuro Rehabilitation Services in Ireland 2011-2015 acknowledges that “historically, neuro-rehabilitation services have been underdeveloped and where they exist, have been developed in an ad hoc manner, primarily by the voluntary sector”.

As the national tertiary provider of complex specialist rehabilitation services, The NRH is the only service in Ireland with the specialist skills to cater for the needs of the most highly complex cases including acquired brain injury, spinal cord injury and congenital/traumatic limb absence. The national quota of 108 in-patient beds and 9 day beds for adults and paediatric patients are totally inadequate to meet the increasing demands being placed on rehabilitation services both in terms of numbers and complexity. In line with international recommendations, Ireland requires over 280 in-patient beds along with a care pathway for slow stream and community based rehabilitation services around the country. Staff ratios are inadequate to provide the level of intensity of treatment needed and the hospital constantly loses bed days due to severe shortage of adequate community service and supports which facilitate reintegration into the wider community. This year to date, the NRH has lost 582 bed days to delayed discharges at a cost of €1,244,530.

Demands on the service will continue to grow in line with changes in demographics such as an ageing population, increased survival following stroke, acquired brain injury, spinal injuries and progressive neurological conditions.

Recommendations:

1. Rehabilitation urgently requires a major investment of resources and funding
2. Implementation of The National Clinical Programme for Medical Rehabilitation as well as the Paediatric Model of Care
3. Investment in the National Tertiary Centre in terms of staffing ratios, outreach and educational services development and complex discharge planning.
4. Development of Managed Clinical Rehabilitation Networks (MCRN) each served by Consultants in Rehabilitation and expert teams.
5. Development of agreed pathways and standards of care so that patients are served in the most efficient and cost effective means possible
6. Investment in community based services to facilitate post discharge in integration into the community
7. Investment in services for patients who are ventilated
8. Development of cross sectoral structures to provide a whole system approach
9. Implementation of a funding structure across the acute hospitals, social care and Primary Care divisions which facilitate the efficient movement of resources to follow the patient and prevent unnecessary hospital admissions and delayed discharges.

Introduction:

Rehabilitation following a neurological impairment or loss of function facilitates those affected to acquire the knowledge, skills and supports needed for their optimal physical, psychological, social and economic functioning. Appropriate intervention should be available as required so that human, financial and infrastructural resources can be utilised efficiently.

The overall aim of rehabilitation is to enhance outcomes for individuals, as well as for the delivery system itself. Rehabilitation also promotes opportunities for 'self-management', where the individual is directly involved in planning and decision-making around their needs and takes responsibility for maintaining optimal health, functioning and participation. In the case of children, a *family-centred approach* must be embraced, which emphasizes the importance of the child within his or her family unit and the need to support parents and siblings, as well as the child him or herself.

There is a strong evidence base from high quality clinical trials to support specialist rehabilitation for complex needs following central nervous system illness or injury (Grade evidence, RCTs). This evidence demonstrates a) the cost effectiveness of high quality intensive interdisciplinary neurorehabilitation with respect to functional outcomes, b) supports the positive correlation between earlier access and better functional outcomes for patients, particularly for those with high costs as a result of severe brain injury, and c) reduced burden of care and lifelong costs following specialist rehabilitation (Turner Stokes, 2008; Turner- Stokes et al 2005; Rice-Oxley and Turner Stokes 1999; Sheil et al 2001; Sirois et al 2004). Further evidence demonstrates that rehabilitation provided within a specialist setting for traumatic brain injury (TBI), Stroke (CVA) and Spinal Cord Injury (SCI) is effective and provides value for money by reducing length of stay (LOS) and the cost of care in the long term (Turner Stokes, 2008; Turner- Stokes et al 2005; DOH UK, 2005)
Research clearly supports early intervention, both in terms of personal outcomes for the individual and also the reduced costs to the system.

The National Policy and Strategy for the Provision of Neuro Rehabilitation Services in Ireland 2011-2015 states that the impact of not receiving appropriate rehabilitation and follow up supports can lead to deterioration in function and the associated physical and psychological consequences as well as increased hospital admissions and delayed discharges and consequently an increased burden on the state.

The NRH delivers specialist rehabilitation through four internationally accredited (Commission for Accreditation of Rehabilitation Facilities – CARF) specialist clinical programmes:

- Brain Injury Programme (BIP)
- Spinal Cord System of Care (SCSC)
- Prosthetics, Orthotics and Limb Absence Rehabilitation (POLAR)
- Paediatric Family-Centred Rehabilitation (PAEDS)

The objective of the NRH is to provide the highest standard of care and treatment, as indicated for each patient's individual rehabilitation programme, in order to enhance the best possible management and or treatment of symptoms. The ultimate goal is to optimise independence for each patient in a timely and effective manner which achieves equity, quality, transparency and accountability.

The Hospital has 108 Inpatient Beds, (102 adult beds and 6 paediatric beds) and 9 Day Beds, (7 POLAR day beds and 2 paediatric day beds). There is a comprehensive Interdisciplinary Outpatient, Day Patient Therapy and Liaison Service across all programmes. Approximately 1600 people are referred to specialist rehabilitation annually and are deemed to require the expertise and facilities of a tertiary specialised rehabilitation service.

The NRH serves all 26 counties and is part of a continuum of care from acute to community. National Policy and Strategy for the Provision of Neuro-Rehabilitaiton services in Ireland 2011-2015 has been drawn up which would place the NRH in the centre of a managed clinical rehabilitation network to include:

- Early acute rehabilitation services post trauma or neurological illness
- Access to complex specialist rehabilitation services at NRH as required
- Regional rehabilitation units served by consultants and rehabilitation and trained teams
- Community based rehabilitation teams providing multi-disciplinary rehabilitation and community supports

The NRH has a proven history of the delivery of high quality rehabilitation and continuous improvement in its service delivery. The hospital collects and validates data which is used to direct the services provided e.g. male / female gender bed allocation, reconfiguration of the Paediatric, POLAR and Brain Injury services and development of day patient services. It has also shown commitment to using innovative means of increasing access to, and improving the quality of rehabilitation for patients on an evolving basis e.g. Early Access Rehabilitation Unit, Pooled Shared Waiting List, CARF Specialty Accreditation and increased outreach services.

Waiting Lists:

The waiting times to gain access to the NRH remain unacceptably high. In the absence of developments across the care pathway, patients will continue to wait for long periods in acute hospital beds and suffering secondary damage such as contractures, infections and depression while options to move people back into their homes and communities will remain limited.

It is clear from the data of recent years that the national demand for specialist rehabilitation is rising and the NRH has observed increasing pressures on its service delivery as a result. On the 22nd August 2016 there were 193 adult patients, mostly in acute hospitals awaiting admission to NRH Brain Injury and Spinal Cord Injury Programmes. Over 40% of these patients present with the most complex of needs. There were 40 children waiting for first access to the family centred paediatric programme with a variety of neurological diagnoses.

Table 1

Number of bed days lost to delayed discharges in the NRH					
	2011	**2012**	**2013**	**2014**	**2015**
Total	1466	1283	1790	1525	2308
Approx NRH cost (€800 per bed day)	€1,172,800	€1,026,400	€1,432,000	€1,220,000	€1,846,400

Demographic factors

The situation is certain to become more acute in the coming years in the light of several key demographic factors:

1. Ireland has an increasing number of people surviving traumatic injuries – the development of an effective trauma network which is currently taking place, has to potential to increase survival by up to 30%. These patients will be highly likely to require a significant investment of rehabilitation services in line with medical advances.
2. Long term care conditions are now one of the biggest challenges to health services in the developed world as people survive longer with progressive conditions and the survival rates following stroke, spinal cord injury and amputation continue to grow. This has led to an increasingly complex cohort of patients presenting to the national centre, considerable challenges in post rehabilitation placement and the need for follow up and review services for these patients. Children with conditions such as acquired brain injury require follow up as they grow and develop in line with international best practice and the number of both children and adults presenting for rehabilitation post brain/spinal tumours has grown considerably in line with the increased outcomes and prognosis following these conditions. It is estimated that there will be over 50,000 new diagnoses annually by 2021.
3. Ireland has an increasingly ageing population which is also ageing with neurological conditions. The needs of those ageing with conditions such as spinal cord injury will require ongoing follow up and support over the life span. Falls are now the biggest cause of first time admissions with neurological injuries among the elderly population.
4. With changes in family structures, increased number of women in the workforce etc, there are fewer carers within home/community settings and greater expectations of the health service in general.

5. The economic crisis and the housing shortage in particular have had enormous effects on rehabilitating patients back into their homes. It is virtually impossible to be allocated wheelchair accessible housing and/or to rent suitable housing.

Road Blocks:

Major blocks in the rehabilitation continuum of care are evident both at the acute stage prior to admission to the hospital and at the discharge phase.

“Patients being discharged from hospital should receive a seamless transition from one stage of care to the next. A coordinated and patient centred approach to planning for discharge can lead to increased satisfaction with healthcare services, reduced length of stay and prevention of unplanned readmissions" (HSE Code of Practice for Integrated Discharge Planning, p.10)

Inappropriate facilities and services in the community is a key factor in delayed discharges alongside delays in terms of housing adaptation grants, income support and provision of essential equipment such as prosthetic limbs, wheelchairs, in home equipment such as hoists and rails, orthotics and assistive technology. Some patients are waiting months for Disability Allowance and Carer's Allowance to be processed while others wait several months for a visit from a community occupational therapist. For patients who require residential care, many options are closed off due to lack of investment in assisted living and transitional living services and they have to be directed to the Fair Deal Scheme. This does not provide for the level of care required and the waiting period for a "top up" from Disability services leads to further unnecessary delays.

The increasingly difficult task of securing home care packages particularly for those with complex needs who have newly acquired injuries has in effect blocked the system for many patients. Local HSE disability managers regularly inform the Hospital that local budgets cannot support the very costly and complex care packages required for NRH patients. Since there is no central funding stream for those with highly complex conditions requests for these costs are then sent up to higher levels in the HSE for discussion. It can take several months and even years to secure HCP's for NRH patients many of whom have to be returned to acute hospitals or remain in the NRH during this time. The loss of functional gains apart from the human cost is an unacceptable outcome of rehabilitation and a very poor use of resources. The NRH requires an €2.5 to €3 million per year of new funding needs to support complex case discharge planning.

Table 2

Number of Discharges to Acute Hospitals from NRH					
	2011	**2012**	**2013**	**2014**	**2015**
Total	36	30	33	24	37
Percentage of total NRH discharges.	8%	7%	7%	5%	8%

Staffing ratios remain a major barrier to providing efficient and effective rehabilitation which meets international standards. Rehabilitation is a labour intensive activity and adequate staffing is required to ensure safe expert care.
In the NRH, effective rehabilitation is delivered by interdisciplinary teams led by a Consultant in Rehabilitation. In comparison to other European countries, Ireland has a very low number of rehabilitation consultants and inadequate levels of therapy and rehabilitation nursing staff.

In 2015 / 2016 the NRH carried out a complex review of services and staffing and submitted a Workforce Planning document to the HSE. The NRH benchmarked its staffing levels for similar services against those recommended by the British Society of Rehabilitation Medicine (2009), the Australian Faculty of Rehabilitation Medicine Standards (2011) and the NHS South of England Spinal Cord Injury Board 2010

In summary the benchmarking process revealed a massive shortfall of 109 WTE posts at NRH with 63 of these posts prioritised in the submission to the HSE. Without adequate investment, the hospital will be forced to limit inpatient admissions to lower complexity cases, resulting in unacceptable waiting times for the most severely affected patients.

The NRH has long advocated for increases in its outreach teams and services to provide more efficiencies in terms of pre-admission and post discharge services and to redirect suitable patients to out-patient and other services. There also needs to be investment in NRH staffing to develop the hub and spoke and outreach model of rehabilitation in line with the Government strategy.

A review by Gutenbrunner *et al* (2006) highlights that patient education results in significant savings on follow-on, long-term costs. If future medical costs are to be contained, especially in the context of an ageing population, then patient education should be central to rehabilitation care. The hospital has developed many educational programmes for patients, carers and Health Care Professionals and is developing a centre for education and research. The development of these programmes at a national level is a key strategic goal of the NRH. This will lead to better and consistent staff competencies across the care pathway and facilitate staff rotations and career progression.

When patients and families can be assisted to self-manage aspects of their care, it leads to reduced reliance on the health care system and greater independence and quality of life

Funding Models

The NRH is a fully publicly funded service and therefore already has a single tiered system in place. The hospital and rehabilitation services in general have suffered from lack of adequate investment over many years and have no means of accessing alternative funding sources apart from compensation following road traffic accidents. A lack of integration between the acute hospital and social care divisions leads to a situation whereby one budget benefits if the other division does not accept the patient into their funding structure. Funding structures need to facilitate the breakdown of these divisions and allow for speedy movement of patients down the continuum of complexity where there needs can be met while reducing the cost to the health service as they improve. A patient getting stuck in the system is very costly as in the example of the pathway of high level spinal cord injured (SCI) patient.

Table 3

Patient with high level SCI	**Ideal cost**		**Actual cost**	
	Bed-days	Cost (euro)	Bed-days	Cost (euro)
Acute care (ICU & SCIC)	120	136,000	879	895,000
Rehabilitation care (NRH)	120	96,000	455	386,750
Local hospital pre-discharge	30	18,000	730[#]	438,000
Total		**250,000**		**1,719,750**

[#] *Currently in step-down facility at local hospital.*

Patients should be entitled to access rehabilitation at the complexity level they require in a timely manner. Services should be as close to their home and community as possible and for children, hospitalisation should only be utilised where necessary. Access to the right equipment and support services can speed up rehabilitation and discharge and be more cost effective in the longer term. A central funding structure for highly complex cases needs to be established and there needs to be planning for those patients who require complex residential services/behavioural units so that they can continue to make gains and move onto a more independent setting.

Data collection and analysis to support the funding model and anticipate needs has been a much neglected area and this has hampered service planning and development.

Recommendations:

1. Rehabilitation requires a major investment of resources and funding in order to meet the objectives of good quality rehabilitation care and to reduce the long term human and financial costs of acquired illness and disability. All aspects of the continuum of care require urgent investment and development.

2. The National Clinical Programme for Medical Rehabilitation model of care should be implemented as a matter of urgency in line with the vision of the National Policy and Strategy for the Provision of Neuro-rehabilitation Services in Ireland 2011-2015 (DoHC 2011). The Model of Care for Rehabilitation of Children with Neurological Conditions contained within the Paediatric Clinical Programme also needs to be implemented and developed.

3. There needs to considerable investment in the National Tertiary Centre which will lie at the centre of the hub and spoke model envisaged in the national strategy and the RMP Model of Care. The welcome development of phase one of the new National Rehabilitation Hospital building should be matched by investment in rehabilitation staffing ratios to bring Ireland in line with its international colleagues and in the hospital's outreach and educational services which could be better utilised right across the continuum of care.

4. Development of Managed Clinical Rehabilitation Networks (MCRN) each one serving a population of 1million people need to be developed in order to connect acute and post-acute rehabilitation units and community based rehabilitation services. This should include the stated aim of creating 4 regional units around the country each served by Consultants in Rehabilitation and expert teams.

5. Development of agreed pathways and standards of care so that patients are served in the most efficient and cost effective means possible

6. Investment in community based services to facilitate post discharge in integration into the community including complex home care packages, transitional living units and community based family supports and therapy.

7. Investment in services for patients who are ventilated so that they can be admitted to the national centre and can have access to home ventilation services. The ventilator dependent patient rehabilitation service would be a low volume high cost service but delivering it through

the SCSC Programme at NRH would bring significant efficiencies. The cost of the UK hospital stay for the most recently returned patient in April 2015 was €370,000. The cost for the same length of stay at NRH would be €220,000. For the patient's family it means travelling and staying in the UK for the rehabilitation length of stay.

8. Cross sectoral structures need to be developed in relation to areas key to rehabilitation including transport, housing adaptation grants and vocational services as well as with the Department of Education and Skills in relation to the Paediatric Population. This whole system approach is a vital component to successful rehabilitation and reintegration into home and community settings as well as vocational and educational settings.

9. Implementation of a funding structure across the acute hospitals, social care and Primary Care divisions which facilitate the efficient movement of resources to follow the patient and prevent unnecessary hospital admissions and delayed discharges.

Appendix A

Young Patient in Minimally Conscious State waiting 12 Months for Nursing Home Placement

Background: 22 year old "John", profound brain injury secondary to a cardiac arrest resulting in hypoxic brain injury.

Functional status: minimally conscious state multiple contractures, spasticity. David is dependent on two people for all activities of daily living and dependent on hoist and 2 people for all transfers. This patient requires 24 hour posture management programme with physiotherapy and nursing input for optimal head positioning, upper limb placement and lower limb positioning, splinting regime for bilateral wrists, knee extension splints, ankle resting splints, stretching programme with nurse and physiotherapist; peg feeding, water flushes and medication administration, bowel programme and sensory regulated environment

This young man was admitted to the NRH from a DATHS Hospital following a long waiting period of approximately 10 months. John had to wait for one of only 3 national beds for patients in minimally conscious states. He underwent a comprehensive assessment and intensive rehabilitation programme over a four month period.

John's family are very supportive and were heavily involved in his care. His mother's wish to take him home was not a realistic option given his severe impairments. Fair Deal was successfully applied for and Hamilton Park nursing home was deemed the most appropriate placement for John. This setting could provide for his complex needs and continue the programme devised by the inter-disciplinary team at NRH. An application was made for the €500 top up funding requested. When the local Disability Services were unable to provide this, John became a delayed discharge. Eventually he had to return to his acute care bed where he remained for over a year.

John was placed on a respiratory ward where he had no shower or physiotherapy for several weeks following admission since the ward did not have the necessary facilities. The family contacted NRH repeatedly in a distressed state and reported that his condition was deteriorating. The acute hospital advised the family that they did not have the skills or time to carry out his care plan. John's regressed in terms of his functional status.

Following extensive representation and negotiations on his behalf John was finally approved for admission to Hamilton Park from the DATHS hospital. This placement process from time of completion of his rehabilitation programme at the National Rehabilitation Hospital took twelve months.

http://www.nrh.ie/

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National Clinical Programme for Paediatrics Model of Care – Chapter on Specialist Rehabilitation 2015

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National Treatment Purchase Fund

The National Treatment Purchase Fund (NTPF) is a statutory independent body established in 2004. Its functions relate to activities around data and quality of hospital waiting lists, commissioning treatment for long-waiting patients and negotiation of prices for long-stay residential care. A key reason for its establishment was to provide a fund to commission individual patient treatments, a role in which it has significant success in reducing waiting lists.

The role of NTPF in the commissioning of individual patient-level treatment was reduced in 2012 in line with Government policy. However, *A Programme for a Partnership Government* (2016) contains actions to address patient waiting times with investment of €50 million per year from 2017 to reduce waiting lists.

Key priorities for consideration for inclusion in a ten year plan for health include: use of maximum wait times for both hospital and community based treatment; greater focus on health and wellbeing and reducing chronic disease; maintaining a strong independent agency ensuring the accuracy of waiting list information; enabling treatment in private facilities for those waiting excessively long periods; greater demand & capacity management; continued central price negotiation for long-stay care in a purchaser : provider environment.

Key challenges to achieving a universal single tier health service include: availability of faster treatment in the private hospital sector. Greater clarity is needed on the definition of universal health care; and the future role of the private hospital sector.

Actions needed in relation to the impact of future demographic pressures include: greater focus on health promotion, prevention & early-intervention in primary and community settings; improved clinical pathways; better access to community-based diagnostics; and increased development of alternative models of care for our ageing population.

Steps for consideration to facilitate moving to integrated care models include: improved multi-annual planning cycles to support an evidence informed health system with new performance & accountability mechanisms; a renewed focus on developing of integrated patient care pathways with an empowered, outcome focused delivery system where artificial boundaries are kept to a minimum.

Some key barriers to be addressed include: changing the current hospital-centric focus of care with its siloed approach to planning and resourcing. Current development such as Activity Based Funding will help to reduce over-reliance on short-term incentives which reward treatment more than prevention. There is a need for access to quality evidence data to support decision making.

Achieving the essential buy-in from health care professionals requires strong communication with an equally strong evidence base to build a multi-disciplinary consensus and the involvement of wider stakeholders to minimise resistance to change. Examples of best practice and recent developments include: Integrated Clinical Programmes; Minor Surgery initiative; National Outpatient Improvement Programme; Planning for Health: *Trends and Priorities to Inform Health Service Planning* document; digital solutions to waiting list and eReferrals; HSE Framework for Improving Quality; developing waiting lists for community based services and hospital-based diagnostics.

Background & Context

This submission is from the National Treatment Purchase Fund (NTPF) to the Oireachtas Committee on the Future of Healthcare (the Committee) in the context of its work on examining future models of health care in Ireland. It focuses on the terms of reference of the Committee and on its scope in relation to making recommendations on a changed model of health care. It is designed to present information to the Committee to help its deliberations. The submission contains recommendations for consideration relating to specific Government action. The focus of the submission is on areas where NTPF currently has a specific role and on areas where the organisation believes it has the necessary knowledge, skills and experience to provide an enhanced role with the ultimate aim of supporting faster treatment of patients and help address unacceptable waiting times for public patients as well as improving patient outcomes.

This submission is made in the context of unprecedented numbers waiting for hospital Inpatient and Daycase procedures as well as those waiting for initial appointments for Outpatient consultation. Numbers waiting are reflective of ever-increasing demand for patient treatment, greater patient expectation, advances in treatments, coupled with increasing population and inefficient practices within the system. There are additional challenges of increased chronic disease, obesity and a growing age population profile with greater life expectancy.

The NTPF is conscious of the on-going transformation programme in the health system and recognises there will inevitably be a requirement for organisational and structural change. The NTPF is anxious to ensure that it is in a position to add maximum value to the health system through its independent assurance role.

Introduction to NTPF

The NTPF was established by Statutory Instrument S.I. No. 179 of 2004 – The National Treatment Purchase Fund Board (Establishment) Order, 2004. The key functions, in summary are to:

- Make arrangements for the provision of hospital treatment as determined by the Minister;
- Collect, collate and validate information in relation to persons waiting for hospital treatment and to put in place information systems and procedures;
- Furnish advice to the Minister on issues relating to its functions;
- Perform any other function in relation to the purchase of hospital treatment the Minister may assign;
- Negotiate pricing for long-term residential care under Nursing Home Support Scheme (Fair Deal), 2009;
- Develop a national outpatient waiting list register and activities in relation to outpatient waiting times.

A key reason for the establishment of the National Treatment Purchase Fund was to provide a significant fund which commissioned individual patient treatment from private providers. Up to 2012, when Government policy led to a change in the role of NTPF, the organisation had significant success in reducing long-waiting lists. Significant increases in waiting times have occurred during the intervening period when NTPF did not commission individual patient treatments.

Since 2012, in line with Government policy at that time, the NTPF has had a significantly reduced role in direct commissioning of patient-level treatment. However, ***A Programme for a Partnership Government*** (2016) contains specific actions to address patient waiting times and has committed to continued investment of €50million per year from 2017 to reduce waiting lists. This figure specifically includes €15million for the National Treatment Purchase Fund to be targeted, in particular, at those most urgent cases and those who have been waiting longest. Detailed planning is underway to up-scale NTPF's operations to focus these funds on areas that will have greatest impact on current waiting lists.

This decision was welcomed by the Board and NTPF is now re-focusing its efforts to tackle waiting lists as well as continuing to deliver its other key activity; Data and Analytics; Pricing and Audit & Quality Assurance. The NTPF has completed a draft Strategy & Action Plan (2017-2019) to deliver on its strategic intent over the coming years. The content of this submission is reflective of its strategic intent as articulated in the Strategy & Action Plan.

Strategy

The NTPF believes key priorities for inclusion in a ten year plan include:

- Continued use of measures such as **maximum wait times** to ensure patients are treated within pre-agreed timelines. Such measures are vital to ensure patients are treated equitably and timely with priority given to those in need of urgent care;

- Extending the concept of maximum waiting times for hospital treatment to cover primary and **community based services** such as Speech & Language Therapy etc. This is based on a requirement to ensure equity and also to shift the focus from treatment of illness to an approach that has prevention and early intervention at its heart;

- Focus on measures aimed at creating positive change in **health and wellbeing and reducing chronic disease** in line with the *Healthy Ireland Framework* (2013) and empowering individuals and communities to play a greater role in staying healthy;

- The existence of a **strong independent agency** is vital to ensure accuracy of waiting list information supported by dedicated Audit & Quality Assurance and Data & Analytics capacity and capability. The NTPF plays a key role in ensuring quality assured data is publicly available in relation to hospital waiting times and is now focusing on waiting times for services available outside of hospitals in primary and community settings. In addition, an agency such as the NTPF plays a vital role in the provision of management information to facilitate evidence-informed decisions on service delivery. Any future system should consider retention of such an independent agency and expansion of its role in collecting and publishing treatment and waiting data. The NTPF has a reputation of delivering accurate and timely waiting list data that is in the public interest and supports the health system in prioritising patient treatment. Comprehensive waiting list data is published on the internet within a week of each month-end;

- A facility should continue whereby **patient treatment can be commissioned from private health care providers** when patients in the public system have been waiting in excess of agreed waiting periods. The NTPF has a track record of success in arranging treatment for patients waiting long periods mainly through the use of private hospitals.

- The 2013 OECD report ***Waiting Time Policies in the Health Sector: What Works***, describes recent progression towards waiting time guarantees incorporating choice and competition in the public and or private sector. It contends that such policies have been effective in bringing down waiting times. In contrast supply side waiting time policies are usually not sustainable or successful.

- Greater emphasis on **Demand & Capacity Management** techniques and processes to ensure that the health system has sufficient insight to (a) appropriately manage ever-increasing demand for health services and (b) match supply with appropriate demand. The NTPF has commenced a programme to develop capability to support the system through providing policies, procedures, guidance and training on scheduled inpatient, and daycase care;

- Increased capacity and scope for **centralised price negotiation** on behalf of the state for a range of residential health care settings and treatments. Since the introduction of the Nursing Home Support Scheme

- *(Fair Deal)* in 2009, NTPF has played a significant role in bringing order and price-efficiency into the market for long-stay residential care by private nursing homes through is price-negotiation process. The present systems for negotiating prices for long-term residential care is under review with a view to increasing efficiency, ensuring capacity and providing greater transparency.

- Implementation of a more structured Purchaser-Provider split should receive more focus. The 2010 OECD Report ***Policies for Health Care Systems When Money is Tight***, concludes that the purchase-provider split is the optimal approach towards governance in health care. It provides superior mapping of responsibilities and enhances the functioning of the supply side. OECD defines this model as forming "an important building block for a more policy- orientated approach to health care arrangements. Health care objectives and targets can be set, resource needs assessed and system performance evaluated".

Key challenges to achieving a universal single tier health service include:

- The **availability of faster treatment** in private hospitals provides a viable alternative which can be attractive for patients waiting excessive periods. The existence of long waiting times in the public system inevitably poses a challenge to achieving a single-tier system with treatment based on need. This challenge can be mitigated by ensuring that treatment times in the public system are similar to waiting times for private treatment. A greater focus on health promotion and prevention with a focus on well-being will also help to eliminate the two-tier treatment regime and will free up capacity for those who genuinely require hospital care;

- Detailed consideration should be given to the **role of the private hospital sector** in a single-tier health service. Government policy should determine if the private sector will form part of the single-tier architecture and, if so, how it will be incorporated into the picture. Areas for consideration include; access to diagnostics in private hospitals;

- There is a need to **define what is meant by universal health care** to ensure a common understanding of what we are trying to achieve. There are also questions as to the scope of services falling within the definition and the extent of eligibility within such a system which need consideration from a public policy perspective.

Actions recommended in relation to the impact of future demographic pressures include:

- **Greater focus on health promotion, prevention and early-intervention** in primary and community settings rather than on treatment in acute settings;

- **Improved clinical pathways** for patients in need of care will ensure suitable alternatives to hospital attendance with treatment locally for minor injuries/ailments. This will free up valuable capacity in acute settings for patients who genuinely need hospital treatment.

- Better access to **community-based diagnostics** will ensure a move away from current hospital-centric approaches to health delivery;

- Increased development of **alternative models of care** for our ageing population will ensure alternatives to long-stay residential care so that older people can be cared for at home or in less-residential type settings. A partnership and cross-sectoral approach will ensure innovative financially sustainable solutions leading to improved quality of life in later years;

Integrated Primary and Community Care

The NTPF plays a key role in tackling issues relating to patients waiting excessively long times for an outpatient appointment or for inpatient and day case treatment. Evidence of ever-increasing demand for all forms of hospital-based treatment results in a constant struggle to provide resources to match demand. It is increasingly clear that this is an un-winnable battle and we need to explore alternative models to integrate primary, secondary and community care with the acute system. NTPF recognises that the current **Programme for Health Service Improvement** in the HSE, overseen by the Department of Health, has a firm focus on integration. This is welcomed and endorsed by NTPF which believes that development and promotion of integrated models will lead to better utilisation of valuable healthcare resources

The following should be considered to facilitate a move to such models;

- There is a need for an **improved planning cycle** which takes a systematic approach to defining population need, assessing resources available, designing services, commissioning services and measuring quality and outcome of services delivered;

- Consideration needs to be given to **multi-annual planning cycles** which introduce more certainty and encourage development of more integrated models of service delivery;

- There is a need to move to an **evidence informed health system** where decisions on provision and quality of services are based on comprehensive evidence readily available to policy makers, service providers and service purchasers. This is in keeping with *eHealth Ireland – "bringing improved population wellbeing, health service efficiencies and economic opportunity through the use of technology-enabled solution";*

- There is a requirement to develop new **performance & accountability mechanisms** that set goals and targets that encourage and reward integrated thinking, decision making and service delivery appropriately balanced between hospital and community;

- There needs to be renewed focus on development of **patient care pathways** that break-down artificial barriers and blockages between primary and secondary care. The focus should be on treating patients as close to home as possible in the most efficient manner to deliver agreed outcomes. Consideration should also be given to extended working hours to maximise the use of scarce facilities;

- There is a requirement for a **new relationship** between the traditional centre of the Health Service (HSE) and new delivery system of Hospital Groups and Community Healthcare Organisations. The relationship needs to be more empowering and outcome focused with clear division of responsibility in a purchaser: provider model;

- There needs to be a changed focus of **medical, nursing and health professionals training** to ensure the boundaries between care in hospitals and community are minimised to facilitate integrated care while attracting and retaining staff of the highest calibre to work in our health service;

From the experience of the NTPF, the key roadblocks encountered and the key barriers to be addressed to achieving such integration include:

- There is currently a **hospital-centric focus** in relation to delivery of care with patients inevitably having to attend hospitals to access services that could more appropriately be delivered in the community

- There is a **siloed approach to planning and resourcing** which seeks to delineate between hospital and community budgets with little incentive for integrate thinking and innovative solutions;

- There is an **over-reliance on short-term incentives** which do not lend themselves to integrative thinking and decision making. There needs to be a focus on tackling root causes of delays in treatment with less focus on simply tackling symptoms;

- There is a need to accelerate roll-out of **Activity Based Funding** programmes in Acute Hospitals and a need to ensure that the recently established programme for community costing be implemented without delay;

- The current funding model for health is characterised by **incentives based on treatment rather than prevention**. In any system where primary funding mechanisms are based on volume of patients treated there is less incentive to focus on preventative health promotion measures;

- The lack of **access to quality evidence data** to base decisions on leads to sub-optimal choices being implemented. We need greater focus on systems and processes to collect such data, particularly in community settings, and make it freely available to support evidence-informed decision making. Improving informatics and analytical capacity and capability of the system is a priority.

It is essential that we achieve a high degree of buy-in from health care professionals to achieve an integrated model. This could be achieved through the following:

- Providing **strong communication** material to ensure health care professionals are aware of the case for change and proposed thinking on development of integrated models;

- Providing a **strong evidence base** for the case for integrated care with practical examples of integrative models working in Ireland and elsewhere;

- Building **multi-disciplinary consensus** across all those working in health as to the need for change and the proposed direction of travel;

- Ensuring **involvement of wider stakeholders** including: Universities; Medical Colleges; Professional Bodies, Representative Groups and Trade Unions to minimise resistance to change;

The Committee may wish to consider these examples of best practice and recent developments:

- Establishment of the five **Integrated Clinical Programmes** by the HSE Clinical Strategy & Programmes Division to integrate health and social care to ensure good patient outcomes are at the centre of all health activity thus ensuring delivery of seamless patient-centred services.

- Development in 2015 of the HSE's **Minor Surgery initiative** by the Primary Care Division. This works with GP Practices to develop the capacity to transfer a significant number of minor surgery procedures from acute hospital settings to accredited GP practices. This reduces the dependency on the hospital system and allows patients to be treated locally in a cost-effective manner with good quality patient outcomes. Initiatives like this not only have the effect of managing numbers of patients going on hospital waiting lists but also allow for retrieval of patients currently on waiting lists and re-directing them to more appropriate care settings where they can be treated faster;

- Development in 2016 of the HSE's **National Outpatient Improvement Programme** by the Acute Hospital Division to re-conceptualise ambulatory services to deliver modern healthcare in the best location, when it is needed, utilising resources in hospitals and the community in a more integrated manner;

- Publication by HSE Health & Wellbeing Division of ***Planning for Health: Trends and Priorities to Inform Health Service Planning*** (2016) provides relevant data to support evidenced informed decision making in planning health services. It is a key resource to inform setting priorities for future health delivery;

- Work by HSE CIO through eHealth Ireland on **digital solutions to waiting list and referral** issues is good example of integrated action. Work on eReferrals seeks to enable better interaction with patients which builds up trust in the process and will reduce incidence of non-attendance for appointments - a long-standing issue impacting on efficiency. Introducing the planned **Individual Health Identifier** will be a powerful enabler of more integrated care;

- Development in 2016 by HSE Quality Improvement Division of the *Framework for Improving Quality* is another example of integrative thinking. It will help the system cope with the current strain it is under at the frontline with a focus on improvement which is so critical to re-orientate planning and delivery of healthcare and **move away from crisis management to proactive service improvement**;

- Integrative thinking and practice is demonstrated through current work of NTPF on **waiting lists for community based services** to ensure patients are seen in an equitable and timely fashion in community settings thus reducing reliance on hospital treatment;

- Work by NTPF on **waiting lists for hospital-based diagnostics** will help ensure better access to early diagnosis and treatment of illness thus reducing the severity of chronic conditions which place disproportionate burden on acute hospitals if not tackled early;

Funding Model

NTPF does not consider the issue of the funding model to be within its remit or competence therefore, it is not addressed in this submission.

Conclusion

This submission is designed to assist the Committee in its deliberations on future models of health care. It sets out priority areas which NTPF believes merit consideration in the context of the ten year plan. It is based on the experience of NTPF in the area of waiting lists data as well as the significant role the organisation has had in direct commissioning of individual patient care in both public and private hospital sectors. It also draws on experience in negotiation of pricing for long-term residential care. The NTPF is fully supportive of the development of integrated care and the submission includes observations and recommendations in relation to achieving integration with views on some key enabling factors. We welcome the opportunity to make this submission and will be pleased to furnish additional material the Committee may require. Representatives of NTPF are available to make a presentation if deemed appropriate.

Jim O'Sullivan, Chief Executive
http://www.ntpf.ie/home/home.htm

Neurological Alliance of Ireland

Over 800,000 Irish people are living with neurological conditions and 40,000 people are diagnosed with a neurological condition each year. The impact on health resources and health service infrastructure of these conditions is considerable and will increase as our population ages

The principal barrier to effective integrated care for people with neurological conditions continues to be underinvestment and underdevelopment of specialist services leading to gaps at all stages of the care pathway. There has been a dearth of commitment and leadership in the health system to date to address the needs of people with neurological conditions with reports remaining unpublished and failure to implement policy.

Lack of neurological care services continues to have a significant impact on the wider health system with longer hospital stays, delayed discharges and requirements for earlier admission to residential care. **Effective integrated care for people with neurological conditions is key to any future healthcare strategy because of the growing numbers of people with these conditions and the impact across the health system.**

The Neurological Alliance of Ireland are calling for the Ten Year Strategy for Healthcare to make neurological conditions a key priority within the health service

A Ten Year Strategy for Neurological Care must:

-Aim to address the critical shortages in staffing and specialist services for people with neurological conditions both in the hospital and community

- Assign responsibility to a designated lead at senior level in the HSE for the development of neurology and neuro-rehabilitation services.

-Implement the framework for neurology and neuro-rehabilitation services outlined in the models of care for Neurology and Rehabilitation Medicine and the National Neuro-rehabilitation Strategy

Meeting the needs of people with neurological conditions requires wider changes in the health system including removing barriers to accessing healthcare supports based on medical card eligibility and funding of long term services and supports for people living with neurological conditions and other disabilities in the community. Investment in proper information systems for the health services is critical to achieving integrated care and effective management of chronic disease and disability across the health system.

The submission outlines a series of principles which should form for the basis for any future funding model for the health services in order to address the needs of people with neurological conditions. These include (i) the funding model is centred around the needs of service users, providing real choices to address the entire range of health and social care needs of people with neurological conditions (ii) recognises and supports the role of not for profit organisations in delivering specialist responses to the needs of people with neurological conditions and (iii) ensuring that appropriate funding is available to secure the critical investment in neurological care that is required now and into the future.

The Neurological Alliance of Ireland has a strong track record of working with the health services, including as part of programme teams for the National Clinical Programmes in Neurology and Rehabilitation Medicine and is willing to work as a close partner with the health services going forward in identifying appropriate responses to meet the needs of people with neurological conditions.

Priority for a Ten Year Plan for the Health Service: Investing and Developing Services for People with Neurological conditions in Ireland

Services for the diagnosis, rehabilitation and treatment and long term support for the 800,000[98] people in Ireland living with neurological conditions are unfit to meet current need and completely inadequate to address future demands. An ageing population with increased prevalence of neurodegenerative conditions, the complexity of care presented by those living with paediatric neurological conditions into adulthood and those surviving traumatic and vascular acquired brain injury and the increasing availability of treatments for many neurological conditions is placing increasing demands on health systems throughout the developed world. The World Health Organisation has recognised this, highlighting that neurological conditions represent “the greatest public health challenge facing public healthcare systems in developed countries worldwide”. Ireland is no exception. Where we are exceptional is the extent to which, uniquely in the developed world, we have omitted to invest sufficiently in the development of neurological care to date, with the result that our health system continues to fail to address the needs of people with neurological conditions.

The second critical problem is an absence to date of a co-ordinated strategic approach to neurological conditions within the health services. The needs of people with neurological conditions have been examined through a series of reports and policy frameworks, some of which remained unpublished and others which have failed to be implemented to date. Responsibility for developing neurological care services lies across a number of divisions within the HSE, with no central strategic approach. Responsibility must be assigned at senior level the HSE to co-ordinate the development of neurology and neuro-rehabilitation services.

Neurological conditions have a significant impact on the wider health system. 17% of all GP appointments are for people living with neurological conditions and they account for one in ten visits to an accident and emergency department[99]. The current situation where these services are either completely absent or underresourced to the extent that they cannot meet the level of need is resulting poor health and quality of life outcomes for people with neurological conditions. It also results in costly impacts across the health system, including delays[100]and blockages[101] within the hospital system and overcrowding in accident and emergency units because services in the community are either completely unavailable or inadequate to meet demand.

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[98] Strategic Review of Neurology and Neurophysiology Services in Ireland (2007) Unpublished Report commissioned for the National Hospitals Office HSE

[99] Transforming Community Neurology: What Commissioners Need to Know (2016) NHS

[100] The number of people waiting more than six months for a first time outpatient appointment to see a neurologist stands at 6,688 in June 2016 up by more than 1000 from January 2016 (Outpatient Waiting Lists by Speciality http://www.ntpf.ie/home/outpatient.htm)

[101] In July 2016, 42 delayed discharges were directly attributable to waiting lists for rehabilitation services in the NRH and other hospitals

Effective integrated care for people with neurological conditions is key to any future healthcare strategy because of the growing numbers of people with these conditions and the impact across the health system. The Neurological Alliance of Ireland is calling on the Committee for the Future of Healthcare to identify neurological conditions as a key priority within a ten year plan for the health services.

Effective integrated care for people with neurological conditions within our health system can only be achieved through:

- **Investment in and development of specialist services** so that there is a viable care pathway for those with neurological conditions with appropriate services available to meet their needs at all stages of their condition
- **Implementing wider changes in the health system including removing barriers to accessing healthcare supports based on medical card eligibility and proper funding of long term services and supports for people living with neurological conditions and other disabilities in the community**

Underdevelopment and understaffing of specialist services for People with Neurological Conditions: Evidence of Need

Effective integrated care for people with neurological conditions requires appropriate services to be in place at each stage of the care pathway. Integrated care is inextricably linked to the issue of investment in and development of specialist services that can provide appropriate responses to the unique and complex needs of people with neurological conditions but also provide the critical expertise to support other areas of the health system in the appropriate management of these conditions. Evidence of need in terms of understaffing and underdevelopment of specialist services for people with neurological conditions is presented in detail in Appendix 1 of this submission.

Changes required in the wider in the Health System to Meet the Needs of People with Neurological Conditions

Effective and integrated care for people with neurological conditions continues to be impacted by the way in which our health system is structured and funded, which creates barriers to accessing healthcare services and supports and a lack of services to meet the needs of people with chronic illness and disability living in the community.

A Ten Year Strategy for Healthcare must address the following systemic issues within the health services which continue to impact on effective and integrated care for people with neurological conditions, and which significantly constrain the introduction of new models of service delivery based on improving integrated care:

1. **Reform of the Medical Card System and Long Term Illness Scheme**

Entitlements aimed at supporting access to healthcare actually create barriers for many people with neurological conditions

(i) Access to a range of healthcare services in the community is dependent on having a medical card
(ii) The financial burden associated with living with a chronic illness or disability needs to be properly assessed and reflected within the medical card system. The current system does not appropriately reflect the cost of living with a chronic illness/disability
(iii) The Long Term Illness Scheme excludes many disabling neurological conditions

The NAI is calling for a ten year strategy for healthcare to implement the recommendations of the Expert Group[102] on medical card eligibility and to review Long term Illness scheme, protecting existing and future recipients for the conditions currently under the scheme but widening entitlement to this scheme across the range of disabling neurological conditions.

Commitment to the development and resourcing of services in the community in line with Healthcare Policy

A shift in healthcare policy over the past two decades towards meeting the majority of healthcare needs in the community has failed to provide the resources and expertise required in the community to make this a reality[103].

The lack of specialist services and staffing in the community to meet the needs of people with neurological conditions continues to result in unmet need and pressures on acute hospital neurology services and the only specialist rehabilitation centre in the NRH to deal with the consequences of lack of services for the long term management of neurological conditions. These include:

-pressures on secondary care to provide frequent review and readmissions to address needs which could be met in the community

-loss of treatment gains and deteriorations in functioning which make the management of neurological conditions more expensive in the longer term because of the need for hospital admissions and early transfer to residential care

Rehabilitation services in the community such as early supported discharge teams for stroke represent a vital link between the hospital and community in supporting effective integrated care for people with neurological conditions, helping to reduce the length of hospital stay, readmissions to hospital and admissions to long term care[104]

Provide a model of individualised supports for people with disabilities living in the community which is informed by and responsive to the needs of people with neurological disability

Reform of existing funding models within disability services to provide a system-wide resource allocation model based on individual support needs has the potential to provide greater equity and choice for people with disabilities[105]. The majority of people with neurological conditions do not live in traditional models of residential care, but wish to live in their own communities with the range of supports they require.

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[102] Report of the Expert Panel on Medical Need for Medical Card Eligibility (2014) Health Services Executive

[103] Report of the Expert Group on Funding and Resource Allocation within the Health Services (2009) Department of Health

[104] Towards Earlier Discharge: Better Outcomes, Lower Cost. Stroke Rehabilitation In Ireland (2014) Report prepared for the Irish Heart Foundation by the Economic & Social Research Institute (ESRI) and Royal College of Surgeons (RCSI)

[105] The Introduction of Individual Budgets as a Resource Allocation System for Disability Services in Ireland (2011) National Disability Authority

It is important that the introduction of a model of individualised supports for people with disabilities addresses the following needs of people with neurological conditions:

(i)the significant deficits in the availability of a range of specialist services for people with neurological disability currently present a barrier to individuals in accessing services to meet their needs. Investment in services for people with neurological conditions is critically required to provide people with a neurological disability with real options and choices about their care.

(ii) people with neurological disability must have access to qualified support to make informed choices about their service needs and accessing appropriate services to meet those needs

(iii)the assessment of individual need must appropriately capture the range of specialist supports and services required by people with neurological conditions and be flexible to reflect changes in their condition and circumstances over time

(iv)a model of funding support based on individual support needs must ensure that there is a co-ordinated approach to service provision for people with complex neurological disability though a central key worker or case management service.

Investment in Services to Support People with Neurological Conditions to live in their Communities, not in nursing homes and other inappropriate settings

People with neurological conditions are among those most impacted by the failure of the health system to invest appropriately in long term care options for people with chronic illness and disability that enable them to continue to live at home or in supported living settings that are appropriate to their needs. Currently, for the majority of people with neurological conditions, the lack of options for home support and appropriate residential care mean that they are accommodated in nursing homes which are completely inappropriate to their needs.

Real commitment to long term care options other than nursing home care must be a strategic focus for a ten year strategy for healthcare. The continued reliance on nursing home care is condemning people with neurological conditions to live in what amounts to a whole new iteration of the problem of congregated settings, denying them choices about where to live and access to a range of community healthcare services, including neuro-rehabilitation services, to meet their ongoing needs.

Investment in Information Systems to Support Effective Integrated Care for People with Chronic Conditions and Disability and a Strategic Vision for Research within the Health system

Provision of effective, integrated care for people with neurological conditions is significantly constrained by the lack of information systems both in the hospital and community.

The models of care in development for neurology and rehabilitation medicine services outline the vital importance of information systems based on a unique identifier to support effective integrated care for people with neurological conditions. Neurology services have been at the forefront of innovation in this area with the development of the electronic patient record for epilepsy, now being piloted across two other chronic health conditions, haemophilia and bi-polar disorder. Neurological conditions will require information systems that share information effectively across a range of health and social care settings if they are to be effective in meeting the long term needs of this population.

A ten year strategy for healthcare crucially needs to support a research infrastructure within the health services through funding, creating links between academic and hospital based research and ensuring that information systems are in put in place.

Key Principles for a Future Funding Model for the Irish Health Service to meet the Needs of People with Neurological Conditions

It is important to note that when the NAI uses the term “effective integrated care” we mean care that is not only responsive to the needs of people with neurological conditions but care that represents the best use of the healthcare spend to meet these needs in the immediate and long term and puts the user at the centre of healthcare provision, providing support and real choice in managing their healthcare needs.

A series of principles are outlined below which should underpin a future funding model for the health services that addresses the needs of people with neurological conditions as an increasing, and to date marginalised group of service users within the healthcare system.

The funding model must have as its fundamental focus the needs of users of healthcare services. This involves adopting an approach to funding health and social care provision for people with neurological conditions which provides for the following:

(i) Recognises that a wide range of factors contribute to positive health outcomes for people with neurological conditions and a future funding model for the health services must aim to support services which provide a holistic response to the range of social and psychological needs of people with these conditions.
(ii) Recognises that health outcomes for people with neurological conditions are inextricably linked to their requirements for practical supports in other areas of their lives including accessing to housing, transport, education, employment and training. A funding model for long term supports for people with neurological disability must provide appropriate support in accessing and co-ordinating the response of these services to needs of the person with a disability. Mobilising effective intersectoral commitment to meeting the needs of people with chronic illness and disability is a key commitment of existing frameworks[106] [107]but has been slow to deliver in practice.
(iii) Recognises that people with neurological conditions need to be given real choices about where and how their healthcare is delivered, providing a funding model which supports people to continue to live in their communities with the support they need and that ongoing care and treatment can be provided as close as possible to where people live.
(iv) A funding model which supports people to be involved in their own healthcare through supporting self-management and service user involvement in the design and delivery of health services

The funding model should recognise the vital role of not for profit organisations in providing specialist services for people with neurological conditions and in supporting the response of the wider health services to meet their needs. Research by the Disability Federation of Ireland and Not for Profit

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[106] Healthy Ireland: A framework for improved health and wellbeing 2013-2025 (2013) Department of Health
[107] National Disability Strategy Implementation Plan 2013-2015 (2013) Department of Justice & Equality

Business Association highlights the significant added value to the disability sector[108] provided by voluntary disability organisations. The provision of specialist supports in the community for people with neurological conditions and their families is completely reliant on not for profit providers with many of these organisations underfunded and underresourced to cope with demand.

A future funding model for the Irish health services must provide a full and clear vision for the role of the not for profit sector, recognising that effective funding mechanisms and partnerships with the not for profit sector are critical to the provision of person centred responses to health and social care needs into the future.

The future funding model for the health services must be able to meet the needs of people with neurological conditions now and into the future by:

(i) Addressing existing critical deficits in neurology, neuro-rehabilitation and long term care services for people with neurological conditions
(ii) Providing investment into the future to allow services to embrace new treatments and responses to the needs of people with neurological conditions. The future funding model must facilitate access to new medications for all those who would benefit from them
(iii) Supporting training and education of staff within specialist services but also across the health services in meeting the needs of people with neurological conditions

About the Neurological Alliance of Ireland

The Neurological Alliance of Ireland is the national umbrella body for over thirty not for profit organisations working with people with neurological conditions. It aims to promote the development of services and supports for people with neurological conditions in Ireland through advocacy, policy development, awareness and research.

Further Information

The Neurological Alliance of Ireland has worked closely with its member organisations and with the Clinical Programmes in Neurology and Rehabilitation Medicine in the development of this submission. It is important to note however that this submission should not be taken to represent the collective views of all members of the Neurological Alliance and individual submissions will be made by many of our members to inform the work of the Committee.

The NAI has had the opportunity to input into the submissions from the Neurology and Rehabilitation Medicine Clinical Programmes and supports the recommendations outlined in those submissions.

Further information is available from Magdalen Rogers, Development Manager, Neurological Alliance of Ireland, Coleraine House, Coleraine St. Dublin 7 naiireland@eircom.net or 01 8724120

http://www.nai.ie/

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[108] Living in the Community: Services & Supports for People with Disabilities (2013) Disability Federation of Ireland and Not for Profit Business Association

List of NAI Member Organisations 2016

Acquired Brain injury Ireland
Alzheimer Society of Ireland
Aphasia Ireland
Ataxia Ireland
Aware
Bloomfield Health Services
Cheshire Ireland
Chronic Pain Ireland
Dystonia Ireland
Enable Ireland
Epilepsy Ireland
Headway
Huntington’s Disease Association of Ireland
Irish Heart Foundation
Irish Hospice Foundation
Irish Motor Neurone Disease Association
Migraine Association of Ireland
Move4Parkinsons
Multiple Sclerosis Society of Ireland
Muscular Dystrophy Ireland
Neurofibromatosis Association of Ireland
North West MS Therapy Centre
Parkinson’s Association of Ireland
Post Polio Support Group
Syringomyelia Support group of Ireland
Spinal Injuries Ireland
Spina Bifida Hydrocephalus Ireland
The Rehab Group

Associate Members
An Saol
Brain Tumour Ireland
Irish Association of Speech and Language Therapists
Irish Institute of Clinical Neurosciences
Irish Society of Physicians in Geriatric Medicine
Myasthenia Gravis Association of Ireland
PSPA Ireland

Appendix 1

Evidence of Need: Underinvestment and Underdevelopment of Services for People with Neurological Conditions

Neurology Services

In 2015, the Neurological Alliance of Ireland in collaboration with the National Clinical Programme in Neurology carried out a nationwide audit[109] of adult neurology services across the eleven neurology centres around the country. Key Findings include:

-The recommended ratio for consultant neurologist staffing is 1:70,000 population. This was exceeded in every hospital group. In the Mid West, the ratio was one consultant neurologist to 200,000 people

-Multidisciplinary teams were completely understaffed in many centres. 5 of 11 centres had no dedicated speech and language therapy, 4 had no dedicated occupational therapy

Neuro-rehabilitation Services

There are dire shortages in neuro-rehabilitation services across all levels of service provision.

-Inpatient specialist rehabilitation services are completely inadequate with less than half the number of recommended beds for our population and a lack of facilities outside Dublin.

-Neuro-rehabilitation services in the community are completely underdeveloped with only three partially staffed community neuro-rehabilitation teams across the country. One team per CHO (Community Health Organisation) is required as an absolute minimum.

Investment in neuro-rehabilitation services is critically required to address significant unmet need which is resulting in increasing disability and poor outcomes for people with neurological conditions and impacting on the wider health system with longer hospital stays, delayed discharges and earlier admission to nursing home care[110]. Plans to develop a trauma network for Ireland will require significant investment to address the dire shortages in rehabilitation services[111].

Services for Children with Neurological Conditions

The National Model of Care for Paediatric Healthcare Services in Ireland [112] highlights the need for investment in services for children with neurological conditions to address deficits in neurosurgery services, access to inpatient rehabilitation and long term services in the community. Consultation with organisations working with children under the NAI umbrella points to the lack of specialist services at all stages of the pathway for children with neurological conditions.

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[109] Summary Findings from the First National Audit of Neurology Services in Ireland (2015) Neurological Alliance of Ireland http://www.nai.ie/go/resources/nai_documents/15-2-2016-summary-findings-from-first-national-audit-of-neurology-services-in-ireland

[110] Model of Care for Specialist Rehabilitation Services in Ireland (Draft) https://www.hse.ie/eng/about/Who/clinical/natclinprog/rehabilitationmedicineprogramme/docsforconsultation/modelofcare.pdf

[111] An Integrated Trauma System for Ireland (2014) Irish Association for Emergency Medicine

[112] A National Model of Care for Paediatric Healthcare Services in Ireland: (2015) http://www.hse.ie/eng/about/Who/clinical/natclinprog/paediatricsandneonatology/modelsofcare/ExecutiveSummaryfinaldraft.pdf

Palliative Care

Research by the Neurological Alliance of Ireland and the Irish Hospice Foundation highlights the lack of specialist palliative care services for people with neurological conditions and the need for appropriate guidelines, support and training for staff working with people with neurological conditions in relation to meeting palliative care needs[113] as well as the development of effective linkages and referral mechanisms from neurology and neuro-rehabilitation services to palliative care.

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[113] The Palliative Care Needs of People with Advancing Neurological Conditions (2014) Joint Study Commissioned by the Neurological Alliance of Ireland and Irish Hospice Foundation

North East Doctor on Call

This submission is made to the Oireachtas Committee from the perspective of an out of hours GP co-operative and the role that our service currently plays in the provision of healthcare to patients, and the role that it could play for the better future health of patients and their health providers.

Our healthcare system is in the strangely unique position of being at the receiving end of criticism from a wide variety of sources whilst ironically receiving great compliments about the care received by patients who have experienced that system and care first hand.

At the core of this submission is the request that this Joint Oireacthas Committee would understand it is not possible to extend care “free” to patients unless the State already has sufficient clinicians and carers to provide that “free” service. Patients understand “free” care to be an entitlement to be seen for whatever their medical concern at any hour of the day and patients will utilise that entitlement – free U6 cards have led to a 19% increase in patient appointments in NEDOC in the year since its introduction.

The NEDOC submission focuses on expanding and growing the existing group practice already in place and expanding that co-op structure into day practice. The existing collegiate grouping with central financial and administrative support structures is easily transferrable to the day time primary care.

We are enthusiastic in our endeavours to find better and more efficient ways of providing appropriate care to our patients with a limited workforce. We are piloting an ED-to-NEDOC referral system of patients who present inappropriately at ED; we have piloted and implemented a telemedic home visits process bringing the skills of trained paramedics to homes and linking patients to on-line GPs for face to face consultation; we are looking at using smart-technology to manage less acute care via smart-phone and reduce unnecessary consultations; NEDOC is currently embarking on a General Practice personnel recruitment project to source locally based experience practice staff for our GP practices; we are looking at the expertise of experienced nurses to bring that skill-set to General Practice and run specialist and routine clinics. NEDOC is advancing the work of GPs with Special Interests who provide minor surgery; minor injury clinics; dermatological services; pain management; fertility advice and more by creating a system of inter-referral amongst GPs which will upskill GPs whilst simultaneously reducing referrals to secondary care.

Ultimately this submission asks the Committee to be realistic about the funding required for primary and community care if that is where patient care is being directed. If the focus for this Committee is to return care into the community, resources must be provided that allow care-givers spend time caring for their patients in an appropriate setting, rather than on how to increase demand with scant financial and manpower resources.

Arlene Fitzsimons
Operations Manager
NEDOC Ltd.

http://www.nedoc.ie/contact-us.asp

The Key Priorities for inclusion in a 10-year plan for the health service

Cross-Party Support:

This committee, comprising representatives from all parties and independent groups has already identified the first priority for inclusion in a 10-year health strategy. While elements of every submission, and the final report, will not sit with everyone's ethos on health – the final report will require the full support of this group.

A true focus on the patient:

Providing a health service to patients when they need it and how to do this within the constraints of a limited budget.

Strong Support Structures:

Provision for adequate funding and manpower resources into these areas must be made.

Training and Education:

A strong health service requires appropriately qualified professionals, ancillary clinicians and support staff who are willing to work in the Irish health system.

Employment Opportunities:

Qualified clinicians and support staff should see Ireland and our health service as a positive and long-term career path where their skills and experience will be welcome, appreciated and developed.

Maintain Community Responsibility:

Corporate Primary Care Services must maintain responsibility for patients in the community, with many new corporate entrants taking on lists but shelving challenging and time consuming care such as nursing homes and home visits to elderly to the established GP community.

Stakeholder Support:

Administrative buy-in and backing from the Department of Health and the HSE, organisations that have seen variations on this theme for many years. Any new plans should try to take account of restructuring work already underway by administrators.

Key challenges to Universal Single Tier service, where patients are treated on the basis of need rather than ability to pay.

Promises v Deliverables:

Single tier service generally means a national "free at the point of access" system. Such systems are generous in their intention to deliver healthcare to everyone, regardless of their ability to pay, but inevitably lead to patient overload of the health system.

The provision of "free" GP care to patients under 6 years of age (U6) is a welcome development for parents, easing a financial burden for many parents who are just outside the threshold for eligibility for medical card/GP Visit Card schemes.

It has however created a demand for often unnecessary GP consultations. It has proven incorrect to assume parents would not use the card on the basis they are working and therefore unable to access a GP during daytime – this assumption disregards non-working parents; parents who do not work 9-5 Monday to Friday as well as access to long-established GP Out of Hours services operating at evenings and weekends.

GP surgeries have seen major increases in attendances in U6 patients leading to an overload on the primary care system. For the first time primary care appointments need to be made 7-10 days in advance for many routine assessments. Urgent day-time GP appointments get booked up quickly resulting in a knock-on demand on the out of hours services for patients of all age who can no longer get appointments with their own GP.

Since the introduction of the U6 card, from July 2015-June 2016, NEDOC has managed a 19% increase in the number of appointments in our centres, equating to an additional 8,332 patients of all ages. In terms of U6 patients only, NEDOC received an additional 4,700 contacts of which over 4,300 were treated by a GP in the service.

Don't promise a free service unless there are sufficient people to provide that service.

People:

Maximising community and primary healthcare for patients is totally reliant on having sufficient numbers of clinical professionals available to provide that service.

GP numbers are in decline, retirements are not being replaced by new entrants, GPs do not want to take on GMS lists linking them to a 24/7 contract for the rest of their working life, newly qualified GPs want to be employed and do not want to take on the role of employer, manager and GP.

The additional workload coming into NEDOC as a result of the U6 GP Visit Card is managed by the same GPs who are working during the day in very busy surgeries. GPs regularly come into work in NEDOC having seen 20 patients in their surgery in the morning, another 20 patients in the afternoon, anticipating a further 16-20 over 4 hours in NEDOC. This system of care benefits no-one, not the patient, the GP or the State as it will lead to burn-out and early retirements with fewer young GPs willing to take on this workload.

One of the greatest challenges facing the Irish health system at the moment is the retention of staff. There is no obligation on newly trained and emerging clinicians to remain in Ireland to provide care to patients, therefore the lure of international employment for what are deemed (and in many cases are found to be) better conditions,

better pay, better personal reward and ultimately better lifestyle for family will always attract well-trained professionals from Ireland.

These highly regarded professionals will always be offered employment abroad, and they will go for a variety of reasons:

- Employment opportunities in Ireland are poor as the State embargo on all health professionals continues regardless of the financial or logistical impact of reliance on agency staff.
- Working conditions are poor, with all clinicians expressing a daily concern about patient safety risks in an overloaded healthcare system.
- Low morale amongst all clinical professionals as they struggle to provide healthcare in a severely critical environment.

- Undermining clinical professionals with “greedy” labelling if they raise issues with the service in which they work.
- Referral delays and poor communication between the various strands of the health service
- Bureaucracy.

Funding:

Money following the patient is very positive and simple in essence, yet it has failed to deliver.

The UK NHS demonstrates that a fully funded State model is enormously expensive, fails to meet the demand of patients with a system currently in crisis and chaos.

A universal insurance model transfers health policy decisions to an international corporate market whose primary aim is profit. The US health model demonstrates that an insurance model is focused not on the patient or stakeholder but on the shareholder. Health policy will be determined by insurance corporations who decide on the basis of their bottom line what health services can be offered and afforded and what services are not provided as they are negatively affecting their bottom line. This system defers responsibility for basic care to those who cannot afford it, while the squeezed middle see their premiums triple or quadruple.

The current system of those who can pay should pay and those who cannot should be state supported seems on examination to be the fairest and most equitable. The challenge is to provide the people to see patients on time. Public-private partnerships with the State at the core or a tax based system may in fact still be the best means of funding health.

Stakeholder Support:

Union support for change is always difficult to achieve. This applies to the health sector as it does to any other industrial relations sector. There is rarely a buy in from the industrial relations sector as they see opportunity for maximising incomes and benefits for their members.

Improving Communication between Primary and Secondary Care:

Communication streams between primary and secondary care have deteriorated in recent years, a situation to be repaired if patient focus is to move from secondary to primary and community care.

What actions are needed to plan for, and take account of, future demographic pressures (population growth, ageing population) and its impact on the health system?

GPs with Special Interests

GPs are working to provide more and more specialist patient care within primary care. The cost of minor surgery in the primary care setting is significantly less than the same care provided through out-patient appointments.

NEDOC Ltd has been working with GPs with Special Interests to develop an on-line platform to refer patients to other GPs in our region and beyond who have a skill set that will manage their patient in General Practice. More and more GPs are actively expanding their skill-set, taking on education and training in Dermatology, Family Planning, Pain Management, Plastic Surgery, Minor Surgery to enhance the service they can provide to their patients.

Our Inter GP Referral platform identifies GPs with particular skills and allows local GPs who do not have those skill sets to arrange an immediate appointment for their patients. This is all done in the

GP surgery by the GP or their staff, with all parties – the referring GP, the patient and the accepting GP – receiving real-time notification of the new appointment.

Recognition must be given in terms of funding and training to GPs who are raising the bar in General Practice medicine to provide this care in their surgeries. The cost of providing minor surgery in General Practice is significantly less than hospital appointments that are often delayed and deferred. Supporting GPs to up-skill to this level will reduce hospital waiting lists, OPD appointments whilst simultaneously generating major savings.

GP Led and Nurse/Ancillary Clinician Delivered Primary Care

With declining GP numbers, transference of clinical care from GP provided to GP-led- nurse-provided or paramedic-provided primary care services, utilising the increased skill-set of prescribing and advanced nurse practitioners in the primary care sector, is set to become the future of healthcare provision.

NEDOC Ltd has been working on a recruitment campaign for GPs in our region, to source GPs and practice staff including nurses, receptionists and managers. We have found through our recruitment campaign that it is difficult for nurses to transfer from secondary to primary care. Those who do so often lose their skill-set and unique experience learned in specialist units.

The future success of primary care will be in enabling a highly qualified and skilled professional group of nurses to bring their specialist skills into primary care, led by a strong GP team and overseen by a collegiate GP/Nurse focussed structure.

This structure can work in out of hours as well as day services. The Out of Hours service continue to be the only health services that patients can ring and receive an appointment to be seen that evening, that day and even within an hour or two of their call. While this

was not the original goal of out of hours, this is the system that has been pushed by policy makers.

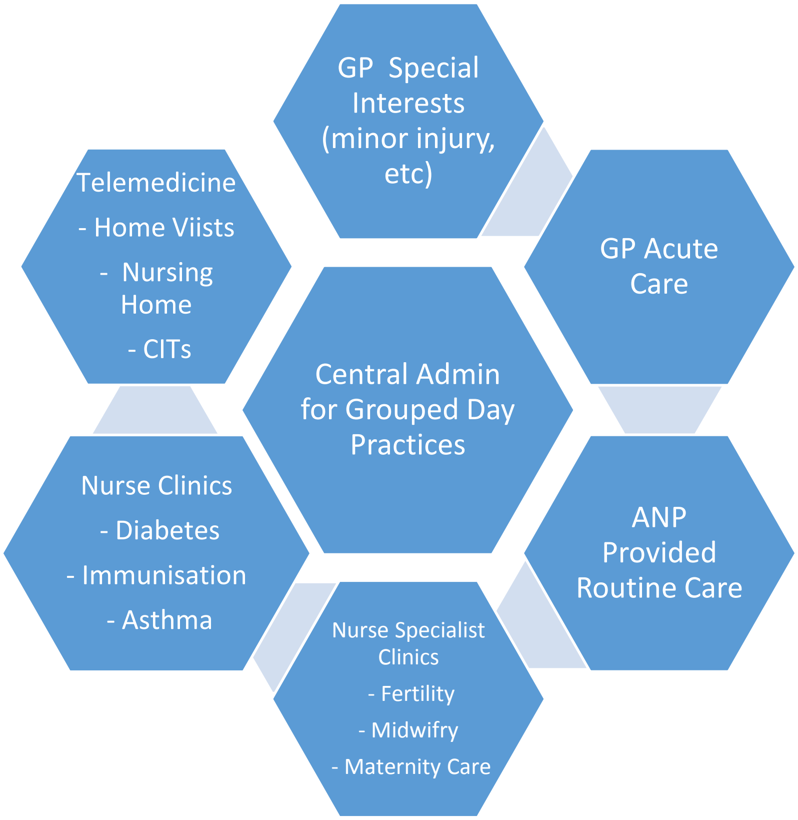
The challenge in out of hours is to continue to deliver the service by a group of professionals that are in decline. This is where the GP-Led and Advanced Nurse Practitioner delivered system comes into action. NEDOC ltd sees the opportunity to bring highly qualified advanced nurse practitioners into the system and provide routine care while GPs see the more urgent and acute patients, reducing the reliance on GPs.

Centralised Structure in Day Time – Expanding the remit of out of hours

Already the GP Out of Hours structure is a collegiate gathering of GPs in each region, working together through an integrated centrally managed system to provide GP care to patients in urban and rural areas irrespective of their public or private status in the healthcare system.

Our system is a central hub rostering GPs, nurses, drivers, receptionists across four centres, managing the care of a population of 350,000 patients whilst working with 80 practices and 200 GPs. NEDOC Ltd has established a system of collegiate care whereby patients are managed by all GPs.

This system can be expanded into daytime care. The opportunity for NEDOC Ltd is to take on the region we service, identify practices that are facing closure as a result of retiring GPs and using our central administrative engine, employ highly skilled doctors and nurses to work with us and provide care to a number of practices – maintaining life in rural Ireland by keeping the local surgery open and operational.



Return on Education

Increased training of professionals with built-in employment opportunities to retain them within the Irish health system.

Sponsored training/education for nurses into Advanced Nurse Practitioner courses in return for a dedicated number of years working in the Irish health service.

An increase in full scholarship opportunities for students who wish to study medicine and nursing in return for a commitment to working in Ireland for a defined number of years upon qualification.

Integrated Primary and Community Care

What steps are needed to move from the current model towards a model based on integrated primary, secondary and community health care?

Utilise the existing out of Hours GP Structure.

Funding agreement to implement the strategy over 10 years.

Achievable Goals

- Employ more paramedics, telemedics, community care nurses, community care teams, advanced nurse practitioners, prescribing nurses.
- Remove employment embargo for support clinicians and healthcare professionals.
- Remove reliance on agency nursing and other staff.
- Willingness to engage with new initiatives.
- Utilise existing out of hours group structures.

Unified approach to delivering care in the Community

- Defined AMAU referral process (see next).
- Defined CIT structure

Fund and Support Primary Care Teams/Community Intervention Teams

- Bring GPs with Special Interests to the forefront, offering dermatology, minor surgery, family planning, phlebotomy, diagnostics, fertility clinics and more, while their team of Advanced Nurse Practitioners and Prescribing Nurses can focus on running diabetes clinics, asthma care clinics, childhood vaccination programmes, maternity services and routine surgeries.

Communication with all stakeholders along the process

What are the key barriers to achieving this, and how might they be addressed?

Mistrust amongst stakeholders:

- requires a strong communication campaign to build bridges between various stakeholders - the HSE, clinicians, unions, support staff, health organisations.

How would you ensure buy-in from health care professionals to progress towards an integrated health care model?

Set out a clear career path for each stakeholder group

Set out the specific funding for each element of the primary and community care development programme

  a. Primary care units
  b. GPs employment schemes
  c. Home carer funding
  d. Community nursing in each area

Collegiate Centralised Day GP Structure

  e. NEDOC provided day services expanding on our role to facilitate GPs in the provision of their contract of care to patients
  f. NEDOC to employ doctors and nurses to maintain strong daytime service in the community working with CITs, AMAUs

Education

  g. Grant funding for back to college for ANP courses – application and take up of each grant funding requires working in Ireland for minimum 5 year period
  h. GP education programmes – fully funded by state on the basis of return to the exchequer of your professional skills for minimum period 5 years
  i. Medical graduate programme – irrespective of the career path sponsorship of the post-graduate programme requires participants to work in Irish health system for minimum period of 5 years or full return of funding loan. Opt out mid-way through requires participant to return full cost of the post-graduate course.

Increased support

  j. IT development

Are there any examples of best practice that the Committee should consider? Please refer to any evidence you have to support this.

St Lukes in Kilkenny demonstrates a very good community system of care for patients with strong communication and integration across all community, primary and secondary care elements of the service. Direct GP referral to AMAU has proven an excellent model of care and should be used as the template for all AMAU referrals that currently vary nationally. For example – Our Lady's

Hospital Navan uses that same GP-referral method to the local MAU however only 15 miles away in Our Lady of Lourdes Hospital Drogheda GPs cannot refer directly to the MAU – all referrals must come through the ED – excluding GPs from the process.

Co-ops demonstrate an established and excellent system of a wider primary care model supporting community and secondary care. The NEDOC model is effectively a group practice of 200 doctors, administered by a secretariat managing all financial, operational and administrative elements of the service for GPs, easily expandable to taking on the full management of the entire infrastructure. NEDOC sees the wider potential to expand the OOH model into daytime service as outlined above – effectively managing the entire IT, database, nursing, driver, reception, GP, administrative element of the service. Rural practice is on the wane, and it is increasingly difficult to identify newly emerging GPs to take up individual rural lists leading to further potential demise of rural communities. In order to keep the life blood of rural Ireland in place, NEDOC Ltd would manage a number of urban centres from where local rural practices would operate morning or afternoon surgeries with employed GPs and nurses working from a variety of venues. This model of primary care support would link with CITs for step down care, utilising an upgraded IT system.

Telehealth

Home Visits are a necessary but very costly element of primary care, provided primarily by GPs during lunchtime or on their way home. GP out of hours services manage a significant number of home visits. NEDOC Ltd has one of the lowest rates of home visits at 7%, for the sole reason that GPs re-triage many of the calls that require telephone advice or in some cases immediate referral to hospital.

Home visits take an average of 45 minutes per call, time that would allow a GP to see 3 or 4 patients in a treatment centre. However often those calls are necessary and it is the time to travel that is the waste-factor.

NEDOC Ltd last year piloted a telemedicine project whereby trained paramedics travelled to see the patient at home, examine them and link to an on-line GP who then undertook the clinical assessment of the patient. All clinical details were recorded with high-tech equipment recording blood pressure, temperature, visuals of throat, eyes, ears, pictures of skin infections and so on. The advanced technology used in this project allows for a full assessment of the patient.

The equipment we used would be ideally suited to nursing home patient care, with a nurse assisting the patient in their GP consultation at any hour of the day. This project proved very successful with plans to extend to two of our centres to minimise time away from the centre and maximise the time spent seeing patients.

NEDOC Ltd is also working on a smart-phone consultation project. While smart-phone technology has limitations in terms of the examination/assessment that can be provided by the patients, it is enormously beneficial in terms of patient triage. All calls are recorded and technology is encrypted to secure patient confidentiality. This is a start-up project for NEDOC ltd with the key challenge to ensure its safety for patient management, minimise risk to the GP and identify a funding mechanism for each call.

NUA Healthcare

People with an intellectual disability in Ireland are living longer, and the numbers requiring support services continue to rise. While a report on the national forecast on future need is expected to be completed in Q4 2016 under the *Transforming Lives* programme (to implement the Recommendations of the Value for Money and Policy Review of Disability Services), intellectual disability health budgets are already experiencing intense pressure.

The State currently spends €1.5bn annually on disability services via the HSE. This cost and pressure on services is expected to dramatically increase over the next 10 years due to demographic changes, a growing disabled population, a drive towards community based care and individualised supports requiring extensive scaling of service provision and a push by HIQA for improved standards of care.

Further, the ongoing Government policy of de-congregation (moving people out of large institutional care environments into community homes) is a substantial service challenge, requiring an additional 200 beds in community homes every year which demands significant capital investment and modes of care, with flexible staffing in smaller units.

While the State runs some disability care services directly, most are currently provided by third party service providers at a cost of some €1bn per annum. Almost all of this funding is assigned to the charitable sector (Section 38 and 39, 'not-for-profit' agencies), with a small allocation to private service providers. The State funds capital and operating costs for these charities, whereas the private operators provide their own capital and the HSE pays a variable fee for the service procured with no commitment to fund ongoing running costs.

A 10-year strategy for healthcare must create an environment which future-proofs against the expected health service requirements and consider new funding models in line with international best practice, to reflect the role private capital can play in helping to drive reform, provide improved services and generate significant savings for the State.

Commitment and action from Government will be matched by a user-centric, flexible, collaborative approach by the private sector. This submission focusses on three key priority recommendations in the Intellectual Disabilities sector which we believe are key to support the development of a meaningful 10-year plan to alleviate current pressures, provide a platform for the necessary service growth and deliver maximum quality care outcomes.

Recommendations

- **All intellectual disability services to be put out to tender in accordance with international best practice.** This would drive significant cost savings for the State, raise standards of care, entice new entrants into the sector and provide a platform for service growth. It would also enable private providers to compete on an equal footing with the charity sector, delivering the best options for service users and the State, irrespective of the service provider's capital structure;
- Implementation of a joined up approach to de-congregation with **consideration of new funding models to reflect the role private capital can play in helping to drive reform** and generate significant capital savings for the State;
- Introduction of measures to ensure that HSE funds are spent **procuring the right services for a particular individual** – in line with Government policy – to ensure value for money and drive cost efficiencies across the continuum of disability care.

Within these recommendations we have sought to address the following questions in the Committee's terms of reference with regard to Strategy; Integrated Care and Funding Models in the Intellectual Disabilities sector in particular:

- *What are the key priorities for inclusion in a ten-year plan for the health service?*
- *What actions are needed to plan for, and take account of, future demographic pressures (population growth, ageing population), and their impact on the health system?*
- *What steps are needed to move from the current model towards a model based on integrated primary, secondary and community health care?*
- *Do you have any views on which health service funding model would be best suited to Ireland?*

While the challenges are considerable, with the right regulatory environment, Nua believes there are huge opportunities for private sector collaboration to deliver high quality, individualised care in the community in partnership with Government and the HSE.

All intellectual disability services to be put out to tender in accordance with international best practice.

Nua Healthcare endorses and welcomes moves to introduce a more open and transparent tendering process within the Disability sector. However, the new Residential Disability Services tender's proposed narrow focus on private sector residential care only, fails to address services in the charitable sector, which account for the majority of the residential disabilities budget, and where we believe there are substantial opportunities for service and efficiency improvement.

Section 38 & 39 service providers currently account for circa 95% of all outsourced residential services with c. 5% of contracts outsourced to the private sector, often on an ad hoc, option-of-last resort basis. For example, Nua understands there has been recent 'closed tender' awards to the Muiriosa Foundation and the outsourcing of three HSE residential services to another voluntary provider, Gheel Autism, without any open tender process to ensure quality and value for money service provision.

Such uncertainty around the HSE commissioning practice has severely limited private sector growth and investment to date and is contrary to international best practice and the UK experience which has moved away from competitive tendering based on cost, to more patient-centric outcomes.

Nua proposes that commissioning in Ireland should move away from the block funding of services to a market based commissioning model over the immediate to longer term whereby agencies (public, private, voluntary) must pre-qualify to provide state-funded care services (based on an ability to meet set operational, governance, quality of life and quality assurance criteria). Funding would then be provided to eligible providers in an open and transparent manner based on a matrix of services and level of care intensity (High, Medium, Low) required by an individual, in line with an agreed personalised care plan and service-user preference.

Nua also recommends that due consideration is given to elements of the New York model outlined in Recommendation 3 below (that is currently operating in a number of states and consistent with current best practice).

Consideration of new funding models to reflect the role private capital can play in helping to drive reform.

The cost of residential care is expected to increase substantially over the next ten years in line with increased demand and moving to care in the community. The recent report of the National Intellectual Disability Database Committee identifies a need for 2,168 additional residential placements by 2019 alone (a 27% increase), with a further 2,480 people requiring alternative residential placements, predominantly moving from congregated settings into community homes. Considerable capital investment and service expansion will be required to meet this demand, and the private sector can provide efficient and high quality solutions to this.

Ignoring private capital options may deny the State substantial savings and quality choices for service users. In particular, we believe the private sector is well placed to offer options for the sorts of small format community care homes now needed and envisaged as core to the evolution of disability provision in Ireland, which will need new capital and tightly managed, flexible workforces if the State is to achieve its objective of moving c.1000 out of congregated settings by 2021 and ultimately eliminating them altogether.

While Nua welcomes the recent €100m funding for the sector in the Programme for Government commitment, such capital funding has been allocated to charitable organisations without due consideration of the role the private sector can play in raising such capital. This is further restricting private sector participation and growth and is another reason why private providers only account for circa 5% of the market, compared to circa 50% in the UK. This must be addressed if Ireland is to benefit from the opportunities that partnership with the private sector could afford over the next 10 years.

Procuring the right services for a particular individual to ensure value for money and drive cost efficiencies across the continuum of disability care.

Despite recent changes (reform agenda focused on person-centred / community-based care; quality improvements following Aras Attracta scandals; HIQA monitoring etc), Intellectual Disability Service procurement continues to be primarily based on cost.

For example, the proposed new Residential Disabilities Services tender emphasises bed price, with little consideration for individual support requirements outside residential settings, nor the requisite staffing and governance levels required to ensure a quality service.

Nua advocates for a more user-centric model whereby HSE funds should be spent procuring the right services for a particular individual – including a mix of residential, day care and clinical care services – in line with an agreed personalised care plan.

Accountable service level arrangements and provider quality assurances will also be paramount to ensure value for money and drive cost efficiencies across the continuum of disability care.

In this context and in accordance with the Government's stated policy of Intellectual Disabilities reform away from congregated settings and towards community-based, person-centred care, the NY State Office for People with Development Disabilities (OPWDD) *"People First philosophy"* provides a useful market-led model for a long-term approach.

In particular, the NY model provides a working example of how services could be further developed to *"--- enable eligible individuals with Intellectual Disability (ID) to build services around their specific goals, needs, desires and that services and supports are created around people and not programmes."*

Rather than the traditional tendering or commissioning funding model, the NY model is person-centred whereby funding is allocated through the following steps:

- An application for the ID person by the family, guardian, case worker, etc to one of the regional OPWDD offices. Eligibility for services is then determined, and involves the use of one of a set of assessment scales and other corroborating information (school, medical, etc) to identify the classification of need category for that person. The eligibility assessment is carried out by a multidisciplinary regional evaluation committee.
- Each classification of need category has a specific basket of services associated with the intensity of need, from a home care level upwards.
- Once eligibility and the classification of need is verified, an intake case worker is assigned to the family/person. They then work together to consider options from the basket of services for the classification of need, and a plan is developed, referral for services made etc (e.g. home adaptive equipment, job support, medical needs, education etc).
- Where a person's classification of need indicates residential care this can be from local supported housing to intensive residential services, then an arm of OPWDD the state program *NY-Cares* is involved in referrals, funding arrangements, supervision, etc. using the same approach described above.
- The agencies who provide services are voluntary/private by a large majority (an historical tradition in America of government setting policy, oversight, funding etc with services contracted to the voluntary sector). The agreement for each person in residential care is based on a multi-year plan.
- Each classification of need will have an array of agencies who are certified to provide that level of service. So, some agencies provided low intensity services and other higher intensity.
- One lead agency in a person's individualised plan will have case manager type of responsibility for the person, but the plan agreed with the OPWDD may have a range of agencies involved. For example, supported residential care with a range of services provided one agency, but also could have job support or literacy assistance provided by another service contracted by OPWDD.
- Each agency involved in an individual's plan is certified for their specific services and required to meet the inspection, quality and outcome measures.

- Referrals to services operate on an overall principle of being part of the person's community, with considerations like geography, ease of access, closeness to family, specialisation required. Referrals are made by the local OPWWD office who also have responsibility for oversight and monitoring of the care plan, quality and outcomes.

This Model, in effect, shapes commissioning from funding services for ID persons TO a commissioning model which invites agencies to be certified for providing ID services within varied levels of intensity that an individual person may need.

The benefits of such model include:

- *Person-centred services (based on assessed user-need, service user empowerment, choice and feedback mechanisms to ensure quality care)* – the ID person +/ their family along with the state intake worker *choose* from amongst certified, inspected and measured agencies which they deem most appropriate for the individual person.
- *Self-regulation* – in effect the market incentivises high quality service as the "market" chooses where to spend the prices basket of services for an individual.
- *Fair competition, cost transparency and value for money* – the model generates competition, based on transparent evaluative processes.
- *Efficient service delivery* - The NY market model approach would also facilitate the State/Department of Health/HSE to move away from its historical agency-based funding approach as funding is provided for specified services within levels of intensity based on objective criteria – not historical allocations.

http://www.nuahealthcare.ie/

Nursing & Midwifery Board of Ireland

The development of advanced practice services in Ireland is relatively recent with The Report of the Commission on Nursing: A Blueprint for the Future (Government of Ireland 1998) establishing the pathway, which led to the establishment of the National Council for the Professional Development of Nursing and Midwifery (National Council). For just over a decade (1999-2011), the National Council published evolving frameworks and minimum criteria and supported the establishment of specialist and advanced practice posts. Thereafter, the Nursing and Midwifery Board of Ireland (the Board) were provided legislative authority to accredit posts and register nurses and midwives in a separate Division of the Register. Although the benefits of specialist and advanced nursing and midwifery services are extensively evidenced in both national and international literature, the numbers of Registered Advanced Nurse Practitioners (RANPs) and Registered Advanced Midwife Practitioners (RAMPs) are low. In fact current levels of advanced practitioners in Ireland are insufficient to meet the ever increasing needs of people accessing health care.

The aim of this submission is to highlight the potential benefits of supporting and enabling nurses and midwives to progress their career pathways to advanced practice. Although this submission focuses on advanced practice, the contribution of Clinical Nurse Specialists and Clinical Midwife Specialists in the provision of quality care, is, and will continue to be significant.

RANPs and RAMPs have the capacity to provide independent, expert, autonomous and safe care to people across all sectors of the health service in Ireland. This submission proposes recommendations that could positively impact on the delivery of effective future healthcare in Ireland.

RECOMMENDATIONS

1. Establish a funding model to enable RANPs/RAMPs to provide comprehensive advanced practice services based on the integrated care model

2. Provide equal access for nurses and midwives working outside the Health Service Executive to progress to advanced practice

3. Undertake a review of current levels of advanced practice services in response to ever-increasing healthcare demands across the care continuum

4. Develop structures to ensure comprehensive advanced practice services are available in the following areas:
    - Mental Health
    - Older Person Services
    - Learning Disability Services
    - Midwifery Services
    - Care of Children
    - Community Care

5. Collaborate with key stakeholders in Primary, Community and Continuing Care to develop advanced practice services across the spectrum, underpinned by the integrated care model

6. Engage in succession and workforce planning to sustain current levels of RANPs & RAMPs, focusing on the age profiles of current registered advanced practitioners and established services

7. Develop advanced practice services in response to changing healthcare requirements and skill mix as outlined in the Creating a Better Future Together – National Maternity Strategy 2016-2026 (Department of Health 2016).

INTRODUCTION

The health service in Ireland continues to experience unprecedented challenges in the provision of timely quality care to the people who need it. The Health Service strategic reform programme aims to move from the current hospital centric model of care towards a new model of integrated care which treats patients at the lowest level of complexity which is safe, timely, efficient, and as close to home as possible (HSE 2014). RANPs and RAMPs have the capability to provide independent, safe, and expert care to people across all services (public and private), supporting the integrated care model which result in better outcomes for people.

BENEFITS OF ADVANCED PRACTICE NURSING AND MIDWIFERY IN IRELAND

Fundamental to reform of the health service, through clinical programmes and structural reforms, is the requirement to continue building the expertise and skills of staff (HSE 2014).

Advanced Practice is a career pathway for registered nurses and registered midwives, committed to continuing professional development and clinical supervision, to practice at a higher level of capability as independent autonomous and expert practitioners (NMBI 2016, publication pending).

The significant contribution of Advanced Practitioners and clinical specialists to enhanced patient care is well documented both nationally and internationally (Begley *et al* 2010, Begley *et al* 2013, Elliott 2014, Wickham 2013, Wickham 2014,). The SCAPE study, conducted in Ireland, examined clinical outcomes of Clinical Specialists and Advanced Practitioners, and 'demonstrated conclusively that care provided by Clinical Specialists and Advanced Practitioners improves patient/client outcomes, is safe, acceptable and cost neutral' (Begley *et al* 2010: 316). Carney (2014, 2016), on behalf of the Nursing and Midwifery Board of Ireland conducted an extensive review of the literature, which is available at http://www.nmbi.ie/Standards-Guidance/Current-Projects/Advanced-Practice.

Although the numbers of advanced practitioners in Ireland do not meet the demand for services, RANPs and RAMPs strive to deliver effective outcomes for the people who attend their services. Extracts cited in Appendix 1, following recent correspondences with advanced practitioners, provide useful insights into RANPs' and RAMPs' perspectives of the services they endeavour to provide. Common themes emerge from these extracts in terms of *'timely access to caring, skilled professionals; early diagnosis; timely interventions; health promotion; assisting people to cope and manage; preventing deterioration, and safe discharge'.*

DEVELOPMENT OF ADVANCED PRACTICE (NURSING AND MIDWIFERY)

The Report of the Commission on Nursing: A Blueprint for the Future (Government of Ireland 1998) recommended the establishment of the National Council for the Professional Development of Nursing & Midwifery (NCNM) with one of its functions being the development of advanced nursing and midwifery persons and posts. In 2010, the Department of Health & Children assigned additional functions to the Nursing and Midwifery Board of Ireland (An Bord Altranais) to determine, in accordance with criteria set by the NCNM, applications for accreditation of posts as advanced nurse/midwife practitioners and applications for the registration of nurses as advanced nurse practitioners and midwives as advanced midwife practitioners (Statutory Instrument (S.1.) 3 of 2010), which was operationalised through the Nurses Rules 2010 (S.I. 689 of 2010).

Since 2010, the Board accredited 234 posts (Appendix 2). Of the posts accredited, the Board registered 196 nurses as Registered Advanced Nurse Practitioners (RANPs) and 7 midwives as Registered Advanced Midwife Practitioners (RAMPs) (Appendix 3). Of the 193 RANPs in post 32% (n=61) are over the age of 50 years. Of the 6 RAMPs in post 50% (n=3) are over the age of 50 years.

By Gender Within Division									
Division	**Gender**	**N/A***	**20-29**	**30-39**	**40-49**	**50-59**	**60-65**	**65+**	**Total**
Advanced Nurse Practitioner	Female	0	0	21	83	51	3	1	159
	Male	0	1	11	16	6	0	0	34
Totals		0	1	32	99	57	3	1	193

By Gender Within Division									
Division	**Gender**	**N/A***	**20-29**	**30-39**	**40-49**	**50-59**	**60-65**	**65+**	**Total**
Advanced Midwife Practitioner	Female	0	0	0	3	3	0	0	6
Totals		0	0	0	3	3	0	0	6

FORTHCOMING CHANGES TO ADVANCED PRACTICE (NURSING & MIDWIFERY)

The Nurses and Midwives Rules (Government of Ireland 2016, pending publication) will provide ANP/AMP Divisions of the Register and Standards and Requirements will permit ANP/AMP's to stay in the Divisions of the Register. The Person and Post that are currently linked under SI 689 of 2010 will no longer remain in place. Standards and Requirements for Advanced Practice (NMBI 2016, publication pending) outline the critical elements of advanced practice, which include an Advanced Practice Model (Figure 1). The Advanced Practice Model (NMBI 2016, publication pending) will provide guidance to healthcare providers and practitioners who endeavour to achieve a higher level of capability in their quest for quality, evidence-based safe practice and person-centred care – Advanced Practice.

Figure 1 Advanced Practice Model (NMBI 2016 publication pending)

FUTURE DEVELOPMENT OF ADVANCED PRACTICE NURSING AND MIDWIFERY

Following enactment of The Nurses and Midwives Rules (Government of Ireland 2016, pending) healthcare providers will approve and accredit advanced practice posts/services. Although the Nursing and Midwifery Board (NMBI) will no longer accredit posts as per the 2010 legislation, NMBI will continue to register nurses and midwives as RANPs/RAMPs and provide support to healthcare providers. The Advanced Practice Model (NMBI 2016, pending publication) will provide a useful framework to support the development of Advanced Practice across all services. Information is available on the Board's website http://www.nmbi.ie/Registration/Advanced-Practice/Advanced-Practice-Post, which support the development of healthcare services. Furthermore, The Office of the Nursing and Midwifery Services Director (ONMSD) in the Health Service Executive (HSE) support healthcare providers to develop advanced practice services. However, there are just two RANPs and no RAMPs currently working in Primary Care (Private General Practice). Appendix 4 provides insight into the current situation for nurses and midwives working outside the HSE who strive to progress to advanced practice.

CONCLUSION

Registered Advanced Nurse Practitioners (RANPs) and Registered Advanced Midwife Practitioners (RAMPs) have the capacity and expertise to deliver timely, effective, and safe care beyond the hospital and into the homes of the people who need it. RANPs & RAMPs strive to achieve good outcomes; however, current levels of service are limited as the numbers of RANPs and RAMPs do not meet the current demand for services. Succession and workforce planning is urgently required to maintain established services. Funding models must incorporate support for nurses and midwives working outside the HSE to enable them to progress to advanced practice. The Nursing and Midwifery Board of Ireland will continue to publish guidance and provide support for nurses and midwives who are committed to continuing professional development and clinical supervision and meet the Board's Criteria for Registration as RANPs/RAMPs.

APPENDIX 1

'Having RANP's in the Emergency Department means that patients have timely access to expert care & diagnosis. The nurse practitioner acts as advocate for them in a busy & complex care system; across the acute hospitals service & community based services. This advocacy ensures that the patient gets the best care possible & is facilitated home as soon as possible. The hospitals gain from the expertise of the RANP too; there's less patients waiting in busy emergency departments; patients are referred to the most appropriate services thereby saving valuable resources. It's a win win situation, supported by the SCAPE study. The difficulty is that we are only at half the number of required RANP's in emergency departments; we need to get to full strength in order that patients gain the maximum benefit from this expertise. Employ more RANP's'.
RANP Emergency June 2016)

" Having an RANP in Perinatal Mental Health (PMH), means that women & their infants, who are at risk from PMH difficulties or currently experiencing PMH difficulties can have access to timely, expert advice about PMH, including factual advice about medication use in pregnancy and while breastfeeding. More importantly, access to early intervention via the RANP in PMH led assessment and intervention clinics, reduce the potential for worsening PMH difficulties. With the recovery model driving the service, the RANP in PMH manages the complexities and duality of holding a space for two, women and their pregnancy and women and their infants, with the goal of supporting mothers in doing the best they can". (**RANP Perinatal Mental Health June 2016)**

'The RANP in Critical Care (outreach) and transport facilitates a new way of working and complements existing roles within the critical care team. The RANP critical care (outreach) plays a pivotal role in managing patients throughout the acute care hospital that are at high risk of deterioration. The RANP critical care (outreach) aims to maintain patients' physiological status and provide early intervention and access to critical care when patients level of care status changes. Aim to avoid patient deterioration and maintain positive patient outcomes. This is achieved through early recognition and early treatment and prevention of patient deterioration and need for admission to critical care. The main goals of critical care outreach are:

1. Identify patients at risk for critical illness and either prevent their admission to critical care unit by timely interventions at ward level or ensure early and appropriate admission to critical care unit.
2. To facilitate timely and safe discharge from critical care by following up patients discharged to the ward.
3. Share critical care skills with ward staff in a clinical leaning environment.

For the role to be a success it is envisage that the service needs to maintained 24 hours a day 7 days a week' (**RANP Critical Care Outreach June 2016)**

‘As an RAMP in midwifery care for the past 5 years, case loading of specific women in pregnancy, intrapartum and postpartum care has facilitated timely care pathways for these women with extra midwifery needs. The autonomy associated with prescribing, perineal repair, and the undertaking of newborn examinations has brought about timely intervention and discharge for women in the maternity services. Ongoing referrals from the other members of the multidisciplinary team facilitate the assessment of women early from a known care giver. The ability to equally refer has proven beneficial and cost effective. The great barrier is time and time management to allow other aspects of advanced practice flourish’. **(Registered Advanced Midwife June 2016).**

‘Attending hospital whilst in psychiatric crisis can be a frightening experience. Going through the Emergency Department, or being on a hospital ward whilst experiencing an episode of poor mental health means that the RANP has an opportunity to intervene and offers a caring, skilled and timely holistic assessment. The RANP is able to assess, diagnose, and treat the patient, either as a prescriber and/or psychological therapies as well as advocating for them within the hospital. This enables the patient to have a rapid service, therefore enabling recovery. Many individuals attend who have strong thoughts of self-harm and/or suicide – many have self-harmed and require a short admission to the general ward. Being able to assess the risk of those presenting allows the patient to have a safe episode of care, and also supports medical and nursing staff who sometimes may find it challenging to care for this patient group. Within Ireland, there are few RANP’s working in psychiatry – however there are so many areas where Advanced Nurses would clearly improve patient care, it is hoped that more will take the lead in specialist areas’ (**RANP Mental Health 2016).**

‘A key service goal within the Emergency Assessment Unit (EAU) is to continue to improve the safety and quality of midwifery care to women and develop a quality-driven efficient service that meets the challenging demands of healthcare and society. RAMP's demonstrate excellence in clinical care, improved continuity in care and offer greater support to parents and colleagues. The presence of the RAMP in the EAU allows for more immediate rapid response to obstetric emergencies, prevents unnecessary admissions, decreases waiting times and provides a more heightened assessment of fetal and maternal wellbeing. Women feel more informed and are given more time to discuss issues related to them. They are seen as an individual and have immediate access to expert care in terms of advanced practice. The future of midwifery requires more advanced practice roles in emergency units. The introduction of the RAMP to the EAU has been very successful but more RAMP's are needed to provide a seven day service’ **(RAMP Emergency June 2016).**

Advanced Nursing and Midwifery Practice is about a genuine desire to create change, and making a difference in people’s lives. I consider the impact of Advanced Nurse Midwifery practice as the positive energy that exists when the service user feels seen, heard, and valued. 2016 marks the 20th year of Advanced Nursing Midwifery practice in Ireland. The ANP/ AMP has integrated and become a valuable member of the multidisciplinary team. We have become integral to health care solutions. Through partnerships and negotiations the ANP/AMP has been instrumental in contributing to changes in legislation which has resulted autonomous practice and direct improvement in the provision of patient / client care. The Irish Association of Advanced Nurse Practitioners was established in 2004. The Association has been instrumental in ensuring the progression of a vision of Advanced Practice at both a national and international level. It’s an extremely bright future. As we look to the next 20 years and beyond we remain committed to strengthening our role, working together towards the realisation of our vision for advanced practice. We must be aware of how decisions are made and how we need to participate in the process. That includes getting to know the political agenda so that when a healthcare issue comes up we can direct healthcare legislative. We are intent on providing autonomous care to effectively meet patient / client needs. We know that in order to do this we need to continue to challenge cultural, regulatory and policy barriers in the interest of improving service provision. **(RANP Emergency, on behalf of the Irish Association of Advanced Nurse Midwife Practitioners IAANMP, June 2016).**

APPENDIX 2

List of Posts Accredited by the Board

Post code	Post Title
01/11PR	Recovery in Mental Health
01/12GE	Emergency
01/13GBC	Breast Care
01/14GR	Rheumatology
01/15GO	Oncology (Radiation)
02/11PL	Liaison Mental Health
02/12GP	Children's Ambulatory Care
02/13MDM	Diabetes Mellitius
02/14 GO	Oncology Radiation
02/14GO-A1	Oncology Radation
02/15GO	Oncology (Radiation)
03/11GH	Haematology (Adult)
03/12GN	Neonatalogy
03/13 GWH	Womens Health
03/14 GN	Neonatology
03/15GO	Oncology (Radiation)
04/11GE	Emergency
04/11GE-A1	Emergency
04/12GC	Older Community
04/13 PCAMH	Child and Adolescent MH
04/14 MN	Neonataology
05/11GE	Emergency
05/12GD	Diabetes Mellitus
05/13 GC	Cardiology
05/14CDM	Diabetes Meillitus
06/11GE	Emergency
06/12 GN	Neonatalogy
06/12GO	Oncology
06/13GN	Neonatology
06/14GN	Neonatology
07/11GE	Emergency
07/12GE	Emergency
07/13CE	Epilepsy
07/13GV	Vascular
07/14GN	Neonatology
08/11GE	Emergency
08/12GE	Emergency
08/13CE	Epilepsy
08/14CE	Epilepsy
09/11GD	Diabetes Mellitus

09/12GE	Emergency
09/13GE	Emergency
09/14GE	Emergency
10/12GE	Emergency
10/13GE	Emergency
10/13GG	Gastroenterology
11/12GC	Cardiology Emergency
11/14GNND	Neurodegenerative
12/12GE	Emergency
12/14GNMD	Movement Disorders
13/12GE	Emergency
13/14GPC	Primary Care
14/12GE	Emergency
14/14CA	Asthma
15/12GE	Emergency
15/14GE	Emergency
16/12GE	Emergency
AP001	Emergency
AP002	Sexual Health
AP003	Emergency
AP004	Emergency
AP006	Rheumatology
AP007	Emergency
AP008	Cardiothoracic
AP009	Cardiothoracic
AP010	Emergency
AP011	Emergency
AP012	Emergency
AP013	Primary Care
AP014	Emergency
AP014-A1	Emergency
AP014-A2	Emergency
AP015	Emergency
AP015-A1	Emergency
AP015-A2	Emergency
AP015-A3	Emergency
AP015-A4	Emergency
AP015-AI	Emergency
AP016	Emergency
AP017	Emergency
AP018	Emergency
AP019	Emergency
AP020	Emergency
AP021	Primary Care
AP022	Breast Care
AP023	Diabetes
AP024	Cardiology
AP025	Emergency
AP026	Emergency
AP027	Cardiothoracic

AP028	Emergency
AP029	Emergency
AP030	Neonatology
AP031	Oncology
AP032	Cardiology Emergency
AP032-A1	Emergency Cardiology
AP033	Neonatology
AP034	Emergency
AP035	Emergency
AP036	Child & Adolescent Mental Health
AP037	Primary Care
AP038	Heart Failure
AP039	Stroke Care
AP040	Child Health & Development
AP041	Oncology
AP042	Emergency
AP043	Emergency
AP044	Gastroenterology
AP045	Palliative Care
AP047	Emergency
AP048	Emergency
AP049	Emergency
AP050	Diabetes Mellitus
AP051	Emergency
AP052	Emergency
AP053	Neonatology
AP054	Oncology
AP055	Diabetes Mellitus
AP056	Pain Management
AP057	Emergency
AP058	Emergency
AP059	Women's Health
AP060	Women's Health
AP061	Cardiology
AP062	Emergency
AP063	Emergency
AP064	Emergency
AP065	Emergency
AP066	Haematology Oncology
AP067	Women's Health
AP068	Emergency
AP068-AI	Emeregency
AP069	Emergency
AP070	Renal
AP071	Emergency
AP072	Older Person Care of
AP073	Haematology
AP074	Older Person Dementia
AP075	Emergency
AP076	Older Adults Community

AP077	Urology
AP078	Older Person Dementia
AP079	Eating Disorders
AP080	Cognitive Behavioural Therapy
AP081	Cognitive Behavioural Therapy
AP082	Emergency
AP083	Emergency
AP084	Emergency
AP085	Emergency
AP085-A1	ANP Emergency
AP086	Haematology
AP087	Specialist Palliative Care
AP088	Midwifery Care
AP089	Cognitive Behaviour Therapy
AP090	Tissue Viability
AP091	Specialist Palliative Care
AP092	Specialist Palliative Care
AP093	Cardiothoracic
AP094	Cardiothoracic
AP095	Cardiothoracic
AP096	Cardiothoracic
AP097	Cardiothoracic
AP098	Liason Psychiatry
AP099	Cardiothoracic
AP100	Occupational Health
AP101	Emergency
AP102	Emergency
AP103	Emergency
AP104	Emergency
AP105	Rheumatology
AP106	Cardiology: Emergency
AP107	Neonatology
AP107-A1	Neonatology
AP108	Midwifery Care
AP109	Emergency
AP110	Addiction Mental Health
AP111	Colorectal
AP112	Emergency
AP113	Diabetes Mellitus
AP114	Emergency
AP115	Emergency
AP116	Emergency
AP117	Pain Management
AP118	Cardiology
AP119	Emergency
AP120	Emergency
AP120-A1	Emergency
AP120-A2	Emergency
AP121	Diabetes Mellitus
AP122	Eating Disorders

AP123	Child Health & Parenting
AP124	Epilepsy
AP125	Bereavement
AP126	Positive Behaviour Support
AP127	Cognitive Behavioural Psychotherapy
AP128	Diabetes Mellitus
AP129	Emergency
AP130	Emergency
AP131	Emergency
AP132	Psychotherapy
AP133	Psychotherapy
AP134	Primary Care
AP135	ID Co-existing MH Dis
AP136	Emergency
AP137	Mental Health & Psychotherapy
AP138	Epilepsy
AP139	Dementia Care
AP140	Neonatology
AP141	Womens Preventative Health
AP141-A1	Women's Preventative Health
AP142	Emergency
AP143	Forensic Mental Health
AP144	Liaison Mental Health
AP145	Liaison Mental Health
AP146	Mental Health & Psycotherapy in Primary Care
AP147	Oncology
AP148	Recovery & Rehabilitation in Mental Health Care
AP149	Emergency
AP150	Emergency
AP151	Emergency
AP152	Emergency
AP153	Recovery & Rehabilitation in Psychiatry
AP154	Dementia Care
AP155	Heart Failure
AP157	Emergency
AP158	Emergency
AP159	Emergency
AP160	Emergency
AP162	Emergency
AP162-A1	Emergency
AP163	Older Person: Rehabilitation of
AP164	Ophthalmology
AP165	Emergency
P015-A4	Emergency

APPENDIX 3

Numbers of Nurses and Midwives Registered as RANPs and RAMPs

Job Title	Count		Job Title	Count
ANP Emergency	78		ANP Cog. Behav. Psychotherapy	2
ANP Neonatology	8		ANP Cognitive Behav. Therapy	2
ANP Gastroenterology	7		ANP Dermatology	2
ANP Cardiology	5		ANP Haematology	2
ANP Cardiothoracic	5		ANP Pain	2
ANP Diabetes	5		ANP Pain Management	2
ANP Epilepsy	5		ANP Primary Care	2
ANP Oncology	5		ANP Psychotherapy	2
ANP Emergency Cardiology	4		AMP Diabetes	1
ANP Oncology (Radiation)	4		AMP Diabetes Mellitus	1
ANP Diabetes Mellitus	3		AMP Emergency	1
ANP Heart Failure	3		AMP Midwifery Care	1
ANP Liaison Mental Health	3		AMP Women's Health	1
ANP Rheumatology	3		ANP Breast Care	1
ANP Women's Health	3		ANP Care of Older Adults Comm.	1
AMP Womens Preventative Health	2		ANP Child & Adolescent M H	1
ANP Children's Emergency	2		ANP Child Health & Parenting	1
ANP Children's Ambulatory Care	1		ANP Occupational Health	1
ANP Colorectal	1		ANP Older Person with Dementia	1
ANP Community Older Adults	1		ANP Ophthalmology	1
ANP Critical Care Outreach	1		ANP Paediatric Emergency	1
ANP Dementia Care	1		ANP Perinatal Mental Health	1
ANP Eating Disorders	1		ANP Positive Behaviour Support	1
ANP Endocrinology	1		ANP Recovery & Rehab. MHC	1
ANP ENT	1		ANP Rehab of the Older Person	1
ANP Forensic Mental Health	1		ANP Respiratory	1
ANP Haematology Adult	1		ANP Sexual Health	1
ANP Haematology Oncology	1		ANP Stroke	1
ANP Inflamm. Bowel Disease	1		ANP Stroke Care	1
ANP Lung Transplantation	1		ANP Tissue Viability	1
ANP M/Health Psycotherapy PC	1		ANP Urology	1
ANP MH & Psychotherapy	1		ANP Vascular	1

ANP Neurology (Movement Dis.)	1	ANP Wound Care	1
ANP Neurology (ND)	1		

APPENDIX 4

‘An Advanced Nurse Practitioner Candidate (ANPc) for General Practice (GP) finished her nurse prescribing in July 2016 and is awaiting her certificate to send to NMBI for registration as a RNP. Her employers financially supported her by paying her fees and mentoring her. The employers are contemplating further support but have not yet agreed to it. If funding was readily available for this Practice Nurse (PN) she could commence the pathway now to becoming an ANP. This year in CHO 5 only two PNs completed their nurse prescribing certificate with financial support from their employers. The employers also act as mentors for the PNs and assist with the development of the Collaborative Practice Agreement. There are a number of PNs in the area who would undertake nurse prescribing if funding was available from the HSE and this service in general practice / primary care would greatly increase the services the PNs offer to build capacity and further enhance long term conditions self-management in Primary Care and support the maximum provision of a local integrated care service. The Office of the Nursing and Midwifery Services Directorate (ONMSD) provides funding for HSE employed nurses who undertake the Certificate in Nursing (Nurse/Midwife Prescribing) postgraduate education programme. Privately employed nurses e.g. Practice Nurses are not provided for by the ONMSD and must self-fund or the GP/employer has funded some but not all of the PNs, while Out of Hours Nurses where privately employed by a co-op or limited company have been funded.

Nurses and Midwives undertake medicinal product prescribing based on service need and the scope of their clinical role. In the case of a PN working at an advanced level the provision of care in areas such as long term conditions management, women’s health, immunisation, anticoagulation management, is greatly enhanced by this expansion of their role’. **(Professional Development Co-ordinator for Practice Nurses, Primary Care Unit (SE), HSE South, The Office Complex, Kilcreene Hospital Campus, Kilkenny).**

NURSE AND MIDWIFE MEDICINAL PRODUCT PRESCRIBING IN IRELAND - FUTURE DEVELOPMENT AND IMPLEMENTATION

RUTH HOBAN ON BEHALF OF THE NURSING AND MIDWIFERY BOARD OF IRELAND

The past decade has seen unparalleled development and change in the Irish healthcare system. One of the most important and significant developments, not only for nurses and midwives, but for patients or service users, and the healthcare system in general was the enactment of legislation and regulation providing prescriptive authority to nurses and midwives. This enables a registered nurse or midwife, who has completed an approved six month post-registration education programme, has the appropriate clinical experience, is registered with The Nursing and Midwifery Board of Ireland as a Registered Nurse Prescriber and has authority from the health service provider that employs them, to independently prescribe a range of medicinal products within their scope of practice.

The nurse midwife medicinal product prescribing initiative has been in place in Ireland since 2007, and there are now 927 nurses and midwives registered with the Nursing and Midwifery Board of Ireland as Registered Nurse Prescribers (August, 2016). The initiative is first and foremost about making a difference for patients and service users. It is also about enhancing professional capacity in order to deliver services that are more patient focused thereby delivering better outcomes.

However, since 2011 the numbers of applicants to undertake the education programme for nurses and midwives with prescriptive authority has been decreasing, numerous factors have contributed to this decline. A collaborative approach was established between the Nursing and Midwifery Board of Ireland and the Office of the Nursing and Midwifery Services Director, Health Services Executive to review the regulatory and implementation systems and processes of this initiative. It is envisaged that the implementation of the 12 recommendations of the aforementioned review will result in a leaner, less cumbersome process in the future.

One of the major consequences of looking at a ten year strategy for health care and health policy in Ireland is the opportunity it presents to consider the various roles played by different healthcare providers. The role of nurse midwife prescriber is exercised in an interdependent system which recognises the expertise of the Registered Nurse Prescriber and avails of the professional knowledge of medical, nursing and pharmacy colleagues.

The aim of this submission is to highlight the importance and necessity for further development and implementation of nurse and midwife prescribing, as this initiative has significant potential to contribute to the current restructuring of the health services in Ireland.

RECOMMENDATIONS

1. Focus on succession and workforce planning to sustain current levels of Registered Nurse / Midwives Prescribers
2. Build capacity of Registered Nurse/Midwives Prescribers within specialist areas of nursing/midwifery practice
3. Effective and efficient utilisation of Registered Nurse/Midwives Prescribers' skills, expertise and knowledge in maintaining a health service that has finite resources.

4. Continued financial support for nurses and midwives who wish to undertake an approved education programme for nurses and midwives with prescriptive authority within a Higher Institute of Education
5. Reconsider and reconfigure systems and processes introduced on the commencement of nurse and midwife medicinal product prescribing, acknowledging that health service providers have advanced their corporate and clinical governance, risk management, quality safety and audit structures and processes since 2007
6. Amendment of the legislative authority for Registered Nurse/Midwives Prescribers to prescribe exempt (unauthorized) medicines

1.0 Introduction

The nurse midwife medicinal product prescribing initiative has been in place in Ireland since 2007, and there are now 927 nurses and midwives registered with the Nursing and Midwifery Board of Ireland as Registered Nurse Prescribers (August 2016). The RNP's are from 112 clinical specialities and 180 health service providers (49 acute hospitals, 124 community health organisations and 7 prison services). There are also 41 RNP's from private health service providers.

The nurse and midwife medicinal product prescribing initiative has significant potential to contribute to the current restructuring of the health services. This includes further developing integrated services to ensure delivery of optimum care and cost effective outcomes in acute and community services. This has real potential to enhance the efficiency and responsiveness of the health services for patients and service users. This initiative forms a central component of government policy for the expansion of the nursing and midwifery role. The Health Service Executive Corporate Plan (2015-2017) refers to the requirement for the development of a national co-ordinated plan for the continued expansion of nurse and midwifery led services based on population need and taking account of service delivery efficiencies. An example where nurse midwife prescribing can contribute to the Department of Health Strategy 2015-2017 relates to the strategic priorities for delivering improved patient outcomes. One of its priorities is to implement integrated care programmes through introducing clinically led, multidisciplinary integrated models of care in respect of patient flow, older persons, chronic disease prevention and management, children's health and maternal health.

The critical success factor for the implementation of the nurse midwife medicinal product prescribing initiative was the development of a robust framework to support the introduction of nurse midwife prescribing nationally. This includes guidance and support from the Nursing and Midwifery Board of Ireland (NMBI) and the Office of Nursing and Midwifery Services Director (ONMSD) Health Service

Executive (HSE) prescribing team, ensuring good governance is maintained. Additionally, Ministerial and government support has been provided throughout the change process for nurse and midwife medicinal product prescribing in Ireland.

However, since 2011, the number of applicants to undertake the education programme (provided by 5 higher education institutions) has been decreasing. Numerous factors have contributed to this decline, including (1) the public service moratorium in place since 2008 resulting in no recruitment, no replacement of retired/resigned staff and allowing only mandatory training, (2) regulatory requirements and (3) requirements for inputting prescriptions into the Nurse Midwife Prescribing Data Collection System (HSE & NMBI, 2015). As a consequence of these factors, in 2015 a collaborative approach was established between the NMBI and the ONMSD HSE to review the regulatory and implementation systems and processes around nurse midwife medicinal product prescribing. It is envisaged that the implementation of the 12 recommendations of the aforementioned review will result in a leaner, less cumbersome process in the future. The NMBI and the ONMSD HSE prescribing team will continue in their roles to support registrants and health service providers in the on-going implementation of the initiative.

2.0 Background

The need for the introduction of nurse and midwife prescribing in Ireland was initially identified in 1998 in the Report of the Commission on Nursing: A Blueprint for the Future (1998) which considered that there was a “need to allow greater flexibility to nurses and midwives in the administration of non-prescribed drugs according to agreed protocols with medical practitioners” (Para 4.15). It was recommended that An Bord Altranais (Nursing Board) review the guidelines in relation to the administration or application of non-prescribed drugs by nurses and midwives. As a result of the recommendations made by the Commission on Nursing, and the Review of Scope of Practice for Nursing and Midwifery – Final Report (An Bord Altranais, 2000), An Bord Altranais and the National Council for the Professional Development of Nursing and Midwifery conducted a joint project to examine the potential future role of nurses and midwives in the prescribing of medicinal products. The project took place over a three and a half year period and concluded with the publication of the Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Products Final Report in 2005. The benefits and outcomes associated with nurse and midwifery prescribing outlined in this review included:

- Appropriate and safe prescribing
- Patient or service user satisfaction
- Convenience and greater accessibility for patients or service users

- Nurses and midwives as providers of information
- Patients or service users having improved compliance with medications
- Fewer pharmacological interventions considered
- Appropriate clinical decision making
- Cost effectiveness

In October 2005 the Irish Minister for Health and Children identified the introduction of nurse and midwife prescribing as a high priority. A number of national and international trends were identified as supporting the extension of prescriptive authority to nurses and midwives in Ireland:

- Social and demographic change (e.g. ageing population)
- Changing services configuration for patients with increased specialisation of services (e.g. diabetes, asthma, oncology)
- Value for money
- Implementation of the European Working Time Directive
- A greater focus on community services.

3.0 Legislation

The introduction of nurse and midwife prescribing is underpinned by a twin-track approach encompassing amending Irish legislation and the introduction of new professional nursing regulations (HSE, 2014). In March 2006 Mary Harney, TD, Minister for Health and Children introduced primary legislation to provide for prescriptive authority for nurses and midwives subject to conditions specified in subsequent regulations. The Irish Medicines Board (Miscellaneous Provisions) Act 2006 and its associated regulations (the Misuse of Drugs (Amendment) Regulations 2007, Medicinal Products (Prescription and Control of Supply (Amendment) Regulations 2007 and the Nurses Rules 2007 form the basis on which nurse and midwife prescribing evolved in 2007. These regulations specify the legislative requirements and conditions for prescribing of medicinal products by nurses and midwives. Table 1 lists the regulations associated with the Act.

Table 1: Regulations Associated with the Irish Medicines Board (Miscellaneous Provisions) Act 2006

The Regulations attach the following conditions which must be met where nurse or midwife prescribing takes place:

- The nurse or midwife must be employed by a health service provider in a hospital, nursing home, clinic or other health service setting (including any case where the health service provider is provided in a private home).
- The medicinal product is a medicinal product which would be given in the usual course of the provision of the service provided in the health service setting in which the nurse or midwife is employed.
- The prescription is in fact issued in the usual course of the provision of that health service.
- The NMBI registration number (also known as the Personal Identification Number (PIN)) must be stated on the prescription.

The Regulations do not inhibit the right of an employer to impose further restrictions including prohibiting a nurse or midwife from prescribing.

From: Office of the Nursing Services Director, Health Services Executive (2014)

In addition, a new schedule setting out restrictions and conditions for RNPs to prescribing certain controlled drugs was established for Ireland. This new schedule referred to as ‘Schedule 8’ names the specific controlled drugs that certain nurses and midwives, who are RNPs, may prescriber relevant to their scope of practice and area of work. The stipulations and particular conditions for prescribing are detailed in the *Misuse of Drugs (Amendment) Regulations 2007*.

This dual framework enables a registered nurse or midwife, who has completed an approved six month post-registration education programme, has the appropriate clinical experience, is registered with The NMBI as a RNP, and has authority from the health service provider that employs them, to independently prescribe a range of medicinal products within their scope of practice (HSE, 2014).

4.0 Professional Regulation

The Nursing and Midwifery Board of Ireland (NMBI) was charged by the Minister for Health and Children in 2006 with devising professional regulation and guidance to augment the medicines legislation authorising a nurse or midwife to prescribe medication. The professional regulatory framework was effected through the changes to the Nurses Rules in 2007, which created a new division of the Register for Registered Nurse Prescribers. It is important to recognise the role of professional regulation in supporting nurses and midwives to provide safe quality care to patients across health and social care settings (HSE & NMBI, 2015). The following publications form the regulatory framework for nurse and midwife medicinal product prescribing:

- Collaborative Practice Agreement for Nurses and Midwives with Prescriptive Authority (2012) 3rd ed
- Practice Standards and Guidelines for Nurses and Midwives with Prescriptive Authority (2010)
- Requirements and Standards for Education Programmes for Nurses and Midwives with Prescriptive Authority (2015).

5.0 National Independent Evaluation of the Nurse Midwife Prescribing Initiative

The evaluation of the extension of prescriptive authority to nurses and midwives has been positive both on the impact that it has had on patient care and also on the professional development of nurses and midwives (HSE & NMBI, 2015). The National Independent Evaluation of the Nurse and Midwife Prescribing initiative (Drennan et al, 2009), demonstrated that the model for nurse midwife prescribing for Ireland was both safe and effective. One of the recommendations of the evaluation related to unauthorised medicines. Current medicines legislation prohibits RNPs prescribing these medicines. This lack of authority has contributed to the delay and inefficiencies for patients requiring exempt (unauthorised) medicine prescriptions as the RNP must refer to a medical practitioner for their prescriptions (HSE & NMBI, 2015). Additionally, there are increasing shortages of authorised medicines requiring health services to source and supply exempt (unauthorised) medicines across the health care sectors (HSE & NMBI, 2015).

6.0 The Future Vision for Nurse Midwife Medicinal Product Prescribing in Ireland

Nine years following the change in legislation, nurse midwife medicinal product prescribing has been effectively embedded throughout the Irish health services. Prescriptive authority has enabled nurses and midwives to provide holistic episodes of care more efficiently. It is envisaged that there will be a large number of nurse and midwife prescribers in Ireland in the coming decade. Building RNP capacity throughout the health services and ensuring the sustainability and continued implementation of this initiative is a key priority going forward. The ability for the RNP to prescribe exempt (unauthorised) medicines would help to ensure more timely and efficient care for patients (HSE & NMBI, 2015). Additionally, it will also contribute to increasing the autonomy and expansion of prescribing practices for RNPs (HSE & NMBI, 2015).

7.0 Conclusion

Nurse and midwife prescribing has been received positively in all areas where it has been introduced and the numerous benefits are now recognised. These include improved services to patients and service users through reduced waiting times and utilising the skills of nurses and midwives more effectively. Nurse midwife prescribers are ideally placed to deliver a more efficient service which supports early intervention of care, early discharge and management of patients in the community and indeed at home where possible. In a climate of increasing demand, nurses and midwives are expected to become more autonomous practitioners themselves. Nurses and midwives with prescriptive authority can meet patient needs in a timely manner leading to better patient outcomes. This important achievement can be attributed to the national framework, which guided the successful implementation of prescriptive authority for nurses and midwives in Ireland and the support from the Irish Government for this initiative.

https://www.nmbi.ie/Home

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Nursing Homes Ireland

The ageing of the population is to be celebrated and is a measure of the advances in living standards, technology and treatment of medical conditions. Over half the persons availing of nursing home care (56%) are aged 85+. This cohort of the population is projected by the CSO to increase by 46% between 2011 and 2021, with prevalence of dementia also to increase by 41% over the coming ten years. As a nation we need to develop a range of policies and services to address the challenges this presents.

Nursing home care has an intrinsic role to play in a continuum of care that must be in place to ensure our increased older population can avail of the specialist care they need, when they need it.

This submission advances the need to place nursing home care on a viable, sustainable footing that encourages investment in capacity to meet the demand for high, complex, specialist care needs within community settings, to reduce pressure on the acute hospitals.

Key recommendations include:

- Introduction of an evidence-based funding model for the NHSS that recognises the assessed care needs of persons requiring nursing home care and their associated costs.
- Utilisation of the expertise, purpose built facilities, specialist equipment and staff within nursing homes, to extend provision of care services such as Day Care, Independent and Supported living etc.
- Development and resourcing of a continuum of care that ensures our older population can avail of the specialist care they require at each stage, with 'ring-fenced' budgets.
- Workforce planning to provide the appropriately skilled staffing complement that will be required to meet our population's healthcare needs.
- A clear and cohesive policy and national strategy for the long-term care of our older population, with certainty, transparency and equality of funding arrangements

The 430+ private and voluntary nursing home providers, who have 'stepped up to the plate' to meet our ageing population's person centred residential care requirements, have the experience, knowledge and proven track record to deliver specialist care services in our communities.

Meaningful engagement with NHI in the development of public policy on future healthcare will enable the realisation of the potential of the nursing home sector in achieving quality value for money healthcare provision for all our aging population.

We welcome the opportunity of making this submission, look forward to contributing to this important debate and eagerly anticipate being invited present to the Oireachtas Committee.

Introduction

The ageing of our population is to be celebrated and is a measure of the advances in living standards, technology and treatment of medical conditions. As a nation we need to develop a range of policies and services to address the challenges this presents.

The ‘shift’ in focus to meeting our healthcare needs through primary and community care is welcome. A continuum of care that ensures our older population can avail of the specialist care they require, at each stage, is critical. Increased community care is vital to support acute hospitals in focussing upon delivery of acute care. Within this continuum and wider healthcare delivery, nursing home care has an essential role to fill.

The lack of a clear and cohesive policy and national strategy for the long-term care of our older population, combined with uncertainty around current and future funding arrangements, poses one of the biggest challenges to the long-term sustainability of the nursing home sector.

A major contributor to the current chronic and ongoing crisis in our acute hospitals is the number of beds occupied by patients who have completed their acute care, but have not been discharged, because arrangements for their post hospital care needs have not been put in place. This care may involve ongoing care in step-down facilities, long term residential nursing home care or the provision of home care packages.

In April 2015 recognising pressures arising within our acute hospitals and A & E departments, the Department of Health announced an additional €74 million in funding to support timely discharge of acute hospital patients back to community care, principally nursing home care.

Subsequently, the HSE Performance Report December 2015 reported: “The number of beds lost through Delayed Discharge during the year 2015 was reduced by 24.7% over the course of the year – a gain of 5,432 bed days.” Then Minister for Health Leo Varadkar informed Dáil Éireann in November the measure had freed up approximately 265 beds every day to be used by hospitals, “which is a capacity increase equivalent to a medium-sized hospital”.

24/7 care in an acute hospital is circa €7,000 per week by comparison with €900 in a private and voluntary nursing home. For every 100 persons who are within an acute hospital setting unnecessarily, the cost per week is €700,000 and over an annual period €36.4m. The equivalent cost for care in a nursing home (long-term or transitional) would be €90,000 per week or €4.68m per annum.

Private and voluntary nursing homes provide 80% of nursing home care. In *An Irish National Survey of Dementia in Long-Term Residential Care,* published January 2015 by the Dementia Services Information and Development Centre reports: “A key finding from this survey is the fact that the private sector is the main provider of specialist long-term care to persons with dementia.”

A properly functioning health service is dependent upon a sustainable private and voluntary nursing home sector. These 430+ specialist care providers, must be supported by a fit-for-purpose funding model, that recognises the complex care needs of people requiring nursing home care. The present funding model, as advanced by independent research, is unsustainable and a barrier to necessary investment to meet demographic demands.

Appendix 1 informs of independent research that highlights the unsustainability of the Nursing Home Support Scheme (Fair Deal) funding model.

Placing nursing home care on a sustainable footing cannot be achieved if private and voluntary nursing homes are tasked with providing care for fees that are 58% below those paid to their HSE counterparts (Department of Health’s Review of the Fair Deal scheme, July 2015). The HSE Annual Report 2015 further highlights this discrepancy. Fair Deal spend to support persons in private and voluntary nursing homes in 2015 was €602.6 million. With 17,266 persons supported in these nursing homes, this equates to equivalent spend of €34,900 per person over the course of the year. By contrast, €328m was spent to support persons in HSE nursing homes. With 4,915 persons supported by the scheme in such homes, this equates to double the spend per person - €66,734. It is simply unsustainable for private and voluntary nursing homes to provide maximum dependency, complex, residential care when there is such a chasm in fee provision.

Dependency levels and complexity of care needs of persons availing of nursing home care are continually increasing. When Fair Deal commenced in 2009 the average length of stay in a nursing home was 4 years. The Department's Review of the Scheme stated average length had reduced to 1.9 years. The HSE Performance Report December 2015 pointed to a 12.3% increase in the number of persons leaving Fair Deal and "a trend emerging that people are applying for the scheme later in life than in previous years and consequently average length of stays are decreasing". These are clear indications that people are only accessing nursing home care when their care needs are most complex.

Over half the persons availing of nursing home care (56%) are aged 85+[114]. This cohort of the population is projected by the CSO[115] to increase by 46% between 2011 and 2021. The prevalence of dementia is to increase by 41% over the coming ten years[116].

The nursing home sector requires an evidence-based funding model for the NHSS that recognises the assessed care needs of persons requiring nursing home care and the associated costs of these care needs. This essential element is currently absent from the framework for 'negotiations' between the NTPF and individual nursing homes. The procedures applied to negotiations with nursing home providers must be fair, transparent and consistent.

This submission advances the policy measures necessary to place nursing home care on a sustainable footing to meet demand and healthcare needs and to support wider healthcare delivery. It also advances measures to support healthcare delivery within the community, removing it from acute settings where possible.

The submission addresses the questions brought forward by the Committee. Its introduction provides background information, including statistical data and independent research that is informing the recommendations brought forward by NHI.

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[114] *NHI Annual Survey 2014 / 2015*, June 2015
[115] Population & Labour Force Projections 2016 – 2046, CSO, 2013
[116] Irish National Dementia Strategy, Department of Health, December 2014

Strategy

What are the key priorities for inclusion in a ten-year plan for the health service?

Recognition of costs of providing specialist complex & high dependency residential care

As outlined within introduction, the present funding model for persons requiring nursing home care is unsustainable.

Private and voluntary nursing home providers, the majority providers of specialist dementia care, are receiving fees that are half those paid to HSE counterparts. This threatens the sustainability of the nursing home sector. DKM analysis states funding model is the "main barrier" to new investment in nursing homes, with the lack of reference to dependency levels of residents an underlying issue[117].

The Dementia Services Information and Development Centre states requirement for the complex and high dependency needs of persons with dementia need to be "more realistically reflected in fairer resource allocation"[118], to recognise skill mix of staff, training needs, and to meet the level of care expected to be delivered to residents with dementia.

Cost of care in an acute hospital is approx. €7,000 per week, seven-fold the cost of providing care in a nursing home. This huge discrepancy and that of fees payable to HSE nursing homes by comparison with private and voluntary counterparts further highlight the critical importance of a funding model that recognises the true costs of the care provided.

A care needs-based funding model that recognises the true costs incurred to meet the complex health and social care needs of persons requiring nursing home care.

Ensuring fees payable to support persons requiring nursing home care recognise the true associated costs will ensure that high dependency specialist care needs of persons can be met within community settings for a fraction of the cost associated with care in acute hospitals.

An indexation mechanism should be considered to ensure budgets keep recognition of increasing costs of care provision and are sufficiently resourced to meet these costs and changing demographics.

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[117] *Potential Measures to Encourage the Provision of Nursing Home and Community Nursing Unit Facilities in Ireland,* DKM Economic Consultants, December 2015

[118] *An Irish National Survey of Dementia in Long-Term Residential Care,* January 2015

What are the key priorities for inclusion in a ten-year plan for the health service?

The Care Continuum

The development and resourcing of a continuum of care that ensures our older population can avail of the specialist care they require at each appropriate stage is a necessity.

Advancement of this is critical for healthcare system that supports acute hospitals in focussing upon delivery of acute care.

'Ring-fenced' budgets specific for differing, specialist care services give transparency within health spend and help ensure the budgets are resourced to meet requirement.

Requirement for policy and related stakeholders to be brought around the table through a forum that will consider, advise and push for the planning, funding and delivery of health services for older people.

Workforce planning

Growth in our population and numbers growing older will place increased demand upon our health services. Health strategy cannot overlook the critical importance of workforce planning to provide the skilled staffing complement that will be required to meet our population's healthcare needs.

What are the key challenges, in your view, to achieving a universal single tier service, where patients are treated based on health need, rather than ability to pay?

A shift in emphasis within health provision to enable easier access to care in the community can support the objective of providing care based on need rather than ability to pay. In tandem with such a shift, the sustainability of the providers of care in the community and what is included within care schemes must be addressed by the State.

Fair Deal provides an excellent example within our health services of persons being enabled to access specialist care based on healthcare need, rather than ability to pay. The principle of resident choice within the Scheme empowers the person to avail of the care in their preferred setting - public, private or voluntary. Funding support is provided on a chronological basis. The scheme is in keeping with the objective of achieving a universal single tier health service.

A shift in emphasis within health provision to enable easier access to care in the community can support objective of providing care based on need rather than ability to pay. In tandem with such a shift, the sustainability of the providers of care in the community and what is entailed within care packages must be addressed by the State.

Fair Deal is in keeping with the objective of achieving a universal single tier health service. A new scheme applying similar principles of Fair Deal should be introduced on a statutory basis for home care provision, providing uniform assessment, equitable access, dedicated ring-fenced funding.

Equal access to therapies & care services

In its report *Who Cares? An Investigation into the Right to Nursing Home Care in Ireland*, the Office of the Ombudsman highlights the exclusion of therapies and social programmes under the Fair Deal scheme. It states this appears at odds with "what (in the words of the Department) is commonly understood as long-term nursing home care". It says the failure to encompass costs for such services is not consistent with obligations under the Health Act.

The HIQA report *Designated Centres for Older People: An analysis of inspection findings during the first 15 months of inspections* states inadequate access to care services such as physio, chiropody, occupational therapy and others highlights a "wider funding and access issue" in particular for private nursing homes.

The continuum of care previously referred to must not only be cognisant of 'demand' but must also ensure that residents retain access to therapies and services that are fundamental to support person's healthcare needs. Deterring access to these services is an abuse of their rights and can lead to further health complications that lead to dependence upon acute services.

What actions are needed to plan for, and take account of, future demographic pressures (population growth, ageing population) and its impact on the health system?

As outlined within the Strategy section, the funding model to support nursing home care is unsustainable and has been independently identified as the main barrier to new investment in nursing home care. With the numbers most dependent upon nursing home care escalating, it is vital that the nursing home sector is placed on a sustainable footing. Failure to address the payment models considerable shortcomings will have very serious consequences for acute care and wider healthcare delivery.

Fees payable for nursing home care must reflect the true costs of providing complex care.

A sustainable nursing home sector is dependent on providers receiving adequate return on capital employed.

Greater healthcare complexities present greater requirement for high skilled staff, specialist equipment and facilities, and other associated costs.

Fees payable should include a reasonable ROI and not an arbitrary decision by NTPF.

Demand-led

Fair Deal funding must be demand-led to ensure persons requiring this specialist care can access it in a timely manner. Failure in this regard has consequences for the person's health and wellbeing and leads to unnecessary increased pressure on acute hospital services.

NHI recommend introduction of multiannual budgeting for Fair Deal. This could enable the Department of Health / HSE ensure the scheme is adequately resourced to meet demand.

Stakeholder input in planning to meet demand

A Department of Health led ‘forum’, bringing stakeholders around the table on a consistent basis to plan for healthcare needs of our older population, can ensure those responsible for planning, funding and delivery can:

Workforce planning

A health strategy cannot overlook the critical importance of workforce planning for our health services. A workforce plan for the entire health service – public, private and voluntary – must be encompassed within a health strategy. This would encompass promoting education / training opportunities to pursue dedicated careers within healthcare, the re-training, recruitment and retention of healthcare staff and access to labour markets where shortages apply.

Integrated Primary and Community Care

What steps are needed to move from current model towards a model based on integrated primary secondary and community health care?

The potential exists to utilise the expertise, purpose built facilities and specialist equipment of nursing homes, and support them in the delivery of a range of services that can include intermediate care, day care, home care, independent and assisted living. These highly regulated, dedicated health settings, with their specialist staff can play further role in meeting healthcare needs in the community.

More formal, ongoing engagement between the relevant stakeholders, as recommended through establishment of a Forum, can enable the development of policy that will facilitate the provision of and timely access to healthcare support services.

Not acknowledging and funding the true costs of specialist, complex care, within the community, leads to unnecessary stays in acute hospitals at a multiple of this cost.

Accessing care services

Persons in nursing home care must not be discriminated against from accessing care services essential to support their health and wellbeing. This submission has highlighted Ombudsman and HIQA concerns in this regard. An unpublished HSE audit of access to therapies for older people in nursing home care revealed December 2013 informed of huge geographical inequalities in accessing these essential services, inequalities between residents in public and private nursing homes and discrimination based on medical card status.

Residents in nursing homes must have access to the same healthcare and health opportunities that they would be entitled to if they were living in their own homes.

Nursing home residents must retain the same entitlements to specialized equipment, therapies and access to allied health professionals as they would if they were living in their own homes.

Community Intervention Teams

Community Intervention Teams are integral to primary care delivery and must be resourced and supported to provide care within communities across the country.

What are the key barriers to achieving this & how might they be addressed?

Not recognising the high dependency health and social care needs of persons requiring nursing home care. Despite growing requirement for services, nursing homes have closed beds due to severe cost pressures being incurred and failure of funding model to recognise these.

Where 'money does not follow the patient' there is inefficient spend within health services.

Lack of access to GP care and other specialist care services & supports within the community, including nursing homes, works against the Government objective of enabling healthcare to be provided within the community where possible.

Lack of regulation of the home care sector leads to inequalities in effective governance, oversight and the cost of regulatory compliance.

How would you ensure buy-in from health care professionals to progress towards an integrated care model?

We need to move from a fragmented, polarised approach to community care, to a rounded, inclusive one.

Good GP and nursing care is essential for reducing acute hospital admissions. Of considerable concern, nursing homes are increasingly reporting difficulties in getting GPs to visit their residents, with refusals and lengthy delays being reported.

An important step would be GP contract stating categorically the obligations and duties of the GP to the resident within the nursing home. This would promote a mutual enhancement of a collaborative relationship that will protect and promote the care given to the residents in nursing homes.

A collaborative approach between GP services, primary / community care services and nursing homes is essential to meet health needs of our population within the community and reduce acute admissions.

Funding model

Do you have any views on which health service funding model would be best suited to Ireland?

'Ring-fenced', dedicated funding to support specific care services in the community can apply greater transparency in respect of health spend and resource allocation. A shift in emphasis towards ensuring primary care is better supported under the 'money follows the patient' can lead to more efficient spend within health services. Fair Deal is a strong 'money follows the patient' scheme and a payment model.

Also, greater oversight needs to be introduced to apply greater fairness and transparency between the procurer of health services on behalf of the State and the service provider. Independent oversight is significantly absent from the procurement of care within the private and voluntary nursing home sector.

A shift in emphasis towards ensuring primary care is better supported under the 'money follows the patient' mantra can lead to more efficient spend within health services.

A new scheme in keeping with that of Fair Deal should be introduced on a statutory basis for home care services

Greater oversight needs to be introduced to apply greater fairness and transparency between the procurer of health services on behalf of the State and the service provider.

What are the main entitlements that patients will be provided under your model?

NHI would recommend any funding model gives entitlement important elements of care that are requirement to support health and wellbeing, including for example provision of therapeutic services such as speech and language therapy, physio, dietetics, activity and social programmes.

APPENDIX 1:

DKM Economic Consultants, *Potential Measures to Encourage Provision of Nursing Home & Community Nursing Unit Facilities*, undertaken on behalf of the Department of Health and published December 2015: "While the [Fair Deal] scheme has delivered many benefits and is a significant advance on what was in place heretofore, its current pricing model operates in an ad hoc manner, lacks rationale, consistency and fairness, only applies to the private sector, and in the long run is unsustainable."

"Our consultations and analysis indicate that the main barrier to new investment in nursing homes is how the pricing model of the Fair Deal Scheme is operated with regard to private nursing homes. This manifests itself in terms of:

- Uncertainty around future income streams;
- Inadequate income levels to enable a return on investment in many parts of the country outside Dublin;
- Lack of reference to dependency levels of residents.

A number of other barriers have been identified during our consultations and analysis of the sector, notably:

- Availability of suitably qualified staff, both in terms of nurses and management.
- Sector fragmentation.
- Lack of available sites
- Inconsistency in the application of standards by HIQA.
- Reputational risk, which results in a premium being required from funders, compared to investment in other sectors."

Dementia Services Information and Development Centre (DSIDC), *An Irish National Survey of Dementia in Long-Term Residential Care*, January 2015: "Our findings would lead us to conclude that the complex and high dependency needs of persons with dementia in specialist care units now need to be more realistically reflected in fairer resource allocation, in recognition of the skill mix of staff employed in specialist care units, their training needs and the level of care expected to be delivered to residents with dementia,"

Oireachtas Joint Committee on Health and Children, *Report on End of Life and Palliative Care in Ireland,* July 2014: "In reviewing the current Fair Deal Scheme consideration could be given to extending the definition of Long Term Residential Care Services, and the range of services covered by the Scheme…In reviewing the current Fair Deal Scheme an evidence-based cost of care model could be used in assessing the real cost of residential nursing home care in Ireland**.**

http://www.nhi.ie/

Nutricia Advanced Medical Nutrition

In Ireland, approximately 140,000 adults with chronic diseases are malnourished and one-in-four patients admitted to hospital are malnourished.(1,2) Malnutrition is not only a common clinical, public health problem, but also a major economic burden on our healthcare. The manifestations of malnutrition are present in every age group, every disease speciality, every hospital ward and every health and social care setting. Malnutrition is both a cause and consequence of disease and has significant implications for a patient's outcome as untreated malnutrition delays recovery from illness and increases complications such as infections, pressure sores and falls. Equally, malnutrition places severe pressure on healthcare resources and acute hospitals, as costs associated with malnourished patients are three times higher (3), patients are admitted to hospital three times more often (4) and hospital stays tend to be three to four days longer.(5) As such, disease-related malnutrition is estimated to cost the State over €1.4 billion per year in health and social care.(2)

With a rapidly aging population and expected increase in chronic disease burden, it is imperative that malnutrition is addressed before this cost and burden on the health service intensifies. A co-ordinated , top-down approach must be taken to ensure that nutritional pathways are implemented to prevent malnutrition, and to increase awareness so that malnutrition is detected and managed as early as possible, to mitigate disease complications before they escalate and alleviate pressure on acute hospitals. There is consensus on the need to shift Ireland's approach to illness from treatment to prevention, moving care from secondary settings to the community. There is strong, international evidence suggesting that since more than 90% of the malnutrition originates and exists outside hospital, preventive measures should be undertaken in the community to reduce the clinical economic burden of malnutrition, while a health economic report from the National Institute of Health Research in the UK (NIHR) has shown that interventions to combat malnutrition in malnourished patients save rather than cost money.(3) The development of primary care centres here provides a real opportunity to introduce a quality assured framework to improve nutritional care in the community, which will not only result in better quality of care but also in a net cost saving.

Nutricia Medical recommends that:

- ***All healthcare professionals be educated on the need to integrate nutrition care into medical practice. Basic nutrition education should be part of all HCP pre registration curriculums.***
- ***Screening for malnutrition become mandatory across all health and social care settings, underpinned by quality standards and adequate resources***

- ***National Quality Standards be developed for good nutritional care in all health and social care settings, with clarity around responsibilities, metrics and compliance incentives/penalties***
- ***Fair and equitable access to dietitians across all health and social care settings, including patients on home enteral feeds to ensure continuity of safe, effective care***
- ***Fair and equitable access to medical nutrition products, irrespective of location or ability to pay. This includes reimbursement of new, innovative products, as well as the inclusion of clinically appropriate medical nutrition products to patients on the Long Term Illness Scheme.***

In this submission, we have focussed on advancing primary and community care services to improve patient outcomes, reduce hospital demand and create a cost-effective healthcare service, in line with the Committee's terms of reference and stated focus.

Nutricia Medical awaits the publication of the Committee's 10 Year Strategy on the Future of Healthcare in Ireland and is happy to provide any further information on any of the points outlined herein.

Good nutritional care is an essential and often overlooked component of healthcare. In chronic diseases, it improves patient and clinical outcomes, reduces community care costs and keeps people out of hospital.

In Ireland, where one-in-four patients admitted to hospital is malnourished (1), resulting in significant negative implications for outcomes and healthcare costs, there are significant benefits to ensure that nutritional pathways are implemented to prevent, detect and manage malnutrition in a community-based setting, thereby alleviating pressure on hospitals and mitigating disease complications before they escalate.

Owing to demographic change, the incidence of many chronic diseases is expected to increase in the coming years. Without specific policy and action to address the malnutrition that will inevitably accompany many of these chronic diseases, the burden of malnutrition will equally increase.

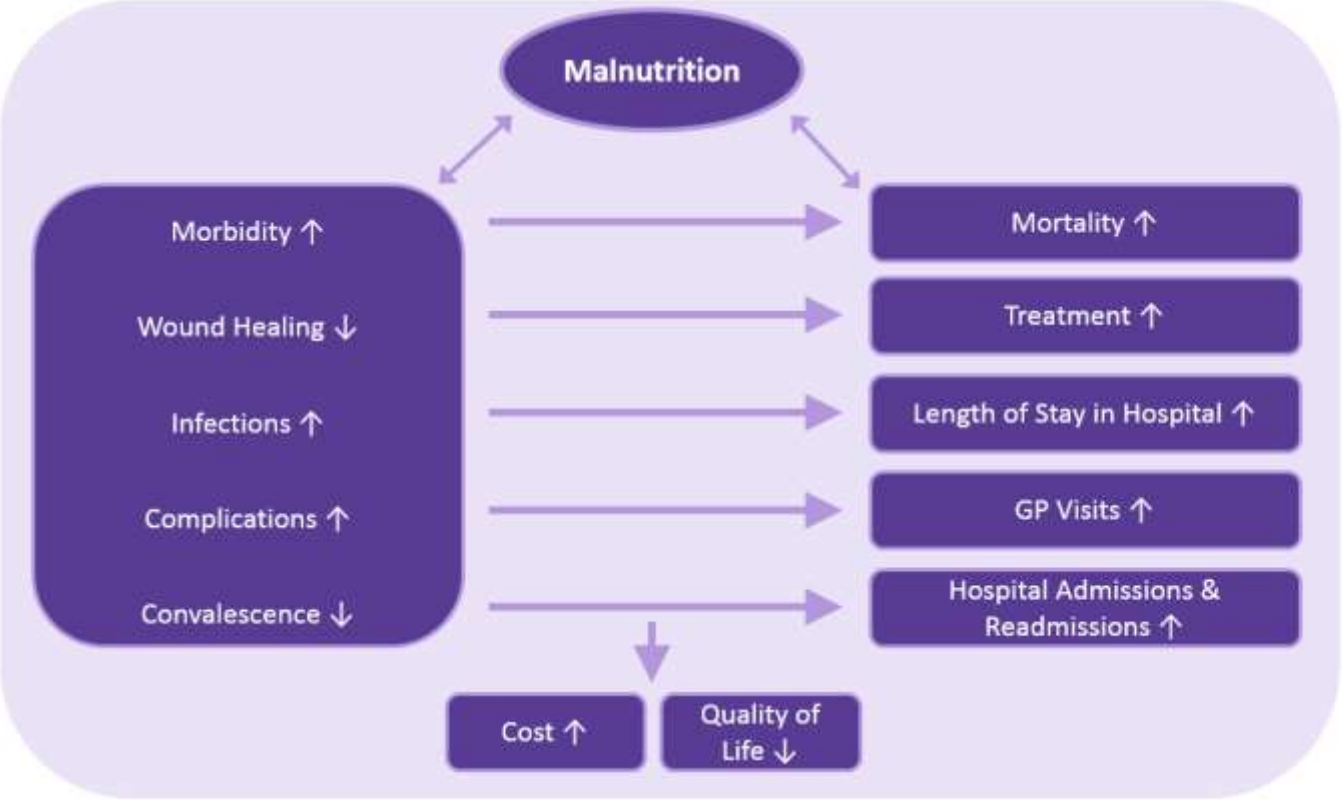
Disease-Related Malnutrition: Disease-related malnutrition, unlike starvation-related malnutrition, is both a cause and consequence of many chronic diseases. In this scenario, the effects of malnutrition complicate the disease itself, leading to a vicious cycle of reduced food intake, altered metabolism, increased needs, exacerbating the physical and psychological effects of both the chronic disease and the malnutrition, resulting in poorer outcomes and increasing healthcare utilisation. Diseases frequently implicated in disease-related malnutrition include **chronic obstructive pulmonary disease**

(COPD), **cancer** and **GI diseases, such as Crohn's disease**. Certain treatments, such as chemotherapy can also have a negative effect on nutrition.

Facts about Malnutrition in Ireland

- Approximately **140,000 adults with chronic diseases** are malnourished in Ireland.(2)
- Untreated malnutrition **increases a patient's risk** of infection, pressure sores and falls. (5)
- Healthcare **costs are three times higher** in malnourished patients. (3)
- Annual costs associated with the health and social care of adult patients with disease-related malnutrition in Ireland is estimated at **over €1.4 billion**. (2)
- Malnourished patients have hospital stays that are **three to four days longer** than average. (5)
- Malnourished patients have **twice as many GP visits** and are **admitted to hospital three times as often**.(4)
- Malnutrition is linked to a **twelve-fold increased risk of death**. (5)
- Early detection / management with medical nutrition can **reduce the average hospital stay by 2 days.** (6)
- Medical nutrition products are clinical interventions used to provide specialised nutrition to patients with a specific clinical need and are used under the supervision of medical professionals. The most common medical nutrition products used are **Oral Nutritional Supplements.**
- Use of Oral Nutritional Supplements has been associated with 1 in 3 **fewer deaths**, 1 in 3 **fewer complications** and 12% **savings** in the hospital setting, and in the community, a reduction in 1 in 6 hospitalisations with 9% cheaper healthcare. (6,9)

Malnutrition has adverse consequences for both the patient and wider healthcare economy:



Tackling Malnutrition in Ireland - Early Identification: Early detection and management of malnutrition is vital to improving patient outcomes in Ireland.

A recent HIQA report on Nutrition & Hydration Care in Public Acute Hospitals (May 2016), highlighted that malnutrition, nutrition and hydration care is "not viewed as a priority for some Irish hospitals", with 21% of Irish public acute hospitals lacking a system of screening in place for the risk of malnutrition.(7) Further, only half of the hospitals reviewed screen for malnutrition within 24 hours of admission in more than 75% of wards, while only 29% of hospitals had a policy on the use of Oral Nutritional Supplements.

A key recommendation of the HIQA report is that all hospitals implement systems that ensure all patients are screened for the risk of malnutrition on admission to hospital, in line with evidence-based practice.

This development, whilst positive, will – in isolation –have limited impact if not replicated in the community, considering how the vast majority of malnutrition develops and progresses mainly undetected in the community, (8) where malnourished patients are twice as likely to visit their GP and three times as likely to be admitted / readmitted to hospital. (4)

Screening for malnutrition become mandatory across all health and social care settings, underpinned by protocols quality standards and adequate resources

A pre-requisite for success will be educating HCPs to ensure that they have the appropriate skills and competencies needed to ensure that the nutritional needs of their patients are met.

As outlined in the case study on the Midlands Project– a co-ordinated approach to malnutrition within the community – educating HCPs on their role in screening, managing and referring onward to dietitians was necessary to establishing a cohesive and holistic community approach (13).

While education programmes should be rolled out to existing HCPs working in the community, the longer-term solution would be to incorporate nutrition education into the pre registration curriculum for medical, nursing and other relevant HCPs. Such a programme should provide future HCPs with training for estimating nutritional requirements, nutritional assessment (to include screening), symptoms of malnutrition and effective management of patients who are malnourished.

All healthcare professionals be educated on the need to integrate nutrition care into medical practice. Basic nutrition education should be part of relevant HCP pre registration curriculums

Tackling Malnutrition in Ireland – Intervention in the Community

At present, when malnutrition is detected by GPs in their practise or by nurses working in Nursing Homes, access to expert dietetic services is sporadic or non-existent. In order to manage malnutrition at as early a stage as possible, thereby ensuring that complications are mitigated before they escalate into costly and lengthy hospital admissions, malnutrition must be screened for in the community, underpinned by appropriate systems and processes for follow up assessment and effective management of those identified to be malnourished.

Primary Care Centres offer the most appropriate setting in which to achieve this efficiency in Ireland. Were all existing and new Primary Care Centres equipped with the resources and expertise to identify malnutrition early and implement appropriate nutritional care plans, many hospital admissions could be avoided.

A recent systematic review and meta-analysis showed that appropriate use of oral nutritional supplements (ONS) in community patients was associated with a significant reduction in hospitalisations. (9) Applying these results to Ireland, a recent paper suggested as many as 460 beds per day could be saved through treating malnutrition in the community with targeted use of ONS rather than acute hospitals (see below). (10)

Considering the current cost and prevalence of malnutrition in Ireland, coupled with the level of malnutrition-driven demand on acute hospitals beds and escalating demographic pressures, the development of primary care centres with adequate dietetic resources and fair and equitable access to medical nutrition provides a strong opportunity to shift the management of malnutrition to the community.

It is vital that primary care centres are aware of their obligations on the need to integrate nutrition care into medical practice. This includes having the necessary resources and expertise to manage patients identified to be malnourished through mandatory nutritional screening.

This can be achieved in the form of strategically allocating dietetic resources according to demographic and clinical need of individual PCC, as well as implementing nutritional policies in the community to ensure GPs, PHNs and other relevant HCPs screen for malnutrition as part of their routine medical care.

To facilitate and optimise this cycle of care, ***the HSE should be tasked with developing National Quality Standards for good nutritional care in the community***, which would include the development of nutritional care plans linked to the results of nutritional screening. These standards should also clarify roles and responsibilities for all HCPs around the management of malnutrition.

The potential of earlier detection and management of disease-related malnutrition with oral nutrition supplements has been recently summarised as the following: (10)

- *Targeted use of ONS in community patients could* ***reduce hospitalisation by 168,438 adult bed days per year, equivalent to 460 beds per day***
- *The potential for reducing the deleterious impact of malnutrition' is* ***greatest in the community***
- *Although malnutrition affects approximately 4% of the adult population at any time,* ***its high prevalence (30%) and severity (75% high risk, 25% moderate risk scores) in patients admitted to Irish hospitals indicates a failure to detect and manage these patients appropriately in primary care settings****, with major clinical and cost implications.*
- *This is perhaps unsurprising given the* ***lack of systems and dietetic resources*** *in place presently to ensure good nutritional care at primary care level.92% of malnourished patients in Irish hospital are admitted from their own home,* ***improvements in screening / recognition of such patients by primary care providers are warranted.***

Case Study in Community Dietetic Intervention – Midlands Model

Patients are at risk of malnutrition due to the absence of routine nutritional screening and a lack of training on the recognition and management of malnutrition in the community.

The HSE Dublin Mid-Leinster (Midlands) area has implemented an evidenced-based structured approach to the management of malnutrition in a primary care setting – the Midlands Model.

Prior to rollout, GPs and Community Nurses reported poor knowledge of malnutrition, lack of evidence-based practice, little training and resources, resulting in no weight being recorded in 80% of medical charts, no structured nutrition screening and sub-optimal prescribing practices. The model developed involves four main community dietitian-led elements:

- Education sessions for key healthcare professionals on the management of malnutrition;
- A validated nutrition screening tool - Malnutrition Universal Screening Tool (MUST);
- A pathway for referral to a community dietitian service; and
- Community dietitian strategies to ensure appropriate prescribing of Oral Nutritional Supplements.

Each Primary Care HCP undertakes co-ordinated roles in identifying and treating malnutrition:

- Community Dietician: Provides education on first line management of malnutrition; Treats patients; Advises GP on Oral Nutritional Supplement prescriptions; Oversees policy development, research and audit.
- Community Nurse: Screens patients using MUST – onward referral to Community Dietician if indicated; Address underlying factors causing malnutrition; Provides first line dietary advice; Carry's out audit and is involved in policy development.
- GP: Screens patients using MUST – onward referral to Community Dietician if indicated; Address underlying factors causing malnutrition; Provides first line dietary advice; Prescribes Oral Nutritional Supplements
- Hospital Dieticians – clear pathway for transfer or care/tracking.

Results: This model has led to a significant increase in HCP knowledge, and improvements in care. Nutritional screening increased by 62%, resulting in the increased identification of malnourished patients in the community, thus keeping patients out of acute settings. Patients have also reported high satisfaction with community dietetic intervention.

A national roll out of the Midlands Model, including nutrition education programmes for all healthcare professionals in conjunction with community dietetic services must be accelerated.

Equally, national and local policies should be disseminated to primary care settings on nutritional screening and health promotion initiatives to highlight malnutrition in healthy older adults anticipated to be at future risk.

Availability of Medical Nutrition Products

Creating a holistic model for the screening and management of malnutrition will have limited impact if not supported by the availability of high-quality medical nutritional products.

Oral Nutritional Supplements are clinical interventions prescribed by HCPs for patients who are unable to eat sufficiently to meet their nutritional requirements. Overwhelming clinical evidence supports the role of ONS in terms of significant health improvements and economic savings, when compared to standard care.

In a hospital setting, the use of ONS **saves one in three deaths, one in three complications (such as infections), and discharges patients two days earlier, resulting in 12% cheaper hospital care**. (6)

ONS in the community, meanwhile, helps keep people in their community. ONS **saves one in six hospitalisations, provides a better quality of life in patients and results in 9% cheaper health care through reduced GP visits, reduced hospital admissions/readmissions and shorter length of hospital stay**.(9)

Despite these proven efficiencies, in recent years, budgetary pressures have forced delayed reimbursement of many medical nutritional products and have subsequently limited the availability of new, innovative products. As a result, a widening gap between products available to patients in Ireland and abroad has emerged, including with Northern Ireland and the United Kingdom, whereby better outcomes are being delivered where a wider range of new medical nutrition products are prescribable. For example, Nutricia Medical have a unique high protein, small volume ONS called Fortisip Compact Protein, that is not currently reimbursable in Ireland, despite being submitted to the Corporate Pharmaceutical Unit some time ago at a lower price than other markets, including NI and UK, and comparable to other ONS prices currently listed in Ireland. Clinical evaluation of Fortisip Compact Protein has shown high patient compliance of 90%, with a significant increase in protein intake (+20.6g/d).(14) This increased protein intake is comparable to the levels reported in a systematic review of high protein ONS demonstrating significant improvements in outcomes. These improvements included increased in weight and strength, reductions in complications (including those associated with healing of surgical wounds, pressure ulcers and infection rates) and reductions in hospital readmissions, in a range of patient groups including those with hip fracture, pressure ulcers, cancer, gastro-intestinal disease and chronic obstructive pulmonary disease (COPD). (15)

Pressure to cut back on the current level of spend on medical nutritional products is counterintuitive to their potential role in reducing overall costs to the state in acute hospital services. It must be anticipated that increased detection and management of malnutrition will increase the use of medical nutrition products. A budget impact analysis from the UK (3) suggests that fully incorporating the NICE national guidelines/quality standard on nutritional support in adults (11,12), with appropriate use of medical nutrition products, results not only in better quality of care but also in a substantial net cost saving. Accordingly, a joined-up thinking approach must be adopted by the HSE and Government, whereby expenditure on medical nutrition products must be viewed against their role in mitigating costly complications and keeping patients out of hospital.

Additionally, in recognising that nutritional products can form a core component of medical management for patients with long-term illnesses, such as Cystic Fibrosis, clinically appropriate medical nutrition products must accordingly be made available for reimbursement to patients under the Long Term Illness Scheme. Recent changes made by the HSE mean that some patients that have long term illness cards are no longer able to avail of the full range of medical nutrition products available to patients with medical cards.

A relatively minor investment needs to be made to make medical nutrition products available where indicated to all patients in Ireland, to ensure fair and equitable access, irrespective of location or ability to pay. This includes reimbursement of new, innovative products, as well as the inclusion of clinically appropriate medical nutrition products to patients on the Long Term Illness Scheme.

About Nutricia Advanced Medical Nutrition

Nutricia Advanced Medical Nutrition is Ireland's leading provider of medical nutrition products, as well as being the largest specialist nutrition company in Europe. Nutricia Medical specialises in the delivery of advanced medical nutrition and is committed to helping people live longer healthier lives.

Nutricia Medical supplies high quality feeds, systems and support services to patients, carers and health care professionals. Nutricia Medical provides products for individuals who need nutritional support as a result of illness, injury or age, and also provides products that focus on the dietary management of specific conditions, such as cows' milk allergy, swallowing problems, Phenylketonuria and Epilepsy. In 2015, Nutricia Medical provided healthcare support to over 700 patients being discharged from hospital on enteral (tube) feeds.

Nutricia Medicals' products are primarily administered in healthcare and community settings via HSE reimbursement for Clinical Nutrition Products

Nutricia Medical forms the Medical Division of the Danone group and shares the Danone vision of ‘bringing health through food to as many people as possible’. In Ireland, the Danone Group employs 520 people across its plants in Dublin (Deansgrange), Wexford and Cork.

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Paddy Kevane, Co. Kerry

It is widely known that the Irish health system is in need of significant reform. Never before has the risk to life been so great. Years of austerity did not perform kindly to the Irish health system. Even though the Irish health system faced significant challenges from austerity, past decisions have had significant implications for the present system.

The following document will explore possible solutions for the Irish health system to achieve greater levels of efficiency, equity and caring for health service users. The first part of this document will recommend the immediate reforms necessary for the Irish health system concerning some personal experience. The second part of this paper will make specific recommendations for both University Hospital Kerry (UHK) and Cork University Hospital (CUH) as they are the main acute hospitals for the Kerry people, whom might feel neglected compared to patients living in the Pale (Dublin). Thirdly this document will look at a health system from abroad. Finally, this paper will recommend longer-term reforms for the Irish Health System.

Immediate Reforms Required

In my opinion, the most pressing issue which needs urgent reform is the ICU bed crisis. At least 300 people every year lose their lives due to the dire situation of the ICU bed crisis. Those deaths are avoidable if the proper systems are put in place and adequately supported. The HSE requested an additional €15.5 million in funding for the ICU bed crisis for 2016, but unfortunately, that was declined. At least €15.5 million should be allocated for the ICU bed crisis immediately so as to attempt to prevent any further avoidable deaths (Mitchell, 2016).

Personally, the decision not to authorise the additional €15.5 million in funding has cost my family a very important member. One such life which was lost as a result of the ICU bed crisis was my late sister Breda Louise Kevane. Breda required immediate treatment and an ICU bed transfer from University Hospital Kerry (UHK) to Cork University Hospital (CUH), or any other significant hospital in the immediate vicinity. All such acute hospitals were unavailable because they were overflown in all the relevant counties. Doctors felt that Breda would not survive travelling a significant distance due to ventilator issues and so Cork or Limerick hospitals where her only option. After a public campaign through various media's, Breda finally got her ICU transfer to Cork University Hospital (CUH). She celebrated her 19th birthday in an ICU facility in CUH. A few weeks later she passed away unexpectedly, shortly after transferring to a public ward. Our family felt that the current crisis in the health system cost Breda her life because of the significant timing delays for vital treatment (McMahon, 2016).

Aside from the ICU bed crisis, another significant issue is the situation with patients on trollies in most of the accident and emergency rooms at hospitals around Ireland. The current situation is unsustainable and threatens patient's health and safety. On the 27th October 2016, The Irish Nurses and Midwives Organisation claimed that there were 319 people on trollies, with a further 99 were in overflow in varies wards. The HSE and Irish government need a fresh approach and must develop a more sustainable and efficient solution to solving this specific crisis. Constructing and extending more hospital facilities should be explored to deal with the growth in population. Various methods for offering more work friendly environments for medical staff should also be explored (Irish Examiner, 2016).

Recommendations for Cork and Kerry University Hospitals

It is widely accepted that in Ireland you cannot have a hospital at every crossroad. It would not be sustainable. The counties of Kerry and Cork are a very large landmass. Infrastructure is a particular issue. Road access to Cork from Kerry is quite poor. University Hospital Kerry (UHK) doesn't offer the extensive medical services that it's counterpart Cork University Hospital (CUH) offers, as CUH is the so-called centre of excellence which must also cater Kerry people. For that reason, Kerry people are faced with significant travel time, if they need medical treatment that the hospital in Kerry cannot provide. Access to CUH by road is a timely process for Kerry and some Cork areas due to the lack of a Macroom bypass. For example, somebody coming from West Kerry will have to travel over three hours to attend a hospital appointment in CUH. If that patient requires surgery or is faced with spending a significant amount of time in that hospital, they face an expensive process that people living near the CUH don't have to face. The government must make the Macroom bypass a priority. It would significantly reduce travel time and cost to the Kerry patient that a Cork city patients simply don't face (O'Connor, 2015).

Both UHK and CUH are faced with significant overcrowding issues. One such issue is medical staff are faced with issues around limited space, especially when trying to manoeuvre and circulate patients. This poses a risk to patient safety and has been recorded as an issue in a recent HIQA report for UKH. Both hospitals require significant expansions to deal with the issue of space. The reopening of closed wards would be a positive step in the direction of dealing with the issue of overcrowding in the Kerry and Cork's main hospital facilities (Radio Kerry, 2016; Evening Echo, 2016).

Families of seriously ill patients in hospital can face great financial pressures. Especially if they have to travel a long distance and need short term accommodation. There is a voluntary organisation called Brú Columbanus founded in 2005 at the cost of €5.5 million. This organisation is based in Wilton, Cork city and offers free accommodation for families of seriously ill patients in CUH, who live a significant distance from CUH. The setup of a similar service for UHK in Kerry, would reduce the pressure for those who don't live in Tralee (Brú Columbanus, 201?).

Long-Term Reforms Required forThe Irish Health System

Tussing & Wren, 2006 recommended a significant number of reforms for the Irish health system. The following are six recommendations for the suggested reforms from that literature.

- The government should invest in increasing services and capacity in all the nation's hospitals.
- Increase the quality services and acute bed capacity by reopening all closed wards.
- Hospitals should be paid the same for both public and private patients to remove any incentives against public patients.
- Introduce a statement of principles affirmatively expressing patients' rights, following the lines of the European Charter of Patients' Rights.
- Maintain sustained investment for future projects and increase spending.
- Standardised health accounts which would be comparable with those of other nation-states, comprehending all care, private and public.

Medical card holders are faced with costs. The medical card doesn't offer everything free. Prescription charges are an uneasy burden for some families and individuals. This can be very challenging for people on the medical cards who are on a low income and who may have an illness/disability. The abolishment of prescription charges for medical card holders should be examined. The abolishment is estimated to cost €120 Million to the exchequer. Prescription charges can greatly increase pressure on low-income individuals and families, threatening wellbeing and overall health. Abolishing prescription charges will ease the burden on low-income individuals and families (Culliton, 2016).

Another significant area of health care, which has been underfunded is the area of mental health. Ireland needs adequate 24/7 crisis intervention services. While €35 million in development funding is widely welcomed for budget 2017, it simply is not adequate. Increased spending is required. Full implementation of the national mental health policy called "A Vision for Change" is also required to tackle the mental health crisis in Ireland at the moment (USI, 2016).

Alternative Health Systems

When looking at alternative health systems, Ireland can look at its closest neighbour for guidance. Although many people believe that the United Kingdom (UK) has not the perfect health system in the world, it is significantly better than other nations and that includes Irish health system, in my opinion. The National Health Service (NHS) is free from the point of entry. It services depend on the nation in the UK. For the purpose of this document, we will look at the NHS in England. What is free in the NHS of England. Well here is some examples; if you need an operation, it is free, if you require visiting the doctor that is also free. Your wealth doesn't affect your access to quality health care. The cost of the NHS for the British tax payer for 2016 is said to be £140 Billion. Although that is a significant amount of money, it is £2,000 per person, per year in the UK. By international standards, that is quite small and affordable (The Guardian, 2016).

Previously, this document discussed the concept of abolishing prescription charges in the Irish health system. While the NHS in England also charges for prescriptions, it varies and can be free for those with serious illness or disability or capped for all others. For most so-called healthy people in the UK, they are charged for prescriptions. At £8.40 per item it may appear expensive compared to Ireland's €2.50 per item, but compare the UK's £8.40 per item to what private patients pay in Ireland, and that is a different comparison completely. For those in the UK who need more than 12 prescribed items in a year, they have the option to pay for a certificate, which gives them prescription cover for 12 months for £104. In my opinion, that is the most equitable system of prescription charges compared to Ireland’s system (NHS, 201?).

While the NHS appears to be a fantastic system, it has its issues. The Health and Social Care Act 2012 has brought significant challenges to the NHS. The Act brings focus on privatisation, competition and marketization. It threatens to bring the NHS to its very knees. Other issues the NHS faces include not having enough GPs entering the profession and simply not enough funding for the NHS. Compare the NHS issues to Ireland and the British problems appear a lesser (Chand, 2016).

As an individual with personal experience of the Irish health system, I have strong opinions of what is needed. I feel that the two-tier health system must be removed. A single health system with equal access for all, a system based on need and not wealth is required. Any other solution will lead to health inequalities in my opinion. Private healthcare puts profit before the patient. That cannot work efficiently. The Irish health system should be patient before profit for all. The current health system is not a caring or equitable system. Perhaps looking abroad may offer possible solutions.

Looking at our neighbours in the UK, Ireland should take note of their successes and failures. Exploring potential partnerships to reduce the costs of drugs and to improve professional practice by working with our counterparts in the UK should be done.

Locally, the Kerry people are in danger with the current health system. Cutbacks, inefficiencies and bureaucracy, cost my family a member and changed our lives forever. Austerity has decimated the health system further than the damage it had already entailed from lack of vision by previous governments. Kerry took significant cuts, possibly due to its geographical distance to Dublin. If vital services can't all be offered by the hospitals in Kerry, then the Kerry people need a Macroom bypass to get reasonable access to medical services in Cork. Ireland exists beyond the red cow roundabout, government and Dublin should take note.

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Patient Hotel Solutions

The problem of lack of capacity in Irish acute hospitals has been present for over 15 years. The HSE has published no definitive strategy to eliminate this lack of capacity in the short to medium term. Traditionally all acute hospital inpatients have been treated the same in terms of their accommodation needs and have all been assigned an inpatient bed.

There is, however, a group of patients in Irish acute hospital who are low acuity, short stay and independent. They typically stay in hospital 2-7 days and when discharged return directly home rather than to a nursing home or similar unit. They do not require an acute bed but do require to remain in the vicinity of an acute hospital to receive treatment, expert opinion or diagnostic tests. Repeated surveys of three acute hospitals have shown that there are significant numbers of this type of patient in inpatient beds at any one time. Summary of survey results below:

1. University Hospital Kerry, 43 patients [26% of inpatients].
2. Cork University Hospital, 76 patients [15% of inpatients].
3. South Tipperary General Hospital, 34 patients [25% of inpatients].

Allowing these patients to be accommodated in patient hotels on the campus of acute hospitals allow them to continue with their care pathways and would free enough acute beds to eliminate the need for trolleys in emergency departments.

The use of low cost, high quality patient hotels should be considered in any hospital currently experiencing overcrowding and lack of capacity.

Definition of Patient Hotel

A patient hotel provides accommodation for patient who need to be close to an acute hospital, but do not need an expensive acute hospital bed. They situated on the hospital campus and are used by people who need brief periods of clinical care, recuperation, are awaiting treatment or diagnostic testing.

Patient hotel rooms are generally designed as a normal hotel room rather than more complex and expensive hospital wards. Patient hotel rooms are generally single ensuite rooms rather than six or four bedded wards and so provide much greater dignity and privacy.

Patient hotels are run like normal hotels in that each guest has a defined length of stay. They differ from normal hotels in that they usually have some nursing staff to look after patients clinical needs and the guests are patients of the adjacent hospital.

Patient hotel accommodation can cost less than 25% of traditional acute hospital accommodation.

Patient hotels are common in Finland, Sweden and Norway. The first in the UK was opened in 1994 at Nottingham City Hospital.

In 2015 new patient hotels opened in Norway, Scotland, Denmark, Germany and Switzerland. [A sample list of established patient hotels is found in appendix 1].

Surveys of Low Acuity Independent Patients

Seven surveys of the adult inpatient wards of three acute hospitals have been carried out. In each of these units a significant number of low acuity patients were identified by the ward clinical nurse managers. Maternity or paediatric units were not included. The average number of low acuity patients identified in these surveys was as follows:

1. University Hospital Kerry, 43 patients [26% of inpatients].
2. Cork University Hospital, 76 patients [15% of inpatients].
3. South Tipperary General Hospital, 34 patients [25% of inpatients].

Details of patient types are found in table 1.

If these patients were to be accommodated elsewhere, 15-26% of inpatient beds could be used for patients on trolleys or extra beds could be closed so reducing the need for expensive agency nurses. However, there is currently no accommodation type for this group of patients in Ireland other than scare and expensive ward beds. Patient hotels rooms are the correct type of accommodation for these patients. It should be noted that these are not high dependency patients and all will be scheduled to return independently to their own homes after discharge.

[Exclusion criteria for patients booking into patient hotel are included in appendix 1].

Reason for stay	CUH.	UHK.	STGH.
Pre-operative	8	5	5
Post-operative	13	9	8
Investigations	13	14	9
Transfusion	5	0	0
Brief Rehabilitation	22	8	3
IV therapy	15	7	9
Total Number	76	43	34

Table 1. Types of patients found in acute hospital surveys who were suitable for patient hotel accommodation.

Research

There is a body of international research that suggests that 30-40% of acute hospital inpatient bed days are unnecessary [see appendix 3].

Some of the reasons for this such as inappropriate conversion rates in emergency departments, long length of stay and delayed discharges to the community have been investigated in some depth and some solutions put in place. This has helped control if not eliminate trolley numbers. However, this is not the only group who are inappropriately accommodated in acute hospital beds.

As mentioned, the group of patients that have not been looked at yet in Ireland are those low acuity independent patients who while not needing an acute bed, do require to remain in the vicinity of an acute hospital. Because they are of low acuity, can move independently and feed themselves, they can be very easier accommodated in less complex accommodation.

These type of patients are accommodated in patient hotels in several countries.

Cost

A patient hotel bed will be considerably cheaper than an acute hospital bed both in terms of infrastructure and staffing.

A patient hotel room will deal with non-complex mobile patients only so does not need to comply with the HBN standards for size and complexity and does not need piped medical gases and other expensive accessories. Therefore, even though the patient will have a more comfortable, private and dignified stay, the construction cost will be significantly less.

According to the UK Institute of Hospitality, the average cost per room of building an economy hotel per in the UK is approximately £36,000. According to the UK government website GOV.UK, the approximate cost of an acute hospital inpatient ward per room is £124,000.

In acute hospital wards in Ireland, the staffing ratio is one nurse per seven patients. In patient hotels, the ratio can be anything from 1-20 to 1-80 lowering considerably the staffing costs.

Length of Stay

There is a worry that if an acute hospital is given extra inpatient beds, the average length of stay will simply increase and the trolley number will not change.

However, a hotel has a significant advantage over an acute hospital in that the booking out is always defined at the beginning of the stay. There is no prospect of patients being "lost" and left as an inpatient for an inappropriate length of time.

This defined booking out date will help the hotel staff to arrange completion all necessary investigations and paperwork prior to the assigned date of discharge and keep the overall average length of stay from increasing.

In fact, using a patient hotel, the length of stay may decrease.

Nurse Recruitment

One of the significant risks of any new acute hospital build in Ireland is that nurses will not be found to staff the unit. A 40 bedded acute hospital ward requires approximately 40 whole time equivalent nurses to staff it. In contrast, a 40 bedded patient hotel using a conservative 1:20 nurse:patient ratio requires 13.5 whole time equivalent nurses to staff it.

As patients in a patient hotel are low acuity and fully self caring, a much broader group of nurses would be eligible to work there i.e. nursing home nurses, newly qualified nurses, back to work nurses.

A privately run patient hotel would also have the option of recruiting nurses who have been forced to retire from the public health system but still wish to work.

A patient hotel provides nurses with the opportunity to work in an innovative and pleasant environment compared to many acute hospitals and nursing homes.

Recommendations

1. A proof of concept trial of the use of patient hotels in acute hospitals should be carried out.
2. Any hospital without the capacity of keep ED trolleys at zero and provide accommodation for elective patients should survey their inpatients to ascertain those suitable for patient hotels.
3. Prior to any new inpatient ward build, hospitals should consider whether less expensive patient hotels would be a viable alternative.

Appendix 1

1. Lund University Hospital, Lund, Sweden.
2. Nottingham City Hospital, Nottingham, UK.
3. Rigshospitalet, Copenhagen, Denmark.
4. Oslo Radium Hospital, Oslo, Norway.
5. St. Olav Hospital, Trondheim, Norway.

6. Sodersjukhuset, Stockholm, Sweden.
7. Tampere University Hospital, Tampere, Finland.
8. CHUV, Lausanne, Switzerland.
9. Great Ormond Street Hospital, London, UK.
10. Aberdeen Royal Infirmary, Aberdeen, UK.
11. University College London Hospital, London, UK.
12. Royal Preston Hospital, Preston, UK.
13. Aarhus University Hospital, Aarhus, Denmark.
14. Tromso University Hospital, Tromso, Norway.

Appendix 2

Exclusion criteria for patient hotel

1. Paediatric patients.
2. Early warning score greater than three.
3. Pain scores greater than five.
4. Communicable infection.
5. High dependency patients with complex nursing care needs.
6. Acutely ill patients who may require resuscitation.
7. Confused patients.
8. Patients awaiting nursing home or home care placement.

Appendix 3

1. Hospital Bed Review 2007Acute: www.hse.ie
2. Identifying System Delays in Patient Flow through Day of Care Survey. www.qihub.scot.nhs.uk
3. Length of stay as a risk factor for inappropriate hospital days: interaction with patient age and co-morbidity. J Eval Clin Pract, 2013 Feb; 19{1}:80-95.
4. Factors affecting appropriateness of hospital utilization in two hospitals in Turkey. Journal of Medical Systems. 11/2001; 25{6}:373-383.
5. Reduction in inappropriate hospital use based on analysis of the causes. BMC Health Services Research. 2012, 12:361
6. Does Clinical Governance Influence the Appropriateness of Hospital Stay? BMC Health Services Research. 2015; 15:142.

Perinatal & Infant Mental Health

Infant Mental Health (IMH) is an interdisciplinary field and embraces the importance of promoting positive mental health development within a relational framework with the child's caregiver(s). IMH practice is best understood along a continuum which includes promotion, prevention, intervention, and treatment integrated across services and disciplines. There is a growing recognition, both internationally and within Ireland that early experiences of infants and toddlers matter. What happens during the early stage of development lays the foundation for psychological, social, and emotional functioning and health and wellbeing. The early relationship with caregivers is an essential component to the establishment of good mental health across the lifespan.

To support optimum relationships between caregivers and infants, it is imperative that in Ireland perinatal and infant mental health is prioritised within a national health strategy, which is underpinned by up to date research alongside the delivery of evidence based population wide preventative interventions as well as tailored early interventions services delivered by skilled and trained professionals. Additionally, the need for the integration of psychological services as an integral part of maternity services - right from conception through the postpartum period and into the early years of infancy is a fundamental step that has been broadly overlooked in health service provision. As it stands access to psychological therapies for children and adults across Primary Care, Disability, Adult Mental Health, Child and Adolescent Mental Health, and Acute Health services, is not currently at the level required. In addition access to evidence based antenatal and post natal psychological services is significantly under represented within the Irish context. This dearth of appropriate psychological services exists despite a well established body of international research that supports the benefit of early psychological support in fostering optimal infant health and wellbeing. Further, there is also universal agreement that from an economic perspective, poor mental health during the perinatal period not only exacts a significant social cost to society but is also related to a large financial burden to a country (BlueBeyond, 2000).

Within an Irish context, there is growing awareness and focus on preventative approaches to wellbeing and mental health. For instance, as part of the recent reorganisation of the HSE into Community Health Organisations, healthcare reforms place considerable emphasis on keeping people healthy and well. Similarly, in their pre budget submission for 2016, Mental Health Reform recognised that early intervention approaches not only incorporate a focus on the infants' physical needs but also their social and emotional health and wellbeing. With this in mind, the development of accessible psychological services that prioritise the early years as a means of promoting well-being and mental health within the context of the wider family system cannot be over emphasised. Therefore, the benefit of a national strategy detailing a promotion, prevention and early intervention approach to perinatal and infant mental health needs to be a fundamental part of health reform in Ireland. The recent establishment of the Perinatal and Infant Mental Health Special Interest Group (PIMHSIG) within the Psychological Society of Ireland as well as the Irish Association for Infant Mental Health (I-AIMH), along with initiatives such as Young Ballymun and Young Knicknaheeny, are further testament not only to the growing interest in this area but also acknowledgement of the substantial body of research internationally that highlights the need for expansion of services in this area.

THE CASE FOR PERINATAL AND INFANT MENTAL HEALTH

We know from international research that perinatal and infant mental health problems are a very real and current threat to the ongoing health of a nation, and that intervening at the earliest stages can mitigate such threats (BeyondBlue, 2008; NZ MHC, 2011; RANZCP, 2010). Therefore the benefit of a national strategy detailing promotion, prevention and early intervention approaches to perinatal and infant mental health in Ireland cannot be overstated. In many countries, including Ireland, perinatal mental illness goes unrecognised, undiagnosed and untreated, leading to avoidable suffering for women, men, infants and their families (Bauer et al., 2014; Mental Health Reform, 2015). Individuals benefit from increased spending on mental health care, but so do communities, society and the economy. For all of these reasons, mental health must become a national health priority, with specific targets for expenditure, evaluation and outcomes (O'Shea & Kennelly, 2008).

Supporting primary caregivers, infants and families to achieve optimum mental health and wellbeing across the perinatal period requires that consideration not only be given to the physical needs but the psychological, social, cultural and geographical issues facing women, men, infants and families (Mental Health Reform, 2015). The key driver in meeting these needs lies in the provision of universal, routine psychosocial assessment in addition to health promotion and early intervention that is delivered by well-trained and supported clinicians and health professionals, following clearly defined pathways to care (BeyondBlue, 2008; Mental Health Reform, 2015).

Effective policy frameworks recognise and support the fact that the social and emotional development of infants and toddlers occurs in the context of supportive early relationships with parents and other primary caregivers. Supporting infants must therefore begin with access to high-quality maternity and perinatal community services (BeyondBlue, 2008; EYS, 2013; OCECYMH; 2014). Support at the earliest point of prenatal development is a critical component of supporting a child's physical and psychological development, and later cognitive, social and emotional development (EYS, 2013).

It is critically important to increase recognition of the fact that social and emotional wellbeing is an essential component of healthy infant development (Macdonald et al., 2005; O'Shea & Kennelly, 2008). To achieve this it is crucial not only to have comprehensive specialist infant mental health services but to also integrate infant mental health practices into all systems serving infants and their families (e.g., obstetrics, primary care, disability, child psychiatry and adult mental health services). Furthermore, in order to deliver such services in a cost-effective manner it is essential to identify existing services, reduce the gaps and overlaps in service provision, and formulate strategies to make services more accessible and comprehensive (Macdonald et al., 2005).

The PSI believes that Psychologists have an important role to play in advocating for infants and their families, raising public awareness regarding the optimal conditions for the healthy social, emotional and cognitive development of infants and engaging with policy-makers and key stakeholders to promote and create national policies to support such a vulnerable cohort. Psychologists can contribute to increasing public understanding by conducting research that addresses key policy questions. Psychologists can help to shape new policies that support infant mental health by conducting research and contributing to the knowledge base that informs policy decisions; by educating the public and policymakers about early childhood development and mental wellness; by promoting the use of efficient, reliable, and developmentally appropriate measures of social-emotional outcomes; by collaborating with paediatricians, health agencies, and child welfare agencies to develop early childhood mental health prevention and intervention services grounded in effective practice; and by participating in the development of policy recommendations that improve access to evidence-based practices in infant mental health (Nelson & Mann, 2011).

Psychologists are well positioned to develop and provide specific perinatal and infant mental health services, which provide psychological assessment of the parent-child relationship, parental and child wellbeing, and child development, as well as psychotherapeutic intervention. The need for perinatal and infant mental health services cannot be understated in terms of their importance regarding the physical, emotional, psychological and cognitive development of our citizens. The PSI calls for government agencies, relevant stakeholders and the public to engage in a consultation process with a view to establishing a national perinatal and infant mental health strategy. Such a strategy provides a framework for the establishment of national inter-disciplinary perinatal and infant mental health network teams.

In order to adequately staff the development of integrated PIMH approaches into current services, in addition to the staffing of future specialist PIMH services nationally, there is a need to ensure that Psychologists, and other health professionals, working with infants, toddlers, and their families have relevant core competencies and appropriate knowledge of early childhood development and an understanding of screening and diagnostic techniques for this age group. As part of their submission to government regarding the allocation of funding in the 2016 Budget, Mental Health Reform endorsed the provision of funds to train and staff in perinatal and infant mental health services (Mental Health Reform, 2015). Furthermore, ensuring that undergraduate, graduate, and continuing professional education programmes include content on perinatal and infant mental health is crucial for the future development of this specialist area.

Providers of specialist psychological assessment require access to continuing professional development and appropriate supervision in order to meet the professional competencies required to carry out direct therapeutic work with the parent- child dyad. Psychologists are well placed to provide complex psychological assessment and intervention and consultation to other professionals.

RECOMMENDATIONS

Based upon the available international evidence, current status of service provision in Ireland across the perinatal and early infancy periods, and in line with international best practice guidelines (e.g. National Depression Initiative & Perinatal Mental Health Consortium, Australia; NICE guidelines, UK; Advisory group to the Early Years Strategy; WHO; UN Convention on the Rights of the Child; YoungBallymun), the PSI have made the following recommendations.

Defining Perinatal and Infant Mental Health (PIMH)

In light of the various descriptions regarding the timeline accorded to the period of ‘infancy’, adopting and promoting an agreed definition of perinatal and infant mental health in order to promote the concept in a cohesive way is important.

Universal Screening

Universal routine screening addressing both current distress and the range of demographic, psychological and social factors known to affect perinatal mental health for parents and infants is recommended. While such screening is not intended to replace clinical diagnosis by mental health professionals, it offers opportunity to screen for family risk factors that might affect an infant’s social, emotional and cognitive development, including, poverty, perinatal parental depression and anxiety disorders, family isolation and parental substance abuse.

Pathways of Care

The identification of quality local pathways to care is required to reinforce the implementation of universal screening in order to address the care and intervention needs of women identified as being ‘at risk’, experiencing mild or moderate difficulties to women experiencing complex and/or severe mental illness. This should include access to timely mental health care for all caregivers and family members. The wide range of agencies currently involved in mental health service provision require a system of care that is effectively networked, collaborative and responsive to the whole family.

Integrating PIMH into Existing Services

Integrating the principles and evidence base for PIMH principles into maternity, primary care, community, disability and mental health services is a necessary interim step in promoting the importance of perinatal and infant mental health within existing services. As the broader health system serving young children does not adequately incorporate infant mental health practices, creating a cross-network of service provision to support children and their families, in which expertise is shared, and professional support offered, is imperative. For those parents with less severe mental health difficulties or those families either at risk for or with known infant mental health difficulties, specialist psychological therapy teams is also required. Thus primary care psychology should be adequately resourced to address the spectrum of psychosocial stressors and mental health needs.

Specialist PIMH Services

Specialist perinatal inpatient services should be designed specifically for mothers and babies, staffed by specialist perinatal mental health staff, including Psychologists, to provide inpatient care for mental health problems within 12 months of birth. A Mother and Baby/Parent Infant Unit can provide short to medium term inpatient care and specialist intervention for mothers, fathers, infants and families with severe and/or complex mental health needs. Research has demonstrated that women with acute and serious perinatal illness have better outcomes and better relationships with their infants if cared for in mother and baby units (JCPMH; 2012). Furthermore, when families receive specialised aftercare in dedicated PIMH services, they have shorter admissions and fewer readmissions (JCPMH; 2012). Women with pre-existing mental illness potentially complicating childbirth require the support of health professionals, including Psychologists, with specialist knowledge and skills. These skills include among others, specialist knowledge of the risks and benefits of medication during pregnancy, the physical, emotional and psychological challenges of pregnancy and education regarding the emotional and physical needs of their infants. Specialist community perinatal mental health teams are also required to support these families outside of an inpatient setting from pregnancy planning and across the perinatal period.

Workforce Development

In order to adequately staff the development of integrated PIMH approaches into current services, in addition to the staffing of future specialist PIMH services nationally, there is a need to ensure that Psychologists, and other health professionals, working with infants, toddlers, and their families have relevant core competencies and appropriate knowledge of early childhood development and an understanding of screening and diagnostic techniques for this age group. As part of their submission to government regarding the allocation of funding in the 2016 Budget, Mental Health Reform endorsed the provision of funds to train and staff in perinatal and infant mental health services (Mental Health Reform, 2015). Furthermore, ensuring that undergraduate, graduate, and continuing professional education programmes include content on perinatal and infant mental health is crucial for the future development of this specialist area.

Providers of specialist psychological assessment require access to continuing professional development and appropriate supervision in order to meet the professional competencies required to carry out direct therapeutic work with the parent- child dyad. Psychologists are well placed to provide complex psychological assessment and intervention and consultation to other professionals.

Social Marketing

Social marketing engages the general public and lawmakers in understanding and supporting system changes, and demonstrating the relevance of service provision to them (O'Shea & Kennelly, 2008). Health promotion, prevention, early intervention and recovery are essential components of a comprehensive plan aimed at promoting PIMH. Psychologists have an important role to play in promoting awareness of perinatal and infant mental health amongst the general public, and raising awareness amongst policy makers, medical practitioners, mental health professionals and other allied health professionals regarding the importance of PIMH and related skills and strategies that promote wellbeing in families.

Evaluation and Research

A key element underpinning the understanding of PIMH and effective strategies supporting wellbeing during the perinatal period and in early infancy relates to the implementation of evidence-based practice. Evidence-based practice involves conducting empirical research regarding the prevalence rates of perinatal and infant mental health difficulties; understanding the conditions that promote mental wellness of infants and their families; determining the most effective indicators in monitoring the mental wellness of infants and primary caregivers; and clarifying effective interventions that support PIMH. Such empirical research can identify the needs of infants and their families in an Irish context and customise service delivery based on these needs. Such research also provides important information regarding the sustainability and efficacy of interventions, based on cost-benefit analyses of such interventions. National policies pertaining to perinatal and infant mental health need to be informed by empirical research carried out nationally and recognise international standards of best practice. Psychologists have an important role to play in developing an evidence base addressing these issues.

Funding and Investment

It is internationally recognised that perinatal mental health services require different resources to those of general adult mental health services. In support of this view, Mental Health Reform, as part of their submission to government regarding the allocation of funding in the 2016 Budget, endorsed the provision of funds for staffing of child and adolescent mental health services and called for a significant rise in the amount of public investment in young children and their families (Mental Health Reform, 2015).

Cross Disciplinary Approaches

In recognition of the inter-disciplinary nature of perinatal and infant mental health, a comprehensive and coordinated response to perinatal and infant mental health requires the collaboration and partnership of multiple public sectors including health and education. Such collaborative approaches ensure the provision of quality services to infants and families.

Governance

Insisting on good governance, accountability and quality in all services promotes accountability and communication regarding the provision of services to infants and their families. The publication of the National Maternity Strategy establishment of provides the opportunity to coordinate these efforts and ensure such governance is upheld.

Empowering Families

The ethos of empowering families and by extension their young children is an integral part of strategies promoting, preventing and responding to perinatal and infant mental health challenges. The strengths of parents and families need to be acknowledged and supported and services need to recognise families' right to care that is responsive to their differing needs. Empowering infants and children involves ensuring their right to the protection support and care necessary for their wellbeing.

Please see our Position Paper available at http://www.psihq.ie/page/art/337/0 for further detail.

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Pharmaceutical Society of Ireland

Like most developed countries, patients in Ireland have an escalating need for healthcare. This escalating need reflects the trend of a rapidly ageing population, expanding at approximately 3% annually, with associated increase in the burden of chronic illness. While national policy is focused on preventing illness, it is also focused on transitioning care such that there is a more effective and efficient use of acute and non-acute facilities. Medicines are the most common healthcare intervention within the health system and both the use and complexity of medicines is increasing.

Pharmacists are the healthcare professional with the widest knowledge of medicines and the potential complexities associated with the increasing use of medicines. Therefore, pharmacy as a profession has a critical role to play within the health system to ensure the rational use of medicines by maximising the benefits and minimising the potential for patient harm.

In 2015, the PSI Council commissioned an extensive research project 'Future Pharmacy Practice– Meeting Patients' Needs', which has examined how pharmacy practice in Ireland could in the future be placed to meet patients' needs in an evolved capacity. This work has been undertaken in view of a changing healthcare landscape, demands relating to population and demographics, and giving consideration to the educational and regulatory facilitators that exist to support a greater pharmacist contribution to multi-disciplinary healthcare provision.

The research was carried out with broad consultation with patients, patient advocacy groups, pharmacists (both community and hospital), other healthcare professionals, national healthcare representatives (including the Department of Health and Health Service Executive), regulatory bodies, academics, pharmacy students and other stakeholders. This was supplemented with national and international research on healthcare trends. Fundamentally, the project's focus was on patients, and how the pharmacy sector can continue to contribute in the most effective and efficient way to patient care. The report, which is due to be published in October, provides an evidential base from research within Ireland and other jurisdictions that will offer new ways of working that will, on the one hand, benefit patient care, and on the other, more fully utilise pharmacists' skills, working collaboratively with other healthcare professionals and carers.

With a young demographic, an unequalled reach in terms of patient contact and access through an infrastructure of 1,885 pharmacies, pharmacists, as experts in medicines, are a unique resource to the health system and patients to support enhanced delivery of cost effective improvements to public health and therapeutic management in a variety of settings. Such improvements include:

- Contributing to **health and wellbeing** initiatives through structured population health information, awareness campaigns and preventative medicine to support the maintenance and improvement of the health of the public;
- Providing expertise in assisting patients to manage their **chronic diseases** and medication through structured initiatives and, where appropriate, through supplementary prescribing in collaboration with a patient's GP;
- **Manage medicines throughout the patient care pathway** via structured initiatives such as medication reviews for at-risk and vulnerable patients in the community and local settings e.g. nursing homes; and the greater presence of pharmacy throughout the patient pathway in acute settings, reducing prescribing errors and optimising the impact of medicines for patients.

Central to the pharmacists' role is their contribution to obtaining optimal outcomes from medicines and providing a sustainable approach to clinical care and cost-effectiveness while reducing avoidable adverse events and waste.

The physical settings for services and care delivered by pharmacists are likely to evolve with changing healthcare delivery patterns. International experience has shown an increase in pharmacists successfully working in GP surgeries, in nursing homes and in tandem with domiciliary care.

About the PSI

The Pharmaceutical Society of Ireland (PSI) is the statutory regulator of pharmacists and pharmacies in Ireland, working to protect and promote the health, safety and wellbeing of patients and the public and to ensure compliance with the Pharmacy Act 2007 and other medicines and pharmacy legislation.

The PSI has a range of responsibilities, established in legislation, which together create a regulatory framework that ensures the safety of patients. Our functions include registration of pharmacists, pharmaceutical assistants and pharmacies, setting standards for pharmacists' education and training, and creating the standards and supports to promote good professional practice. We carry out inspections of pharmacies, and we can take action when there is a concern about a pharmacist or a pharmacy, including when we receive a complaint from a member of the public. In addition, the PSI also has a duty to take suitable action to improve the profession of pharmacy.

The PSI is an independent body and an agency of the Department of Health. It is governed by a 21-member Council appointed by the Minister for Health.

Introduction

Since its establishment under the 2007 Pharmacy Act, the PSI Council has put in place mechanisms to oversee the pharmacy profession in delivering high standards of care, professional advice, medicines dispensing and treatment provision. As the health system in Ireland continues to be reformed, policy-makers should give consideration to the role that pharmacists, with their unique expertise in medicines, could play as part of an integrated solution to patient and healthcare demands. In making this submission, we highlight how pharmacists, working with other healthcare professionals, can better contribute to a future, changed model of healthcare in Ireland.

In 2015, the PSI Council commissioned an exploratory research project to examine how pharmacy practice in Ireland can most valuably contribute to and benefit the health and wellbeing of patients and an evolving health system. The outcome of that work is a report to be published in October 2016, 'Future Pharmacy Practice –Meeting Patients' Needs'. The focus of the project is to address the envisaged role that pharmacists should be playing in the context of national health strategy, pharmacists' education, expertise and existing innovations in pharmacy practice internationally and nationally.

The project was overseen by a project Steering Group, chaired by the retired Chief Pharmaceutical Officer from Northern Ireland and included expertise of representatives from the Department of Health, Health Service Executive, academia, industry, hospital and community pharmacists, patients and health care professionals, and was undertaken in the context of the significant challenges facing

Irish healthcare. These challenges include an ageing and changing population, the changing needs of patients who require more support in their homes in the future, the significant growth in the incidence of chronic illnesses, new healthcare technologies, the development of more sophisticated and more individualised medicines, as well as the cost burden of providing a good standard of healthcare to all in the future.

As part of the research element of the project, the project team consulted widely with many people and organisations, including consultations and focus groups with pharmacists, patients and other key stakeholders. The project also involved both national and international research in order to identify current best practice around the world, including the UK, Canada, Australia, the Netherlands, New Zealand and the US.

The recommendations from the report fall into five broad categories:

- Health system reform
- Pharmacy supporting health and wellbeing
- Supporting and improving the health of patients with chronic disease
- Managing medicines through the patient pathway
- Enabling future pharmacy practice

The research and recommendations of the report provide the basis of the PSI's submission to this consultation. We have focused on some of the key findings which identify where pharmacists might play a greater part in a multi-disciplinary approach to healthcare delivery at all levels, whether in primary care or within more acute settings. Our submission also highlights barriers and enablers to change so that in examining future models of healthcare, the realities of the pharmacy landscape and priorities can be adequately assessed.

Pharmacy in Ireland

The Future Pharmacy Practice report recognises the rapid and significant growth in patient demand for healthcare in Ireland. The only affordable solution to meeting this demand is through a multi-disciplinary approach to deliver the highest quality of care, as close to a patient's home as possible.

It is useful to contextualise the current pharmacy landscape before envisaging those changes that might facilitate a better future. The pharmacy profession represents a cohort of highly skilled individuals with a high level of clinical governance and regulatory structures. As a profession, it has changed and evolved in recent years, with community pharmacies providing patient consultation rooms, supporting health information campaigns and successfully delivering public health initiatives such as vaccination programmes. In hospitals, pharmacists have successfully contributed to antimicrobial stewardship and infectious disease care and emerging advanced practice in multidisciplinary teams.

A regulatory framework has been established by the PSI, under the Pharmacy Act 2007, that facilitates and supports good professional standards, which recognises the weight of responsibility on pharmacists, and creates a system of accountability. By operating this regulatory framework in an efficient and effective manner, the PSI is also serving the broad public interest by facilitating expanded roles for pharmacists and pharmacy practice where there is patient need. The regulatory framework includes ensuring that adequate training and guidance is available for pharmacists in their delivery of new services, and that the level of their delivery is subject to review. The PSI will continue to provide this oversight as health strategy and policy evolves.

The PSI tries to anticipate developments in the pharmacy profession having regard to the healthcare needs of patients, and in the context of Government health policy and strategy. The introduction in September 2015 of the new five-year Masters in pharmacy in the three Irish universities is designed to equip new pharmacists with many of the skills required for modern practice, including greater interaction with other healthcare professionals and more hands-on learning experiences. The Irish Institute of Pharmacy (IIOP), established by the PSI to oversee pharmacist engagement with mandatory continuing professional development (CPD), also supports national health policy by providing or accrediting training that is necessary for pharmacists to provide particular services in the public interest. CPD will become an increasingly critical component in maintaining and enhancing professional standards, and will be a strong enabler of future practice pharmacy as it continues to evolve.

Key areas of healthcare and patient need that can be addressed by pharmacist contributions

The PSI's remit is focussed on the provision of care by pharmacists, ensuring that it is delivered in a competent, professional and ethical manner and in an appropriate environment, to the highest standards of quality care and best practice. With that vision, the research from the Future Pharmacy Practice report demonstrates particular areas in which pharmacists' contribution can allow for enhanced delivery of cost effective improvements to public health and therapeutic management in a variety of settings. The broad recommendations of the report are items for consideration for a new State healthcare model.

Three core strategic areas emerged as central to the evolving role of pharmacy in meeting patients' needs:

1. **Improving health and wellbeing of the public** –making every contact count. A recent survey confirmed that there are about 2 million visits by the public to the community pharmacy each month.

2. **Supporting and improving the health of at-risk patients with chronic disease** – acting as partners in care, implementing National Clinical Effectiveness initiatives, such as Asthma Care, Diabetes and Cardiovascular Care.

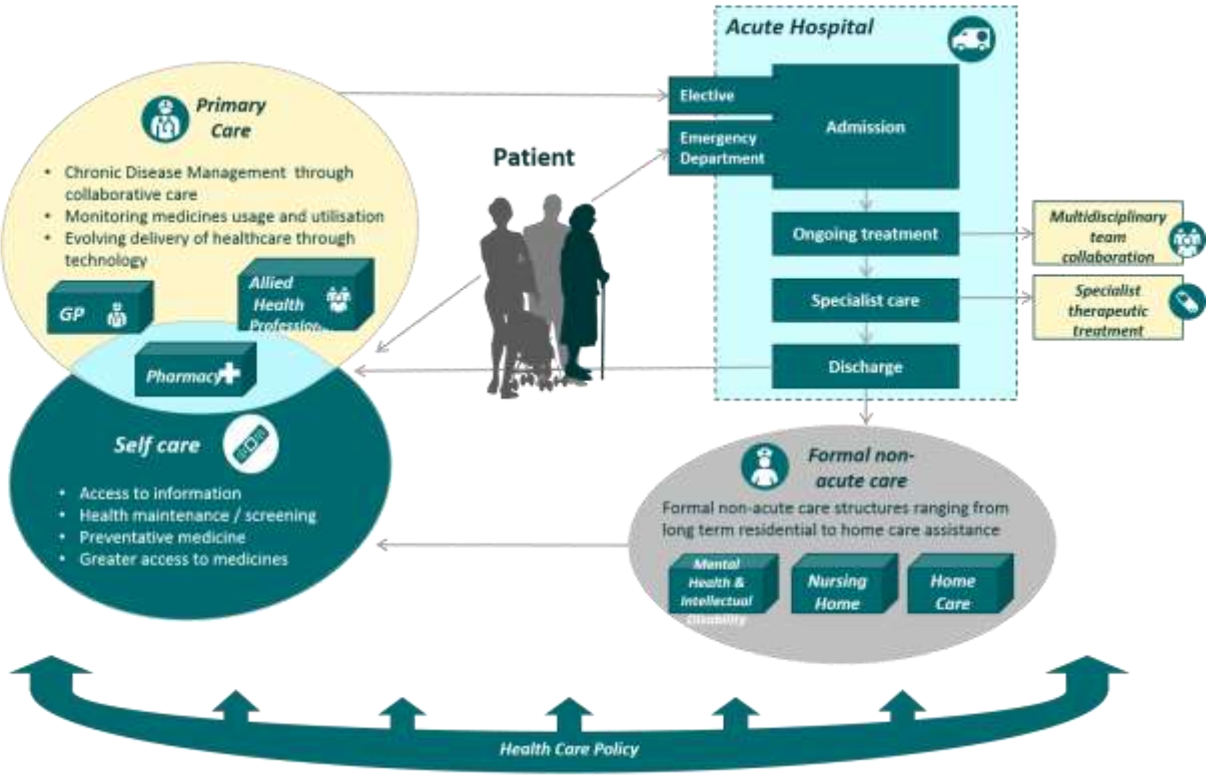
3. **Management of medicines throughout the patient pathway –** in the future patients will be managed at home or closer to home. Pharmacists as medicines managers have an important role in supporting patients in their medicine use to ensure maximum benefit and minimum risk to the patient. This needs to happen in all care settings – self-care, primary care, residential/formal care and acute hospital care.

Each of the three areas are elaborated on with recommendations below.

The Patient Care Journey

Patients and the population receive healthcare in various settings across the health system and at different stages in their lives. The patient care journey is illustrated below to demonstrate how pharmacy is well placed in each setting to address patient need. Medicines are the most common healthcare intervention within the health system and both the use and complexity of medicines is increasing.

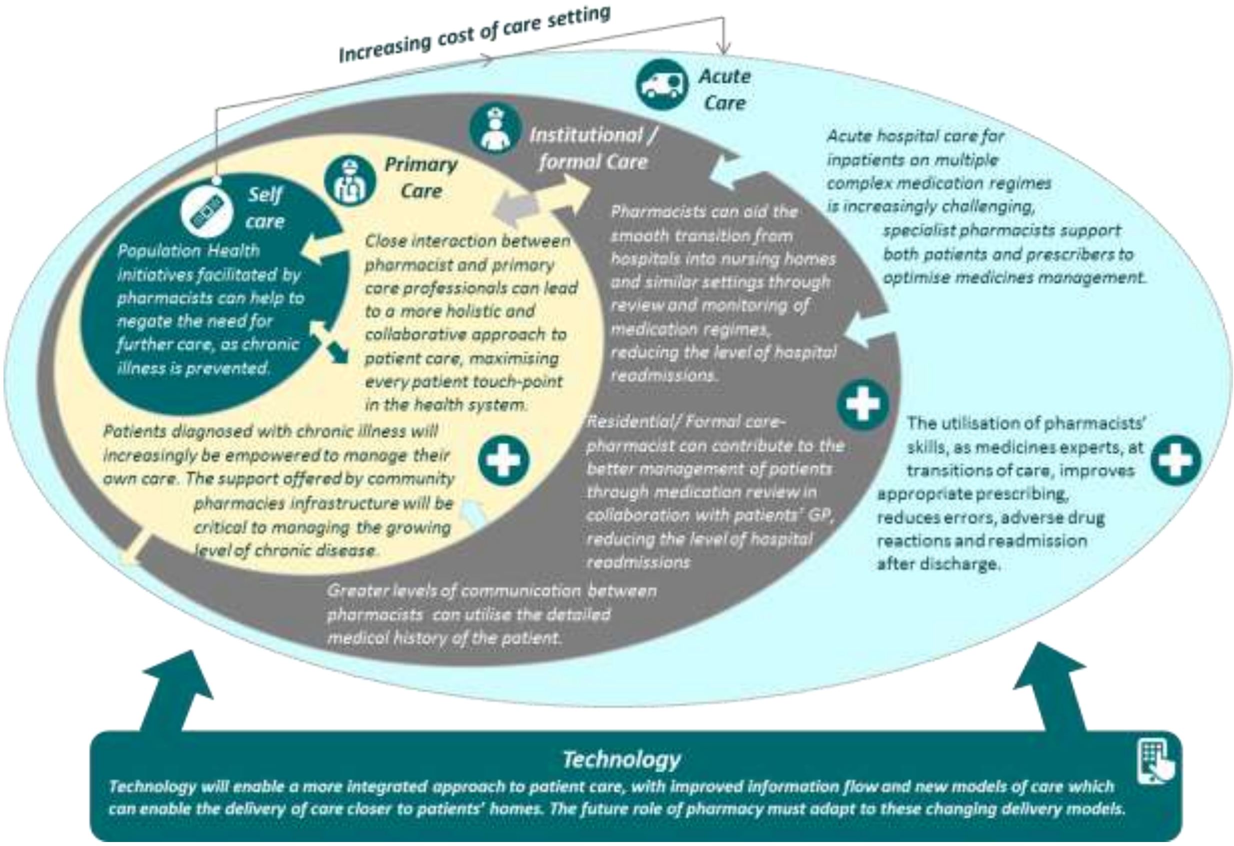
Figure 1. Outline of the patient care journey and touch points with pharmacy



Potential role of pharmacy in patient care across Irish healthcare settings

Figure 2 demonstrates the potential role of pharmacy, as a strategic part of Irish healthcare, with the skills of the profession utilised in collaboration with other healthcare professions to enhance patient care and experience, increasingly empowering patients so they can be treated as close to their own home as possible. As the health system undergoes reform, policy makers should consider the greater, or more effective, integration of pharmacists' expertise in an integrated solution to patient and health sector demands. The resource that pharmacists in hospital and community care settings can provide should be considered for the enhancement of patient care.

Figure 2. Potential role of pharmacy in patient care across Irish healthcare settings



Population Health initiatives facilitated by pharmacists can help to negate the need for further care, as chronic illness is prevented.

Close interaction between pharmacist and primary care professionals can lead to a more holistic and collaborative approach to patient care, maximising every patient touch-point in the health system.

Patients diagnosed with chronic illness will increasingly be empowered to manage their own care. The support offered by community pharmacies infrastructure will be critical to managing the growing level of chronic disease.

Pharmacists can aid the smooth transition from hospitals into nursing homes and similar settings through review and monitoring of medication regimes, reducing the level of hospital readmissions.

Residential/ Formal care- pharmacist can contribute to the better management of patients through medication review in collaboration with patients' GP, reducing the level of hospital readmissions

Greater levels of communication between pharmacists can utilise the detailed medical history of the patient.

Acute hospital care for inpatients on multiple complex medication regimes is increasingly challenging, specialist pharmacists support both patients and prescribers to optimise medicines management.

The utilisation of pharmacists' skills, as medicines experts, at transitions of care, improves appropriate prescribing, reduces errors, adverse drug reactions and readmission after discharge.

Technology will enable a more integrated approach to patient care, with improved information flow and new models of care which can enable the delivery of care closer to patients' homes. The future role of pharmacy must adapt to these changing delivery models.

Click on **ctrl** Future of Pharmacy Practice Project

1. *Improving health and wellbeing*

Elaborating on that patient journey, statistics (figure 3) from the HSE indicate the extent of patient contacts throughout the health service in one year. This includes the dispensing of 20 million prescriptions demonstrating a significant contact point between the public and pharmacists. In a public survey conducted by the PSI in March 2016, 58% of 1000 respondents said they visit a pharmacy at least once a month or more frequently, and 89% were found to support expanded health services and promotion from community pharmacies.

Promoting and supporting wellness as well as assisting those with ill health is a recognised public health initiative as we increasingly battle rising levels of chronic conditions. Preventative healthcare has the potential for enhancement through promotion of self-care and health behaviour change by pharmacists, given the already high level of contact between patients and pharmacists. *Healthy Ireland* recognises that a partnership, cross-sectoral approach is required to have an impact on the many health determinants and inequalities, and to enable people to look after their own health. Figure 4 demonstrates the role that pharmacists could play in supporting the health and wellbeing of the population.

From the health system perspective, it makes sense that pharmacists be included in training and developments on health and wellbeing interventions, and as a potential provider of suitable national screening services.

4.59m
People live in Ireland

1.8m
People have a medical card

68,000
Babies are born

3m
People have a consultation with a clinician

10.3m
Home help hours delivered

20m
Prescriptions filled

1.43m
People receive either inpatient or day case treatment

1.3m
Dental visits

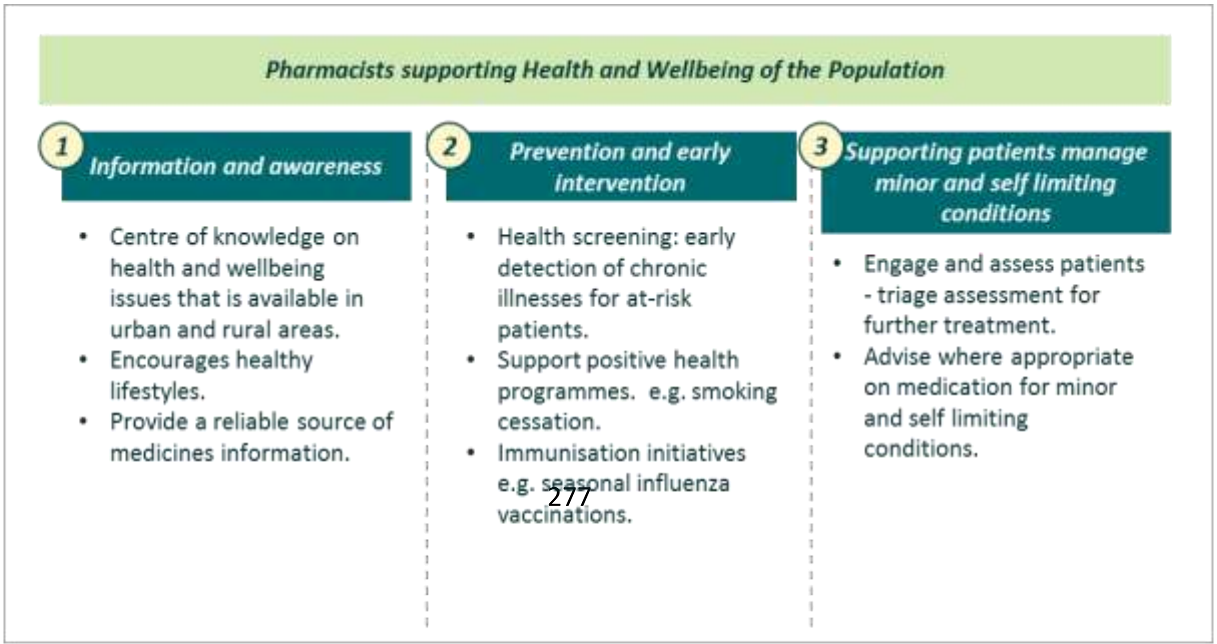
1.2m
Patients seen in an Emergency Department

5m
Public Health Nursing contacts

290,000
Emergency calls receive by national Ambulance Service

Figure 3. Average number of health service contacts in a year (HSE)

Figure 4. Overview of pharmacy role supporting health and wellbeing of the population



Pharmacists supporting Health and Wellbeing of the Population

1 Information and awareness

- Centre of knowledge on health and wellbeing issues that is available in urban and rural areas.
- Encourages healthy lifestyles.
- Provide a reliable source of medicines information.

2 Prevention and early intervention

- Health screening: early detection of chronic illnesses for at-risk patients.
- Support positive health programmes. e.g. smoking cessation.
- Immunisation initiatives e.g. seasonal influenza vaccinations.

3 Supporting patients manage minor and self limiting conditions

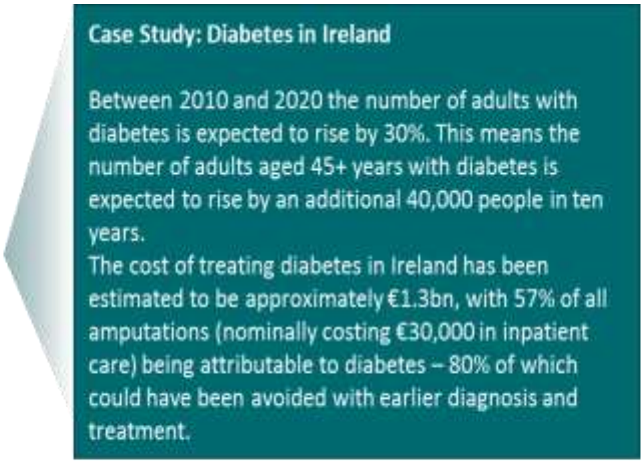
- Engage and assess patients - triage assessment for further treatment.
- Advise where appropriate on medication for minor and self limiting conditions.

Supporting and improving the health of at-risk patients with chronic disease

Our research also confirmed the rising levels of chronic disease expected in the future (figure 5). Considering the frequency of attendance by patients with chronic diseases, community pharmacists should be considered well placed to support patients living with chronic conditions, in improving the ongoing management of a condition and in order to remove repetitious visits to GPs or hospital clinics, where these might not always be necessary. There is scope for pharmacists to be integrated into a system of structured patient education and adherence in the monitoring of a condition. Collaborative working with a GP in many of these cases should be explored. This could include supplementary prescribing by pharmacists in line with agreed protocols. Figure 6 demonstrates the role that pharmacists could play in supporting patients in the prevention and management of chronic disease conditions.

Figure 5. Chronic disease statistics in Ireland

Chronic Disease	Population	Estimated Cost	Annual Growth
Coronary Heart Disease	182,000	€2.3 billion	3.75%
COPD	110,000	€0.4 billion	2.3%
Diabetes	225,000	€1.3 billion	3%
Asthma	450,000	€0.5 billion	N/A
Cancer	129,000	€1.5 billion	6.5%

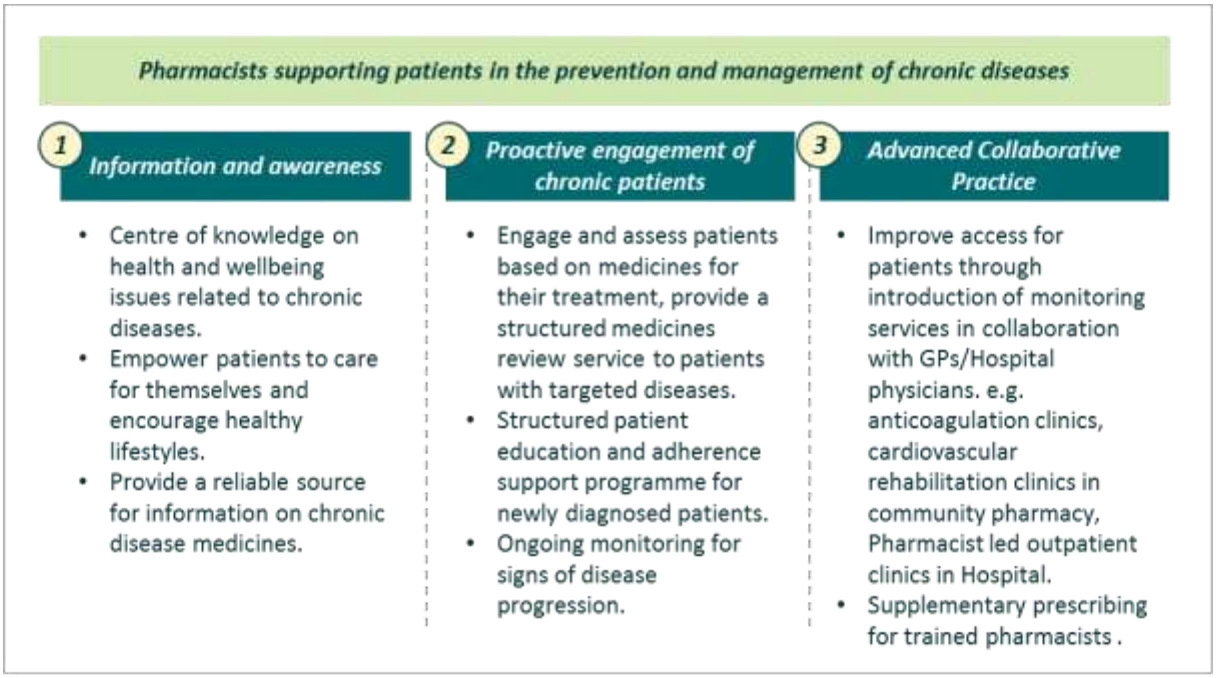


Case Study: Diabetes in Ireland

Between 2010 and 2020 the number of adults with diabetes is expected to rise by 30%. This means the number of adults aged 45+ years with diabetes is expected to rise by an additional 40,000 people in ten years.

The cost of treating diabetes in Ireland has been estimated to be approximately €1.3bn, with 57% of all amputations (nominally costing €30,000 in inpatient care) being attributable to diabetes – 80% of which could have been avoided with earlier diagnosis and treatment.

Figure 6. Overview of the role of pharmacy in chronic disease prevention and management



Pharmacists supporting patients in the prevention and management of chronic diseases

1 Information and awareness

- Centre of knowledge on health and wellbeing issues related to chronic diseases.
- Empower patients to care for themselves and encourage healthy lifestyles.
- Provide a reliable source for information on chronic disease medicines.

2 Proactive engagement of chronic patients

- Engage and assess patients based on medicines for their treatment, provide a structured medicines review service to patients with targeted diseases.
- Structured patient education and adherence support programme for newly diagnosed patients.
- Ongoing monitoring for signs of disease progression.

3 Advanced Collaborative Practice

- Improve access for patients through introduction of monitoring services in collaboration with GPs/Hospital physicians. e.g. anticoagulation clinics, cardiovascular rehabilitation clinics in community pharmacy, Pharmacist led outpatient clinics in Hospital.
- Supplementary prescribing for trained pharmacists .

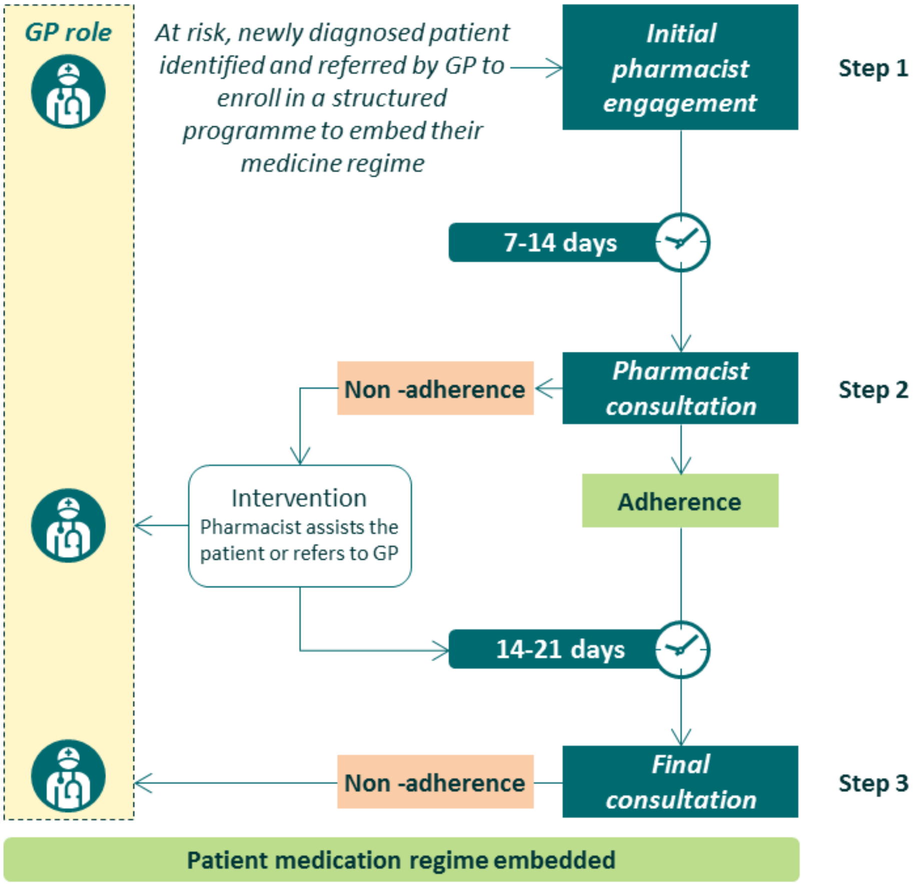
International and national research produced case studies that can be relied upon to demonstrate the value to patients and the health system where pharmacists can contribute to the better management of chronic disease patients in the community.

Case Study 1: UK New Medicine Service

Newly diagnosed patients with a chronic disease received structured support by a pharmacist to increase adherence and optimise therapy

Chronic illness patients in England who are initiated on medication can avail of a structured patient education and adherence programme called the New Medicines Service. This service involves three consultations with the patient where the pharmacist answers any questions regarding their medicines along with other educational aspects such as lifestyle choices. The purpose of this service is to reduce the levels of non-adherence, which, for conditions such as diabetes, can be as high as 78%. Research indicates that this service in England increased adherence in patients by 10% with long-term analysis showing positive patient outcomes for the NHS, with a cost-effectiveness of £20,000 per QALY (quality-adjusted life-year). The openness and collaboration in these services regarding the patient and their pharmacist also fosters an improved relationship between the parties, promotes medication safety, partnership in their healthcare, and gives the patient confidence in the self-management of their condition.

Figure 7. Outline of the process for structured introduction to medicine



Case Study 2: Collaborative Drug Therapy Management (CDTM) for chronic disease patients in Arizona

El Rio, a health centre in Arizona, serves a large Hispanic and Native American patient population, many with diabetes. In 2011, they saw 76,190 patients, over 56% from public healthcare (Medicaid and Medicare), 13% had private insurance and 28% were uninsured patients. In 2012, approximately 800 patients received Collaborative Drug Therapy Management (CDTM) services, mostly for diabetes. The CDTM protocols also cover hypertension, hyperlipidaemia, asthma, and other conditions. Collaborative Practice Agreements (CPAs) authorize pharmacists to assess patients, review medication regimens, adjust medications in approved drug classes, and perform specified examinations (e.g. foot examinations) as well as patient drug reviews for medications that require monitoring, such as anticoagulation therapy. The service is reimbursable by public healthcare and private insurers.

Management of medicines throughout the patient pathway

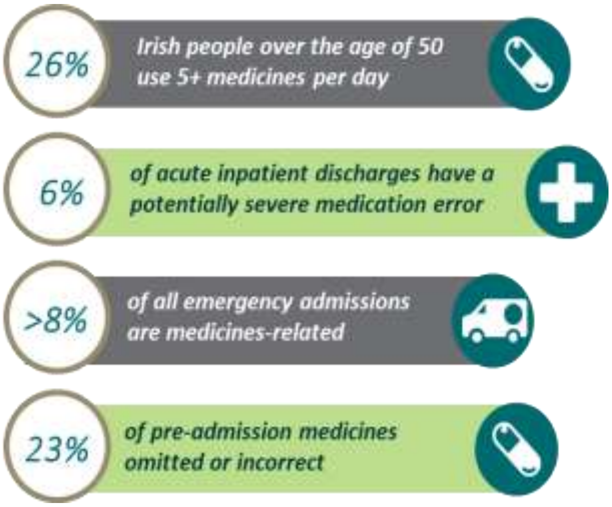


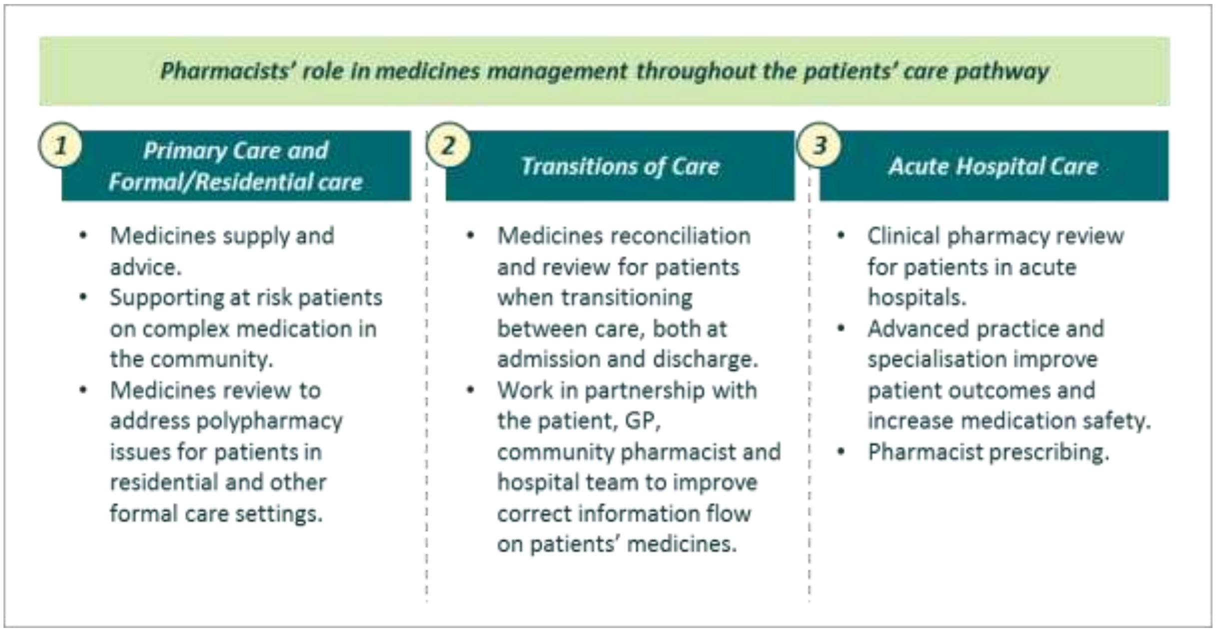
Figure 7. Medication related risks

Pharmacists are the healthcare professional with the widest knowledge of medicines and the potential complexities associated with the increasing use of medicines. Therefore, pharmacy as a profession has a critical role to play within the health system to ensure the rational use of medicines by maximising the benefits and minimising the potential for patient harm. Figure 7 shows the extent of medicines use and adverse effects or error.

Our research has found that polypharmacy (the use of five or more medicines daily) has increased in recent years, particularly for older people. The prescription error rate, especially for hospital discharge prescriptions is high, and can continue unchecked post discharge often due to communication issues.

More than 8% of all emergency admissions to Irish hospitals are medicines related. At least 23% of pre-admission medicines are omitted or incorrect for patients in our hospitals. We also found a continued variation in clinical pharmacy staffing levels and services provided for pharmacist review of prescriptions for hospital patients. Figure 8 demonstrates the role that pharmacists could play in supporting the management of patients' medicines throughout the care pathway.

Figure 8. Overview of the role of pharmacy in medicines management for patients



Pharmacists' role in medicines management throughout the patients' care pathway

1 *Primary Care and Formal/Residential care*

- Medicines supply and advice.
- Supporting at risk patients on complex medication in the community.
- Medicines review to address polypharmacy issues for patients in residential and other formal care settings.

2 *Transitions of Care*

- Medicines reconciliation and review for patients when transitioning between care, both at admission and discharge.
- Work in partnership with the patient, GP, community pharmacist and hospital team to improve correct information flow on patients' medicines.

3 *Acute Hospital Care*

- Clinical pharmacy review for patients in acute hospitals.
- Advanced practice and specialisation improve patient outcomes and increase medication safety.
- Pharmacist prescribing.

In the UK, clinical pharmacy services improve the quality of care for patients, particularly allied to the safe and effective use of medicines. It also attains significant cost savings for the health system. International research showed that a core set of clinical pharmacy services is associated with favourable outcomes such as decreased mortality rates, reduced length of stay, and avoidance of adverse events for the patient. Structured pharmacist interventions were found to improve both the appropriateness and accuracy of medication regimes and the prevention of adverse drug reactions of older hospitalised in-patients. Many of the medication related admissions to hospital have been shown to be avoidable. One study in Cork found that 8.8% of all admissions to an Irish hospital were medication related, with over half of these being avoidable. The cost associated with these admissions are also considerable, with average costs of over €6,000 for one potentially preventable, medication-related hospital admission.

The below two case studies demonstrate the effective implementation of a clinical pharmacist in review of patients' medication regime, resulting in increased effectiveness and safety and cost savings.

Case Study 3: Northern Ireland Integrated Medicines Management Programme

In Northern Ireland, the Integrated Medicines Management Programme introduced in 2000 has demonstrated the use of comprehensive pharmacy teams involved at admission, inpatient stay and discharge, incorporating communication at intersector transitions at admission and discharge where most medicines–related problems occur. This medicines optimisation programme resulted in reduced length of stay for patients by 2 days, decreased re-admission rates post discharge, has had a positive impact on risk adjusted mortality index, improved communication across transitions of care and a return on investment of £5 to £8 for every £1 invested.

Case Study 4: Collaborative Pharmaceutical Care in Tallaght Hospital (PACT)

Traditionally, clinical pharmacists are ward-based, contributing to medication history taking and prescription review, but not involved at discharge. The innovative PACT intervention involved clinical pharmacists being team-based, leading admission and discharge medication reconciliation and undertaking prescription review.

The PACT intervention allowed for the clinical pharmacist, in consultation with the medical team to make major and minor changes to the patient's drug chart or patient's discharge medication list. These activities are consistent with the notion of collaborative prescribing. There is evidence that collaborative prescribing reduces the prevalence of medication error and unintentional discrepancies in emergency department and perioperative settings. This is consistent with the study finding that PACT patients experience more clinical pharmacist recommendations that are accepted more frequently and earlier in the hospital episode than standard care.

The initiative was found to protect against severe medication errors in acute medical patients and improved prescribing quality in older patients. Cost effectiveness research work is currently being undertaken for the PACT model of care.

Funding: Potential Cost Reduction Opportunities

Part of the Future Pharmacy Practice project was to analyse the potential cost reduction opportunities associated with the introduction or expansion of pharmacists' clinical activities. The project was to review three potential new services available in other jurisdictions. The analysis was to assess the benefit to the patient and the wider health service. The Project Steering Group agreed three case studies for analysis:

1. Medicines Management in a Hospital Setting – Clinical Pharmacy Services
2. Medicines Optimisation Services – Newly Diagnosed Asthma patients, with structured support to optimise therapy
3. Medicines Optimisation by a pharmacist in a nursing home setting, in collaboration with the nursing staff, patient and the patient's GP.

A summary of the services and benefits are outlined below:

	Summary of service	*Benefit to patient*	*National cost impact*
1. Medicines Management in a Hospital Setting- Clinical Pharmacy Services	Clinical Pharmacy Services extended to all hospitals in Ireland, to include 1) Clinical pharmacist intervention at the point of admission; 2) pharmacist-led patients chart review; 3) pharmacist reviews conducted at the request of another health professional.	Improved patient outcomes through the reduction in adverse drug events and deterioration of their illness due to omission of medicines.	• Net cost avoidance associated with potential additional treatment as a result of adverse drug events of €19.7m in smaller Irish hospitals, creating a nationwide cost avoidance of €40.1m in all Irish hospitals • Potential additional reduced cost due to a reduction in the volume and value of drugs prescribed and the use of therapeutic substitutes, preferred formulations and biosimilars.
2. Medicines Optimisation Services- Newly Diagnosed Asthma patients, with structured support to optimise therapy	A structured introduction to medicine regimes for chronic illnesses via three structured consultations with the pharmacist in the first three weeks of the regime. Non-adherence is intervened through a collaborative approach between the pharmacist, the GP and other healthcare professionals.	An increase in the probability of adherence to the medication regime and thus better disease control.	• A cost reduction of €1,466 over the lifetime of each patient. • Nationwide implementation over a five year period would achieve a net cost reduction of €2.3m
3. Medicines Optimisation by a pharmacist in a nursing home setting, in collaboration with the nursing staff, patient and the patient's GP.	An annual multidisciplinary structured medicines review for older residents of Long Term Residential Care who are prescribed 5 medicines or more to identify and reduce inappropriate prescribing and limit associated potential Adverse Drug Events.	Improved health outcomes in terms of a reduced likelihood of adverse drug events and associated hospitalisation.	A potential reduction in cost associated with hospitalisations resulting from inappropriate polypharmacy of €2.74m per year.

Challenges and enablers to support the recommendations

Challenges and enablers to change have been identified in the PSI Future Pharmacy Practice report. These are particularly relevant to the future models of healthcare currently under examination by the Committee, along with awareness of legislative barriers that require addressing if some of these proposals, for example pharmacist prescribing, were to be considered.

Facilitating and encouraging **integrated and collaborative care** requires commencement of shared **education and learning** opportunities amongst trainee health care professionals from undergraduate years through to practice, and consultation and communication with all relevant parties, including through the integrated clinical care programmes. Collaborative working of health and social care professionals is vital so that service users benefit from unified but individual skills and expertise.

Pharmacy resourcing both in hospitals and community pharmacies, and reimbursement for service, are substantial enablers to the advancement of clinical pharmacy activities. Due consideration to effective deployment of the pharmacy workforce and adequate resourcing of a new model of healthcare will prove beneficial in the longer term.

Leadership is critical at all levels of care provision to optimise pharmacists' inclusion in a multidisciplinary model of healthcare. At a time of proposed developments in the health service, the role of Chief Pharmacist in the Department of Health would provide suitably positioned leadership, legislative, policy and strategic guidance at national level to guide healthcare workforce planning alongside counterparts in medicine and nursing. The Chief Pharmacist role has ensured that the requisite medicines and pharmacist expertise is available to support government, and that structures are in place to oversee legislative and policy development for the safeguarding of access to and use of medicines, medical devices and pharmacy services.

Greater consideration is being given to the role of **technology** in modern care settings. Technology should be used to enable shared patient care and information, realise work efficiencies and facilitate safe transitions of care. Digital solutions that will allow greater cohesion amongst all those providing health supports is a vital resource for effective collaborative care. To fully implement and support medicines management throughout the patient pathway, electronic patient medication records need to be accessible to all healthcare providers. This would help to resolve current communication failings at the point of transitioning care. The development of national IT systems should explore how best to incorporate the pharmacist input and retrieval of data.

Advancing practice and the implementation of certain technologies, may warrant the examination of current **legislation** and payment structures, which may not allow for, facilitate or encourage the immediate delivery of a changed care model. Current payment systems and structures of access may need to be examined to ensure that tax payers/exchequer money is being spent most effectively. The Future Pharmacy Practice report will outline particular cost benefits of pharmacist provision or contribution to patient care should they form part of interventions at an earlier stage in the community and at the point of transitioning care.

A robust **regulatory system** is essential for the continued development and advancement of the profession, including pharmacist prescribing. As pharmacists take on increased patient care activities, they must also take on the increased responsibility and accountability that comes with these enhanced roles. As the professional regulator, the PSI, has a responsibility to ensure that registered pharmacists are fulfilling their professional obligations in respect of the services they provide and holding them accountable for doing so.

In addition, in the roll out of any pharmacy service identified, good **governance** of the service is considered essential to ensure the service operates in the manner intended. The design and management of the service should be underpinned by principles of quality and risk management and incorporate a system of audit and review in order to ensure that the delivery of the desired patient outcomes are achieved.

Conclusion

Patient demand for healthcare in Ireland is growing at a rapid rate in terms of volume, cost and complexity. The only affordable solution to meeting this demand is through a multi-disciplinary approach to healthcare to deliver the highest quality of care, as close to the patient's home as possible. Pharmacists are one of the key healthcare professionals to support patients in optimising their medicines, and in so doing, their health.

Central to the pharmacists' role is their contribution to obtaining optimal outcomes from medicines and providing a sustainable approach to clinical care and cost-effectiveness while reducing avoidable adverse events and waste.

This submission demonstrates where the pharmacy profession, within the context of Government strategy, could add more value and highlights that healthcare reform should provide for multidisciplinary team working and a more integrated approach to managing the care of patients and the public in Ireland.

The recommendations outlined as to where pharmacists might contribute to health system and patient need are presented so as to provide realistic and workable examples of how pharmacists' skills and expertise might be used differently or more effectively within an integrated and regulated structure. The Future Pharmacy Practice Report contains significant research and evidence as to what patients want from a health service and how pharmacists, due to their accessibility and expert knowledge can meet patient needs and play a vital role as part of any future model of health care in Ireland. We will be happy to share the full evidence-based report with the Committee.

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Pre – Hospital Emergency Care Council

The Pre-Hospital Emergency Care Council (PHECC) was established in 2000 by the Minister for Health and Children by Statutory Instrument Number 109 (PHECC Establishment Order). PHECC's responsibilities were extended by Statutory Instrument Number 575 of 2004 (PHECC Amendment Order), The Health (Miscellaneous Provisions) Act 2007, Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2014 Statutory Instrument Number 300 of 2014 and Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2015 Statutory Instrument Number 449 of 2015. Statutory functions include education and training, examinations and registration, research, development of Clinical Practice Guidelines, fitness to practice and other tasks and functions as directed by the Minister.

Since its establishment, PHECC has championed change and guided the improvements in the standard of services afforded to patients and the quality of clinical care. It is committed to developing a 'common currency' for patient care in Ireland (PHECC's Strategic Plan 2015-2017). In recent years internationally however, the definition of prehospital emergency care has evolved, with this area of care experiencing explosive growth and demand worldwide.

Currently, internationally, there is a global movement towards change and increase in capacity and scope of Paramedicine and we are beginning to see development in this area within several healthcare systems. As the Irish health service goes through the most fundamental reform in the history of the State, best practice internationally predicts major modifications to our prehospital emergency care services and their very definition. The role of paramedicine in the health system overall is being well recognised for their contribution in the areas of primary care delivery, where community care services are struggling to cope with the needs of older patients with long-term care requirements. The international trend utilises Paramedics to address gaps in service delivery at community level. Paramedics are recognised as equal providers of healthcare well beyond the traditional emergency response and transportation roles.

1. Incorporating paramedicine as a resource within the health system as it addresses the needs of the patient in the community.
2. Exploring options for developing an expanded scope of practice for prehospital practitioners in Ireland.
3. Facilitating collaboration of the prehospital practitioners into multidisciplinary teams.
4. Developing information systems which support the integration of prehospital patient data with tertiary and primary care data – paper and electronic.
5. Exploration of opportunities in the area of non-emergency transport.
6. Integration of Community First Responder groups into the existing networks, supported by Auxiliary and voluntary organisations particularly in in the rural context.
7. Supporting and developing research in the field of Paramedicine.
8. Practitioners exit the educational process having competencies to practice autonomously with other healthcare professionals.

Overview of Paramedicine

As the world's population grows and ages so too does the prevalence of chronic diseases and risk factors such as increasing frailty and obesity. These changing demographics present major significant challenges for our health services as we now know them.

Internationally paramedics are increasingly accepted as healthcare practitioners who can make significant contributions toward improving the health and well-being of populations beyond traditional emergency response and transportation roles[119]. As a result, in many instances the prehospital emergency care sector is taking on a greater workload and seeks to fill some of the gaps emerging.

The UK association of Chief Ambulance Officers (2011) maintain that one in ten 999 patients are at risk of dying; three factors improve their chances of survival:

1. a fast response;
2. high quality care from highly skilled ambulance clinicians; and
3. being taken to a hospital that is appropriately skilled and equipped to deal with their emergency [1].

Examining this 2011 UK statement within the Irish context:

The Irish healthcare system, like most others, is struggling with balancing the realities of an ever increasing demand for services especially when viewed in the context of rural versus urban service delivery. The trend internationally is on the integration of existing resources as being of paramount importance in achieving faster appropriate response in the community.

Best practice supports the concept of placing a highly educated and clinically effective Advanced Paramedic or Paramedic practitioner on-scene at a clinical event where they can deliver medications or carry out life-saving procedures in a timely manner. Within the Irish context PHECC's vision is that Practitioner may deliver care as part of a multidisciplinary healthcare team in a primary care setting responding to the 'acute' event which occurs and requires unplanned access to their broad range of skills such as intravenous placement, 12 lead ECG and medication administration.

In the best interest of the patient, placing the right patient in the right facility where they can access the right level of care is of paramount importance. In line with this concept we have supported the development of procedures to assist prehospital practitioners to bypass the ED if appropriate for Major trauma, Stroke and Acute Coronary Syndromes (STEMI). These systems are currently in place in Ireland and they are saving lives and increasing patient survival rates and reducing mortality rates associated with these situations every-day in this country. The recent helicopter based aero-medical initiative has led to patients being rapidly delivered to the appropriate facility by Prehospital Practitioners working within that critical care context. PHECC has also supported the implementation of Protocol 37 which helps hospitals access immediate transport services for the sickest patients in our system.

Paramedicine is changing: Community Paramedicine

The growing pressure on the health system and a significant shortage of health professionals has required consideration of alternative models of healthcare delivery. Over the past 20 years, a fundamental shift has occurred in healthcare delivery worldwide, largely due to advances in science and technology. This shift has been paralled by increasing recognition that healthcare is no longer the primary preserve of doctors and nurses. Rather, healthcare delivery is a team effort with optimal results being harnessed with a multidisciplinary approach to care delivery and paramedics are well positioned to be part of a multidisciplinary team approach to primary care and contribute to the advancement of patient access to care in Ireland.

Internationally, the approaches for dealing with increased service demand have varied. However, paramedics are increasingly recognised as healthcare providers who can make significant contributions toward improving the health and well-being of populations beyond traditional emergency response and transportation roles. As a result, internationally, in many instances the prehospital emergency care sector is filling some of the gaps emerging.

Within the Irish healthcare system, like their peers internationally, paramedics have the potential to have a real impact on patient outcome, value for money and fiscal efficiencies whilst addressing many of the difficulties that are inherent in the healthcare system as we now know it. Prehospital practitioners are fully regulated professionals who are skilled and competent in many important advanced medical techniques which have traditionally resided within other medical professional grades. Recent international trends indicate the importance of exploring opportunities to expand the scope of practice of Paramedicine in Ireland.

UK Case study - Community Paramedics in North East Ambulance Service NHS Trust[1]

The Community Paramedics of the North East Ambulance Service NHS Trust have modernised health care in the rural localities of Northumberland with a more dynamic and proactive service than the traditional blue-light service which existed previously. As well as responding to 999 calls, they also work closely with other healthcare professionals, such as GPs and nurses, to avoid unnecessary admissions to hospital when appropriate. The difference comes from their increased involvement in primary health care and not just emergency patient management. This includes assisting the primary care team to keep patients in their own home. If GPs are busy, a Community Paramedic is dispatched, where appropriate, to assess the patient, report back to the GP and initiate appropriate treatment. Since community paramedics started working in 2006, there has been a drop of nearly half of all patients from some of the most rural localities in north Northumberland being transferred to the local district general hospital because they are being seen and treated quicker in their communities. An audit of health services in north Northumberland showed that of 36 patients attending the Wooler Health Centre, only four required further treatment at their district general hospital which is over two hours drive away. The rest were treated and discharged. Prior to the introduction of the Community Paramedics most, if not all, would have travelled to hospital, leaving the rural areas without Paramedic ambulance cover.

Emergence of 'Specialist Paramedics' (UK) [1]

These staff have training in a number of additional clinical techniques and a wider range of clinical practice related to primary care. For example they can clean and close wounds e.g. with steristrips, tissue adhesive or sutures, can diagnose more conditions and have access to a range of drugs appropriate to their role using Patient Group Directives (PGDs). In future the extension of independent prescribing to paramedics could enhance their effectiveness to patients and the health care system.

Potential for the Future

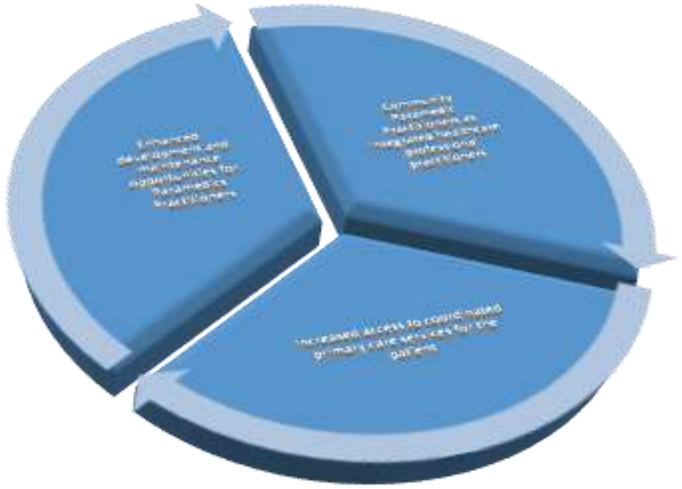
Based on international best practice and evidence from research the four themes outlined below represent a ‘no limit, balcony view’ of the potential for deployment of Paramedics in the community serving the needs of the patient as part of a multidisciplinary team.

	Emergency Care	Urgent Care	Monitoring & Maintenance	Patient Services (supporting existing systems)
Key Themes	Managing of Primary Care callouts in the community.	Managing on-going care in the community with high risk groups.	Reducing in-hospital/ clinic attendance.	Support the delivery of regular medical services in the community.
What is possible in a new system	Integration with the Primary care team & delivery of high level assessment, treatment and initial stabilisation of patients requiring emergency care in the community.	Management of patient groups that have the potential to draw upon significant resources. i.e. patient groups with a high potential to utilise emergency or hospital based services if not treated in the community.	Monitoring & Maintenance of medical conditions in the community that require ongoing observations with high clinical assessment availability and access to a suite of medications plus clinical ability to provide emergency treatment if required and initiate the escalation to in-hospital services.	Performance of routine technical medical tasks that support the wider health system. e.g. -post-discharge visits -administering vaccinations

Community Paramedic Practitioners as integrated healthcare professional practitioners

Significant benefits and value could be attained by delivering care within the community and subsequent direction of patients to the appropriate services for follow up or reducing the rate of readmission by performing follow up services in the community post-discharge.

Increased access to coordinated primary care services for the patient



Increasing access not only serves the health system agenda but also improves patient outcomes and should create a positive experience of the system by delivering early and timely care to the patient and reducing waiting times to access care.

Expanded care models have been introduced to provide better health service, help fill deficits in health provision and provide new career pathways for paramedics and other allied health workers.

Australian Centre for Prehospital Research, (2006) ***expanded paramedic healthcare roles for Queensland****. University of Queensland* [2]

Enhanced development and maintenance opportunities for Community Paramedic Practitioners

Development of Community Paramedicine promote multidisciplinary model of care delivery and ensure high quality assessment and treatment in the community.

Healthcare system change and improvement can be achieved through driving the integration of the current capacities within the healthcare system and connecting existing practitioners in a new national model of community care that promotes the multidisciplinary delivery of healthcare in the community. Internationally there is a shift occurring and Paramedicine is becoming an important discipline within the global healthcare system.

Case study - International Context - Future vision for UK Ambulance Service [7]

The Inaugural Larry lecture took place in London in July 2016. It was addressed by Professor Douglas Chamberlain who 30 years ago set up the first Paramedic unit in the UK. Professor Chamberlin delivered his vision of the future and made the following recommendations on the future of Prehospital care in the UK.

- A single service with regional autonomy for population areas of 1-2 million.
- Use of private services for non-emergency transport (Not to be used for emergency calls).
- Better communication system.
- Closer relations with the fire service moving towards full integration.
- Better co-operation with international Ambulance bodies to exchange information and learn from each other.
- Full community involvement to include first responder alert in 30 seconds of an ambulance call.
- Effective CPR via telephone instruction to achieve first compression within 2 minutes of a cardiac arrest.

Critical Care Paramedicine

Internationally Critical Care Paramedics (CCPs) now represent the highest level of prehospital and inter-hospital care available in Australia and New Zealand (Intensive Care Paramedics – ICPs), South Africa (Critical Care Assistant – CCAs), Canada (Critical Care Paramedics – CCPs), the USA and UK. These specialist paramedics operate with the goal of initiating and maintaining tertiary-level emergency and ICU level care for patients with the greatest clinical need, while facilitating their transport by air, land, and sea to the most appropriate medical facility [6].

Broadly defined, there appear to be two distinct roles for Critical Care Paramedics:

1. The Critical Care Paramedic working as an autonomous practitioner, providing scope-of-practice above the level of a non-CCP paramedic in the prehospital environment (prehospital critical care)

2. The Critical Care Paramedic working as part of a multi-disciplinary prehospital/critical care transport team, alongside other medical / nursing / allied health professionals, to provide care for patients who are unstable during either air or ground transportation (retrieval paramedic)

This International development deserves further exploration in an Irish context.

Integration and coordinated care models:

Integration
The focus is moving from vertical integration of care (linking primary, secondary and tertiary care) to placing more emphasis on horizontal integration**.** This involves moving away from a model where the GP acts as the sole gatekeeper to a model where inter-professional multi-disciplinary teams are the gatekeepers to specialist services and integration between the care sectors (social and health). Evidence of this integration is prevalent in Torbay Care Trust in England, who are perceived as the integration pioneers in the NHS. They illustrate positive examples where the prehospital workforce work jointly with local hospitals to improve the quality of care and overall service delivery.

Integrating care and encouraging partnerships and collaboration between personnel, sectors and systems.
Many territories are focusing on integration between prehospital emergency care, acute care, primary care and community care. This approach is delivering improved patient outcomes and care closer to home for patients. It is also encouraging better coordination of patient care pathways and improving dialogue between sectors and key players (frontline professionals, the governments and healthcare providers).

Investment in initiatives to reduce hospital readmissions.
There has been a drive at both local and national level in many countries to reduce the average length of stay and the readmission rates in the acute sector. A number of initiatives in Australia are underway to reduce patients' reliance on emergency departments as their first point of access and to avoid unnecessary admission.

This involves more interoperability between emergency teams. For example 'hospital at home care' is supported by paramedics operating in expanded roles, providing care to non-acute conditions under supervision from emergency doctors. The collaborative team approach is strengthening the workforce, optimising capabilities and leading to improved patient outcomes. Another prime example is the 'Human

Service Referral Program' in Arizona where the use of a computer based system allows the despatch centre to automatically relay information and refer the patient to a community-based partner agency for non-emergency cases.

Education

A key hallmark of Professionalisation in the medical sector has been the successful transition from vocational to tertiary level education and the embedding of it in the third level educational system. The importance in shifting paramedicine from its vocational origins to the tertiary level education environment has been echoed internationally. This transition is becoming apparent worldwide, with Australia leading paramedicine in this domain (with >10 universities in Australia offering degree courses) and post-employment training being slowly phased out in most states.

International trends, and an analysis of the existing situation in Ireland, suggest many challenges to prepare paramedics for their evolving role in the Irish health system. The emerging consensus is that these practitioners will be autonomous professionals at the point of registration and well placed to effectively deliver a patient centric, out-of-hospital health service.

Community First Responder:

Nationally many types of community first responder programmes have been established in Ireland:

Linked community first responder whereby on receipt of a 999 or 112 call in ambulance headquarters a rostered volunteer community first responder is dispatched. The responder is dispatched to life threatening emergencies such as: cardiac arrest, adult chest pain choking and stroke.
Public access defibrillation scheme whereby communities have purchased defibrillators and placed in an accessible location in the community. Trained or untrained people can use them.
Others such as GP programmes, off-duty national ambulance service personnel who volunteer to be first responders, fire service and Gardaí in some areas.

Currently the role of the community first responder in delivering appropriate care to the patient in a timely manner is undergoing change. In the best interest of a successful outcome for the patient it is well recognised that the responder needs to be dispatched in a timely manner. A Responder Alert Application (RAapp) proof of concept has been developed by PHECC and implementation of the RAapp, integrated with the National Ambulance Service control centre system, will occur shortly.

This will facilitate the timely dispatch of the community first responder, the recording of response time data in addition to out-of-hospital arrest data which will contribute to the patient data already collected on the out-of-hospital cardiac arrest register (OHCAR). In cardiac arrest the best chance of survival is defibrillation within 3 minutes so it is paramount that community first responder
programmes are given the resources required to have an impact on patient outcome after a cardiac arrest if we expect to see an increase in our survival rates.

Technology and integrated health records

The implementation of the electronic health record in line with the eHealth strategy for Ireland will transform healthcare as we know it. eHealth will enable the delivery of safe care to the patient and the inclusion of prehospital data integration is paramount to this complete picture; in order to achieve safe care delivery to the patient each time a call is made to 999 or 112.

Research in other jurisdictions indicates that prehospital electronic data collection has proved a powerful tool in monitoring important patient key performance indicators (KPIs), research, analysis and in areas of auditing and quality assurance. For the paramedic, electronic health record enables rapid retrieval of records and transmission of data while enroute to the destination hospital. Equally, for the purposes of clinical audit, it enables clinical practice to be assessed seamlessly against standards of care. eHealth also facilitate the destination hospitals providing clinical feedback to the both the paramedic, the GP and the primary care community services enabling a seamless continuation of the patients care ensuring the best possible outcomes for the patient.

Mobile tele-presence technology is also presenting opportunities in parts of Europe for ‘at home’ GP-authorised treatment and discharge without an ED attendance being required. This has led to significant improvements in medical productivity and more appropriate care for the patient.

In some countries, EDs are being upgraded to include an electronic portal to provide medical treatment in underserviced or remote areas resourced by paramedic. These paramedics have the opportunity to work closely with other healthcare professionals and to significantly expand their scope of practice under direct guidance from medical colleagues.

https://www.phecit.ie/

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Primary Care Dermatology Society of Ireland

I am writing to you in my capacity as treasurer of the Primary Care Dermatology Society of Ireland. We are a registered charity set up to promote postgraduate training and education among general practitioners in Dermatology. We run an annual 3 day scientific meeting with lectures and workshops. Any surplus funds are given out in bursaries to doctors in primary care who wish to gain postgraduate qualifications in Dermatology.

We have about 200 members and our focus is on primary care to promote and improve the management of skin conditions in the community. We find interest among general practitioners is increasing.

We are finding it is increasingly difficult to get appointments particularly for our public patients and some patients wait up to 18 months, as you will know. Access to the private system is extremely expensive for patients.

Dermatology comprises approximately twenty percent of a general practitioner work load. As our population ages this workload is only going to increase. The burden of skin disease among the elderly is particularly high with increasing incidence of skin cancer, sun damaged skin and other chronic conditions. There is also increased demand among all age groups for dermatology services.

We note the constant call to appoint more hospital consultants. We do not believe that we will ever be able appoint or train enough consultant Dermatologists to meet present demand let alone the projected increase into the future. So this can only be part of any solution, to this growing problem.

I think the time has come to turn some focus on primary care and community based services to help solve some of the issues we facing.

We believe that establishing a cohort of general practitioners who have enhanced experience in Dermatology is a way forward which should explored.

We believe part of any solution will have to come from Primary Care and we would see any work we do as complimentary to the hospital service but enhancing the overall service to patients.

We would see such doctors having enhanced experience in lesion recognition and enhanced knowledge in the management of the more common chronic skin conditions. Some of this could be acquired through post graduate qualifications and more through the meetings we run ourselves. A lot of GPs are trained in Dermoscopy and in minor surgery

Such a system exists in the UK with the ‘general practitioner with special interest scheme’-the so called gpsi scheme. This seems to work quite well.

Some colleagues have proposed that we establish an inter general practitioner referral system whereby GPs who are interested in Dermatology would receive referrals from other GPs with less experience in dermatology.

Any Primary Care based service could be very cost effective, improve access and would be based in the community which patients would greatly value.

Such a scheme would require funding and support and would not work under present funding arrangements.

What I am submitting is a proposal to improve dermatology services at primary care level to highlight that primary care has to be part of any solution to this growing problem and this proposal should form a basis for future discussion.

Yours

Dr George Roberts
Treasurer
Primary Care Dermatology Society of Ireland
Dr Finbarr Fitzpatrick Chairman
Dr Bernadette O'Leary Secretary

Dr David Buckley ,Dr Karen Reidy and Dr Conor Brosnan

http://pcdsi.com/

Primary Care Surgical Association

General Practitioners are anxious to retain responsibility for the provision of a range of traditional and newer skin surgical and other procedures.

Research has indicated the success of community provision and the viability of an accreditation process for GPs and their clinics. This should underpin future commissioning of work in an integrated approach to meeting the needs of patients across the country.

Barriers remain in the form of inadequate remuneration for many of the more complex and even some basic procedures and in the incomplete process of defining the role of primary care in the diagnosis and management of skin cancers.

This submission recommends recent evidence to the Committee in relation to services for public patients as a model of appropriate transition of care to the community.

The submission confines itself to primary care surgery and does not address global aspects of healthcare reform.

Background

GPs have traditionally provided many surgical services to their patients. In recent years, lack of time, funding and accreditation have tended to dissuade GPs from pursuing such work , especially for patients without private health insurance or the means to pay fees that adequately reflect the cost of providing the service.

The Primary Care Surgical Association, founded in 2012, has a membership of approximately 120 general medical practitioners who have a special interest in the provision of skin surgery in a community setting. It is estimated that two thirds of GPs provide some procedures in their clinics, of whom half provide services very regularly and covering a large range of procedures. (S McKenna Oral Presentation PCSA Limerick 2012, N Maguire *Forum Journal of the* ICGP 1992)
The membership of the PCSA, represents those among the approximately 2,800 GPs in the state who would have the greatest interest and experience of skin surgery and other procedural work.

The organisation was founded to promote the further development of education in procedural practice for aspirant and established GPs as well as to enhance the capacity of primary care to retain and increase this traditional element of the GPs work.

These objectives have been addressed by a number of academic and political activities.

These include:
1)The elaboration of quality standards of best practice.
2)The development of a mentorship programme to complement basic surgical training.
3)The creation of a national community surgical audit service operated in conjunction with the Irish

Primary Care Research Network
4)The production of a core curriculum for procedural practice for GP specialist training.
5)The representation of members in discussions with the National Treatment Purchase Fund, the Primary
Care Division of the HSE, the private health insurance providers, the National Cancer Control
Programme(NCCP) the Irish College of General Practitioners (ICGP) , the Irish medical Organisation,
the National Association of GPs, the Irish Skin Foundation, the National Clinical Programme in Surgery,
the National Clinical Programme in Dermatology and the Primary Care Dermatology Society.

6)The promotion and delivery of a pilot community surgical accreditation process commissioned of the
ICGP by the HSE, which delivered 4,600 surgical procedures over a six month period in 2016
7)The hosting of annual conferences and on-line learning supports for members.

The past three decades have seen the expansion of the infrastructure of general practice, incenitvised in large part by Government such that most GPs now work in groups, with practice nurses and clinical facilities that allow GPs to undertake special interests and meet high standards of hygiene and patient comfort.

Strategy

The PCSA believes that a strategy which espouses greater care delivery in the community should look to the example of community surgery as a model of a patient-centred, high quality and cost effective alternative.

In 2014 the National Clinical Programme in Surgery estimated that 32% of day surgical cases in our hospitals could have been performed in the community or outpatient settings. The cost saving of transferring such work from day theatre to outpatient rooms was estimated to amount to €8,722 per week of operation of a single surgical site.(Prof F Keane, Join Lead National Clinical Programme in Surgery 2014, personal communication)

The Association of Surgeons in Primary Care , our sister organisation in the UK advises that procedures can be contracted in primary care, to exacting standards in relation to clinical care, access and patient satisfaction at 50-60% of the cost of the same service in the hospital sector. (Prof V.A.Kumar , President ASPC, personal communication). It is the view of the PCSA , that appropriate remuneration would encourage GPs to take up work traditionally undertaken by family doctors , but which have tended to be neglected for want of incentive.

The sorts of disease that GPs regularly treat include: Lacerations, ingrown toe nails, sebaceous and other cysts, lipomas, warts, joint effusions, minor cosmetic skin lesions such as skin tags and seborrheic keratosis, skin abscesses, premalignant and malignant non melanoma skin cancers.

The sorts of procedures that GPs undertake regularly include: Suturing, biopsy of the skin, ellipse or modified ellipse excision of the skin, electrocautery and curettage of the skin, incision and drainage, cryosurgical freezing of skin, aspiration and injection of inflamed joints.

Additionally, many GPs will undertake dermatoscopy for diagnosis of skin cancer, vasectomy, the provision of long acting reversible contraceptive implants and intrauterine contraceptive device insertion.

In relation to skin cancer specifically, GPs are ideally placed to contribute to the diagnosis and management of melanoma and non melanoma skin cancer. Early diagnosis and urgent referral of suspected melanoma by the increasingly prevalent use of dermatoscopy is practiced by a growing number of GPs. Similarly, early recognition of non melanoma skin cancer and biopsy and/or curative excision in accordance with NCCP guidance allows GPs to contribute to the care of the 9,000 patients who present with this disease annually in Ireland.

Integration of Primary Care.

Any future strategic shift in the orientation of our health services should recognize the capacity already existing with general practice to provide procedural services and which could very rapidly be expanded.

The accessibility of the GP, the short waiting times and high satisfaction rates repeatedly demonstrated in surveys of community based surgery argue for such services to be encouraged.

The inclusion of the nationwide network of GP clinics within an integrated community surgical arrangement for public and fee-paying patients requires that (a) money follow the patient and that (b) the community resource is integrated with the overall provision to be made for such disease.

This integration could be fostered by incentivizing GPs to undertake accreditation for skin surgery, to develop explicit linkages with relevant hospital colleagues (dermatologists, histopathologists and plastic surgeons) and to commit to surgical audit upon which continued commissioning of service would be dependent.

Funding issues.

At the present time, while GPs are enabled to provide such services for fee-paying or insured patients, the level of compensation available to medical card patients is insufficient to encourage GPs to take the time and make the investments required to afford the same service to public patients.

A basic fee of less than € 25.00 for the Special Type Consultation by which such additional elements of service are remunerated in the Choice of Doctor (GMS) scheme is simply not sufficient to offset the cost in time and equipment required.

Very recently, improved fees have been agreed for the suture of lacerations and this is to be welcomed.

Barriers other than funding.

A further barrier to the integration of community based surgical/procedural services with the requirement of the HSE has been the want of a formal accreditation process for clinics, where such work can be undertaken on a commissioned basis.

In 2015 the Primary Care Division of the HSE, under the leadership of Mr John Hennessy and Dr Joe Clarke commissioned a unique experiment in shifting care to the community. By investing €0.5M in a pilot project to develop an accreditation process for community surgery and deliver a quantum of care to some 2,300 GMS patients, who would otherwise have required referral to hospital, significant new insights have been gained into the process of transitioning care.

The report of this project has revealed a broad case mix, high levels of patient satisfaction and low levels of complications. A robust accreditation mechanism has been designed and tested, thereby removing an important barrier to the commission of work from GPs operating community surgical services.(Dr A Ni Riain, Dr C Collins, Report of the Accreditation Research Project. Dublin, ICGP July 2016). Dr L Vardakar and Mr S Harris have, in succession as Minister, supported this project for the retrieval of appropriate clinical services from the secondary sector.

Remaining obstacles are as follows:

a) The need to incorporate appropriate compensation for procedural work in the new GMS contract and to do so quickly so that the HSE project commenced in 2015 can move beyond the pilot phase.
b) An urgent need to formalize the relationship with hospital colleagues of GPs acting as skin cancer specialists under the terms of the draft NCCP referral guideline for non melanoma skin cancer.
c) The recognition of modern techniques for the early diagnosis and management of skin cancer, including the encouragement of the use of dermatoscopy by GPs
d) The promotion of inter-referral among GPs so as to avoid hospital referrals and attendant delays and costs.

General practice has developed to the point at which it is fully capable of resuming the provision of procedural services that have traditionally been within its remit. GPs are established in every corner of Ireland, in high quality health centres, increasingly with dedicated treatment rooms. The diversion of many sorts of skin surgery and other procedures from secondary care to primary care can be shown to be cost effective and safe. Recent investment in pilot research by the HSE is tending to address barriers to exploiting this resource. More needs to be done so that community surgery can serve as a model of integrated care for patients at the right time, in the right place.

http://pcsa.wpengine.com/about-us/

Private Hospitals Association

The Private Hospitals Association (PHA) represents 19 hospitals across Ireland that deliver a significant amount of acute, medical and mental health care to patients every year. We welcome the opportunity to contribute to the Committee's deliberations and to brief members on the extent of the work done in private hospitals which considerably reduces pressure on the public system.

Our modern and technologically advanced hospitals will continue to make a significant contribution to care in Ireland into the future and we look forward to discussing with the Committee, how this contribution can be most effective.

We commend the principle underlying the Committee's establishment – long term certainty on health policy will enable all health care providers, including private hospitals, to deliver high quality health care effectively and will facilitate appropriate investment in a timely manner. We would underline that the Committee's most important contribution would be to provide a high level strategic vision for the future.

In our submission we take the opportunity to outline the extent to which treatment in Ireland is provided in our members' facilities. Future planning for the system should take account of the extent of our network and the expertise and innovation which it brings to the overall health mix in Ireland.

In our submission we also highlight key enablers for an effective health care system which we would encourage the Committee to emphasise – notably the integration of enhanced primary care with the hospital system, the supply of skilled medical personnel and investment in eHealth.

When considering the necessary steps to progress towards the Committee's ten-year vision, this submission draws members' attention to our recently published proposals to Government on improving patient care by fostering closer collaboration between the public and private systems.

We note that work on future funding mechanisms is ongoing and we look forward to contributing to this aspect of the debate once options and proposals are developed.

http://privatehospitals.ie/

The Private Hospitals Association recommends that the Committee:

1. Acknowledges the mixed nature of health care provision in Ireland and the significant proportion of care delivered by private hospitals;

2. Offers a strategic vision of healthcare in Ireland in 10 years' time that recognises the benefits of this mixed delivery system and provides a stable environment for investment in the sector;

3. Focuses on how, as primary care services develop, they can integrate successfully with all providers of hospital care;

4. Places due emphasis on the issues of health sector recruitment and the need for sustained focus on attracting nurses, doctors and other clinical specialists to work in Ireland by establishing an *Expert Skills Group on the Medical Professions;*

5. Supports the importance of investment in eHealth initiatives as an important enabler of truly joined up healthcare;

6. Supports closer cooperation on patient care between public and private systems during the transition period between now and 2026.

We would welcome an opportunity to meet with the Committee in the coming months as it's deliberations develop.

The Contribution made by Private Hospitals in Ireland

Thirty percent of Ireland's 70 hospitals are in private ownership. These hospitals, spread across the country, provide a range of acute medical and mental health services. Private Hospitals Association (PHA) members delivered a wide range of care to Irish patients during 2015 including more than **250,000 in-patient procedures, 3 million diagnostic tests, over one million bed nights to patients, and 10% of inpatient mental health care**.

The Committee may wish to note, in particular, our capacity to deliver elective care – we estimate that **50% of all elective procedures in Ireland last year were performed in our members' hospitals.** On average patients are discharged from our acute hospitals 4 days after admission. In addition, half of our hospitals operate **Emergency Departments and or Medical Assessment Units which in total see more than one thousand patients each week, admitting at least 250 of these patients, thus providing an estimated 100,000 bed nights of medical care to patients admitted on an emergency basis each year.**

Private hospitals mainly treat patients with health insurance but also provide care to self-paying patients and, when requested, provide care to patients referred by the public health system. On occasion such arrangements are made centrally by the National Treatment Purchase Fund or the HSE's Special Delivery Unit. On other occasions individual public hospitals or hospital groups contract with private hospitals to address particular backlogs in patient treatment. The treatment we provide under such arrangement is delivered at a rate that is comparable to costings in the public system.

While our hospitals are consistently busy, we have demonstrated the flexibility to provide care to additional patients referred from the public system - particularly when this is planned in advance.

Private hospitals in Ireland provide 2,500 beds for patients which is a very significant addition to the stock of acute beds in public hospitals. PHA members, which are a mix of not for profit trusts and privately owned businesses, continually invest in the expansion and upgrading of our facilities and in new medical technologies so as to ensure that we provide advanced health care in a suitable environment.

All our hospitals are accredited by an internationally recognised accreditation body such as Joint Commission International (JCI) and are committed to delivering on recognised standards including HIQA's Standards for Better Safer Healthcare. Our hospitals providing mental health services are approved by the Mental Health Commission. We have long argued that a single quality regulatory regime should apply to all Irish hospitals and welcome the forthcoming HIPS legislation which will bring this into effect.

The merits of a long term strategic view on healthcare in Ireland

The PHA is very supportive of the Committee's ambition to set out a 10 year vision for Irish health care and to achieve cross party consensus on the future direction. Consistency of Government policy is of great importance to businesses in a sector such as health – where capital investments tend to be very large and take a long time to be paid back. The clearer the trajectory of health care, the easier it is for providers (public or private) to develop plans, secure Board and investor approval and negotiate affordable financing so as to deliver the right facilities for patients. A stop-start approach to healthcare policy ultimately increases the costs of treatment for all patients as well as compounding delays and risking some patients not being treated at all.

Below we identify some areas where we believe the Committee should agree a direction <u>at a strategic level</u> so as to enable policy makers, agencies and service deliverers (such as PHA members) to plan effectively.

A combined focus on primary care and integrated care

The PHA supports the broad consensus that the Irish health service should place greater emphasis on primary care in the coming years. Integration of an enhanced primary care system with the hospital sector will be an important part of that design – the extent to which primary care centres will be able to commission treatment, the role of hospitals in providing diagnostic services, the role of primary care system in treating patients after discharge from hospital etc. This design should have regard to integration with private as well as public hospitals.

A focus on the health care workforce

The fact that Ireland's population is ageing faster than that of any other developed country will compound the health sector work force problem which is a global dilemma. For at least the next ten years Ireland will need sustained national focus on nursing education, recruitment and retention as demand for this profession which is already tight should be expected to increase dramatically. We must similarly recognise that the market for medical consultants is global and ensure that Ireland is an attractive place for highly skilled specialist physicians to practice. This focus will also be required on allied health professions.

We believe the Committee should recommend the establishment of an *Expert Skills Group on the Medical Professions* involving public and private employers as well as the relevant colleges, universities, professional regulators and other stakeholders to be charged with developing a ten year plan for a healthcare workforce.

A focus on eHealth

Ireland has lagged behind other developed countries in the implementation of eHealth initiatives which has at least provided the benefit of learning from the mistakes of others. At this point, however, it is time for us to crystallise a vision of how ICT can serve our healthcare system and to invest in that vision. The PHA welcomes the planning work being undertaken be EHealth Ireland and looks forward to the rollout of Electronic Health Records and other tools that facilitate better patient care through greatly improved sharing by different stakeholders in healthcare – public and private.

Interim Steps when working towards 2026

The PHA recommends a specific focus on the potential for closer co-operation between the public and private systems so as to make best use of existing infrastructure and resources in patients' interest over the next few years while developing a long term plan. In April of this year the Association published a paper[120] setting out six proposals for action by Government to improve patient outcomes by maximising synergy between the two systems in Ireland. These were to:

1. *Design a joint public and private sector initiative to tackle waiting lists for both inpatient and outpatient treatments including a focus on diagnostics;*
2. *Move patients more quickly through Emergency Departments by using all available beds in both the public and private sectors;*
3. *Address the gaps delaying patient treatment by launching a coordinated approach to attracting consultants and other health professionals to work in Ireland;*
4. *Introduce a new competitive system for commissioning hospital care by 2018;*
5. *Coordinate planned investment in medical facilities and equipment to avoid duplication, get value and create efficiencies;*

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[120] http://privatehospitals.ie/pha-publish-six-proposals-ease-pressure-health-service/

6. *Establish a task force to boost co-operation between public and private healthcare systems.*

We would commend these steps to the Committee as an important part of any transition strategy towards its long term vision for healthcare.

Future financing of health care

We note the particular focus of the Committee's consultation on design of funding for a future model of health care. However, we also note in the 2016 Programme for Partnership Government that further to the project undertaken during the last government on the costs of introduction of universal healthcare, work is being conducted on the costs of various models and that the Government proposes to ask the Oireachtas Committee on Health to conduct "hearings on how best to move forward on the outcomes of the work".

We look forward to contributing to that aspect of the debate in due course and at this initial stage would simply point out that, currently, insurance premiums contribute circa €2.5bn to Irish health care each year and this money is mainly devoted to treatment of patients in hospitals – private and public. These additional voluntary contributions by Irish taxpayers serve to relieve a significant portion of the burden on the exchequer. Given that about two thirds of insured patients' treatment is provided in private hospitals, this also significantly relieves the burden on the public hospital system.

Appendix - Hospitals Represented by the Private Hospitals Association

- Aut Even Hospital
- Barrington's Hospital
- Beacon Hospital
- Blackrock Clinic
- Bon Secours Hospital Cork
- Bon Secours Hospital Dublin
- Bon Secours Hospital Galway
- Bon Secours Hospital Tralee
- Clane General Hospital
- Galway Clinic
- Hermitage Clinic
- Highfield Hospital
- Kingsbridge Hospital Sligo
- Mater Private Hospital Dublin
- Mater Private Hospital Cork
- Sports Surgery Clinic
- St John of God Hospital
- St Vincent's Private Hospital
- Whitfield Clinic

Professor Anthony Staines, DCU

I review my own perspective on our health services, placing them in an international context, and drawing on two decades of experience working with HSE and the Health Boards, nearly a decade in the NHS, and the wider literature on health care reform.

I conclude that the Irish system is expensive, unsustainable, and works badly, despite the generally high standard of most of those working in it. The overall design of the system is not fit for purpose. I call for a system redesign based on some key ideas :-

1. A right to health and social care
2. Patient centred health and social care, with an emphasis on prevention
3. Focus on health and social care delivery in the community and in primary care
4. Better information for better care and accountability

I add one caveat. The most obvious way to do this is to restructure HSE. This would be a mistake, and will guarantee no change for four to five years, and probably overall failure. The Irish state does not have the capacity to oversee such a top-down change management program, even if it were desirable. The existing structures are quite capable, if you leave them alone, and can deliver better health care for our current investment. The best way to do this may be to move the negotiation of contracts, and the staff involved, away from the Department of Health and give HSE the responsibility and the authority to do what is necessary.

Who am I?

I am a doctor, who originally trained in paediatrics, and then in public health. I have worked in academic public health in the UK and Ireland since 1990. I am an active researcher, who has managed many millions in grant funding, and written over 180 papers. I have worked, closely, with the health services in Ireland, and the UK, for my whole career. I have developed health information systems for HSE, and worked on health service funding. I spent much of 2013 and 2014 working for HSE on a strategy for health information in the Irish Health Services.

I also study health systems in other countries, not just the USA and England, where we tend to look for ideas, but also other EU countries, and many countries further afield, such as New Zealand, Australia, Canada, Taiwan, Norway, Switzerland, and Korea.

I was a member of the Irish Health Insurance Authority, the private health insurance regulator, for four years (up to the beginning of 2016). I chair the Irish Blood Transfusion Service.

What is the problem?

The key issues are two.

Ireland is one of the highest spenders in the the EU, and indeed in OECD, when health expenditure is considered as a percentage of Gross National Product, and particularly of Gross National Income. It would be impossible to argue that we get one of the best health services in the developed world. We do not. England, where the NHS has a financial crisis, and where general practice is in turmoil, still has a far better health care service than we do, on about 9% of GNP. Irish patients have among the highest out of packet payments for health care in the OECD, a reflection of the poor coverage both of the State health system, and of private insurance.

The Irish health care system is very different from other developed country systems. The existing system strongly encourages people to use acute hospital services, especially hospital outpatient services, which are largely free, instead of using primary care services, which are expensive, unless you have a medical card. Private health insurance largely pays for inpatient and day-case hospital care, but not for primary care. As a result, Irish hospitals are crammed with patients who would never see a hospital in most other health services. A very large proportion of care for chronic long-term illness takes place in acute hospitals, not in general practice, where it ought to be. Primary care is very underdeveloped, and very poorly resourced.

Solutions

The system needs major work in several areas. This work will take about a decade to have a major impact. This is why political agreement on what the system ought to look like is vital. No single Dáil can ever see it through. We need to learn from the disastrous experience of the NHS in England, where frequent restructuring, over almost thirty years, has lead to a mess. (It still works better than our services, which should give us pause.) Restructuring is easy, but it is not the answer, it only gives the illusion of reform.

Rights based

There has been opposition in Ireland to the idea of a right to health and social care. It’s not clear to me why this is so. My own view is that we need a clear articulation of a reasonable right of timely access to health and social care, within existing resources. This would set a marker of intent, and give us a destination to aim for.

Patient centred

This might seem obvious but it isn’t. The Irish services are very focussed on organizations, and their needs. The interests of patients come a long way second. Organisations fight all the time about protecting their budgets, and seek to shift costs. A very recent example is the decision to provide no further home care packages in one HSE CHO area. The effect of this was to lock a significant number of frail elderly patients into acute hospital beds, with bad effects for those patients, and for the hospitals. You may remember the sorry saga from some years ago, of a middle-aged man, who stayed as an inpatient in Beaumont for over a year, while the hospital and his home health authority argued over who would pay for (I think) ten hours of home-care a week. This culture needs to change.

Population ageing

Right now, Ireland has very favourable demographics. We have one of the youngest populations in the developed world. Over the next twenty years, this will change rapidly. Every year, the number of people aged 65 and over will rise by about 60,000. These people are much healthier than their peers from thirty years ago, but there are a lot more of them. People are living longer, and they are healthier, which is great. However, the number of people with serious illness, and the number of people needing long term care, will both rise steadily. The health system is failing with our current population structure – it will fail much worse with the population in ten years time. Our current system is not sustainable.

Primary care led

I argue for a primary care led service. Specifically, based on the evidence I have seen, GP's are the core of the whole system. To build a workable and sustainable system, we need to build it around them.

Role of acute hospitals

At the moment the Irish system is dominated by acute general hospitals. This is not unique to Ireland. As highly visible and valuable pieces of a health system, acute hospitals are prominent in every health system, and often have substantial political clout. What is different here, is the limited extent to which the hospitals feel responsibility for anything outside their front doors. This is best shown by the severely limited access for GP's, and their patients, to hospital based investigations, such as ultrasound, radiology and endoscopy. The vast majority of health care contacts are in primary care, specifically in general practice, and I argue that the hospital should be seen as a support for this. Most Irish GP's are very well-trained and highly competent. I agree that ways of managing the few exceptions are needed, but this could be done through the GP networks.

We have relatively few hospital beds, compared with international norms, and grossly excessive (100% +) bed occupancy rates. However, simply pouring more beds into our system will gain us little. We could easily spend a billion a year on extra beds, but without fixing the existing problems, all we would have would be a slightly better working, and much more expensive health care system.

Multi-morbidity

The large bulk of health care spending goes on a very small number of patients. In the US, 20% of expenditure goes on 1% of patients, and 50% goes on 5% of patients. Comparable Irish data does not seem to exist. Most of these patients have what is know as multi-morbidity, that is they have more than one chronic disease. General practice and, to a lesser extent, geriatric medicine, cares for most of these people. There is reasonable evidence that care for this group of complex patients is best delivered by integration between general practice and acute hospital services. HSE has made huge progress on clinical care pathways, but these still focus on single diseases, and remain very hospital led. The US has the concept of a patient centred medical home, a service based in the community, which co-ordinates the care for these complex and expensive patients. We could learn from this model.

Social care

One of the big benefits of the Irish system is that health and social care are provided from the same overall budget by the same organisation. This could be an immense benefit, although it would be fair to say that HSE gains too little from this in practice. Many patients arrive in hospital because of deficits in social care, and they often remain there, for long periods of time, for the same reason. This is very expensive, leads quite directly to trolleys in A/E, which are not a feature of most other health systems, and reduces the quality of life of the people concerned. There is good evidence from the NHS that linking health and social care properly can bring great benefits to health, and reduce costs. We need to do this here.

Mental health and disability services

These are notoriously the Cinderella services. The quality of care provided in some facilities, and the quality of the infrastructure in many facilities, should be wholly unacceptable. Part of the problem, again, is the Irish obsession with institutions – given a social problem, out first instinct is to build an institution and hide the problems. We've done this in the past, with Mother and baby homes, industrial schools and reformatories. We continue this with asylums, for people with mental health issues, and congregated settings for people with disabilities, both, I hope, being phased out. We are now doing it again, with nursing homes for the elderly.

We need to stop. There are good examples of excellent practice in the provision of care in the community for all these groups, including many Irish examples, and these need to be rolled out. Institutional care needs to be the exception, and not the expectation.

Primary care

Primary care is built around general practice. There is a lot of evidence of the benefits of general practice, both in Ireland and abroad. Our current system, where much of primary care operates independently from GP's is inefficient, and needs to be fixed. There is a culture of mistrust of GP's in parts of HSE and the DoH, and this needs to be tackled, and changed. None of this is popular, but it is important.

The GMS contract was, I think, unfit for purpose when it was first negotiated, and remains, with its emphasis on payment for activity, and its reluctance to fund continuing care, entirely unsuitable as a basis for future developments in primary care. We need, as the highest priority, a modern workable GP contract, with a path towards either free care, or a mixture of free care, and very minimal charges (€5 to €10), at the point of access. This could be done relatively cheaply.

Reducing the cost to consumers of the DPS scheme would be more costly, and the priority for this ought to be people on lower incomes, but without medical cards. It should be possible to identify these people quite easily from state records, and it would reduce a significant burden on many people.

Placing GP's in a leading role in primary care might be opposed by the CHO's, and some other staff, but it is the only workable solution. Someone has to be responsible for the whole show, and GP's have the necessary public trust. We could investigate the GP commissioning models used by the English NHS, if we wished to move to a commissioning system over time.

Information

The health service spends €13 billion a year, with information systems that would be shockingly bad for a turnover of €1.3 million. It is not an exaggeration to say the the CEO of a hospital with a budget of €600 million has much less useful day-to-day operational and financial information than the manger of his or her local Super-Valu branch. The current ICT strategy is beginning to address this, but it needs to reach out into the community services and the electronic records used by GP's as well.

Funding

We pay too much out of pocket, and too much for private health insurance. Overall, for the money we pay, we should have an amazing system, and we do not. We have a very large private acute hospital sector, which depends on enormous public subsidy, and is not sustainable. Some of these costs are fees to consultants, and some are charges for services. I believe that we need to end up with a better balanced system, where the public sector is trusted to provide good quality care, and the private sector primarily works more like the Section 38 and 39 bodies, providing services, nder contract, to the public system. Very roughly, €600 million would buy us good general practice services. This is not an inconceivable sum, and would be the best place to start a reform program.

Over time, phasing out subsidies for private hospital care, separating private and public facilities, and requiring staff to work either in the private or public sectors, but not both, could achieve much. Paying consultants for their on-call might be the easiest way to sweeten the pill for them, but there is no doubt that many consultants will earn less under a mainly public system than they do now. The public will only accept this if they are confident that there will be no excessive waits in the public system – certainly this is not the case now. That is why I believe this is a ten year process.

How it is funded is secondary. The current system is not very good, but could be made to work better. A single financial system for HSE is an absolute pre-requisite. A single-payer health insurance system is also entirely viable, providing that a clear mechanism exists to limit the overall budget. Multi-payer insurance is a non-starter here. The costs are unmanageable, and none of the existing providers could do the job. Structures matter much less than activities. Tax-based systems are in fact more efficient than insurance based systems, and the real difference between a compulsory single payer social insurance system, and a system funded from general taxation, or particularly a hypothecated tax is negligible.

Capital funding

A slightly separate issue is capital funding. The ways in which we fund and account for capital expenditure are damaging. We should use the accruals approach, and properly depreciate capital assets over time. Costs for maintenance, and future replacement need to be included, and need to be realistic. This applies as much to buildings as to individual items of equipment.

Political challenges

Norway, allegedly, has had no health service reforms since the Second World War. This does not mean that the service is the same, rather it means that within an overall political consensus as to what the service ought to look like, the service has grown over the years to continue to meet the needs of Norwegians. This ought to be our ideal. If we can come to a common view on what we want, we can start moving towards it. We must accept that this is a journey, and it does not stop.

There will be winners and losers from these changes. As already mentioned the private providers will lose. They do play an important role in our system, but they cost far too much, and they do not account for the huge subsidies we provide to them. My consultant colleagues with large private practices will lose income. I fell strongly that consultants ought to be very well paid, as they have an exceptionally responsible, difficult and demanding job. Most work significantly more than their contracted hours in the public sector. However, the combined public and private income of many consultants is more than we can afford. It is possible that by combining an attractive base salary and payment for on-call, we can come up with an acceptable package.

Without public support, all of this is smoke and mirrors. Unless people trust the public service to, over time, provide good quality, accessible services, with modest waiting lists, no change will occur. I argue for a phased change over time, starting in primary care, and social care, so that hospitals will work better, and moving to acute care, both urgent and elective, in a second phase. I believe that this is possible, and affordable within the budget we have now. Unless we move to a more sustainable health care system, we will not be able to provide decent care for our ageing population.

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Professor Allyson Pollock

How much should rich country governments spend on health care?

Comments to the Oireachtas Committee on the Future of Healthcare, 28 September 2016
Prof Allyson Pollock, Professor of Public Health Policy & Research, Queen Mary University of London

The decision to have a universal public health care system is always political. Many countries have decided that universal health care (access to services on the basis of need and free at the point of delivery) is the hallmark of a civilized society and that it is both necessary and affordable for governments to legislate for its citizens to that end. The question of how much any country should spend on public health care is inextricably linked to the chosen model of funding and provision, the degree of marketisation and how much risk selection and denial of care a government is prepared to tolerate in its health system.

In respect of a single tier health care system, it is important to note that there is no country in the world that has delivered universal health care through a market and for-profit provision or private insurance. This is because markets operate through selection and exclusion, transferring risks and costs back to the users of services and denying care to those that need them most. Risk selection and exclusion is built into the design of market administration; in contrast, inclusion and redistribution must be built into the systems of public administration for universal health systems. Risk selection and risk avoidance mechanisms undermine the goal of access and universality.

The US, with health expenditure of around 18% of GDP, denies more than one in five of its population access to health care. Overtreatment and denial of care, health care fraud, catastrophic costs and spiraling health expenditure are the hallmark of US health care. Those countries that have adopted the US model of mixed funding (public and private) together with public and private provision have more marketisation, higher administration costs, the greatest inequalities in access and health outcomes, lack of coverage, and highest out of pocket payments. Out of pocket payments are major barriers to access and the committee has heard evidence on the effect of out of pocket payments on patients. It has also taken evidence from GPs involved in the Deep End Initiative about the “inverse care law” and its operation in Ireland because resource allocation does not follow need resulting in maldistribution of funds and services.

> “The availability of good medical care tends to vary inversely with the need for it in the population served. This ... operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced.”
>
> “To the extent that health care becomes a commodity it becomes distributed just like champagne. That is rich people gets lots of it. Poor people don’t get any of it.”

The UK put in place its National Health Service in 1948, as a universal integrated public health system free at the point of delivery and funded through central taxation. Central taxation is the fairest and most efficient way of funding. The legislation and the system became the model for many countries’ health systems across the world. The UK NHS had the lowest cost, and the most efficient and fairest system, guaranteeing health care to all its citizens without fear of catastrophic health care costs or being denied care. In 2012, following two decades of market incrementalism, the government in England abolished the universal public model by abolishing the duty on the Secretary of State to provide key health services throughout England. Instead it has made commercial contracting virtually compulsory; has introduced new mechanisms for fragmenting and dismantling care and reducing services; and has made foundation trust hospitals structurally 49% private thereby diverting their focus to private income. US inspired market risk selection mechanisms have been introduced with catastrophic consequences for universal public health care. Scotland and Wales have retained the universal single tier integrated public NHS model. However, the Westminster UK Treasury controls the funding through the block grant allocation which puts their systems under severe pressure. In England, 75% of foundation trusts are in serious financial deficit; in contrast, no hospital in Scotland is going to the wall. This is because hospitals and community services are integrated into and directly managed by the health boards.

If universal health care is the goal, we need first to understand how the principles of universal health care underpinned by public health need, redistribution, and risk-pooling or social solidarity are alienated by markets and marketisation. Second, clear and strong laws are required to enact universal health care. It has been argued that incrementalism may be the best strategy for Ireland. I disagree. Of course, every country must build on existing infrastructure and take account of its own history of services development. However, all countries with an NHS have put in place a law and strong legal framework to ensure that a universal national health service happens and that parliament commits to it. This has required building a strong political consensus in order to overcome the many vested interests that would retain the fragmented, marketised private elements and jeopardise the health of many. My understanding is that given the committee's commitment to articulating a vision of universal single tier health service, an NHS Bill for Ireland is the essential first step in the ten year plan.

If a law is enacted which commits the government to providing a universal health care to all citizens and residents throughout the land, parliament will decide how much it will spend. It is the task of the administrative bureaucracy to determine how the functions will be implemented and to ensure that resources are allocated fairly and appropriately. A bottom up approach can be adopted. Access to universal health care requires strong systems of public administration and adherence to six common principles: fairness of financing; fairness of resource allocation; risk pooling and social solidarity in service provision; political accountability and control; service integration through geographic units of administration; and public accountability through strong systems of information and surveillance systems.

As the committee has heard primary care teams including general practitioners are the gatekeepers to acute and specialist care and have a major part to play in prevention and rehabilitation working with social services. A strong primary care and social care system rooted in strong information systems is essential to ensure health care for all.

In my opinion a Bill to give the legal framework for a National Health Service throughout Ireland is essential and is the necessary first step towards achieving the Sustainable Development Goals for universal health care and access to rational and essential medicines.

How much should rich country governments spend on health care?

The argument commonly made by politicians in richer countries is that a universal health system is unaffordable because of the enormous gains in life expectancy leading to an aging population and that market driven competition and choice is preferred because it increases efficiency. Not only is there is no evidence to support these claims, there is evidence to the contrary on both counts. The ageing of the population contributes little to the overall growth in expenditure, which is largely attributable to increasing marketisation of health systems and costs of medicines and technologies.

Since 1948, the UK has had a universal integrated public health system free at the point of delivery and funded through central taxation. The UK NHS became the model for many countries' health systems across the world, as having the lowest cost, most efficient and fairest system, and guaranteeing health care to all its citizens without fear of charges or denial of care. In 2012, after two decades of market incrementalism, the universal public model was abolished in England, although Scotland and Wales still retain it, in favour of a model which increasingly resembles the non-universal market form of the US where risk selection and denial of care prevails.

The US is one of the richest countries in the world, and has the most expensive health care, but in spite of that it denies more than one in five of its population access to health care. Overtreatment and denial of care, catastrophic costs and spiraling health expenditure go hand in hand in the US. Those countries that have adopted the US model of mixed funding and private provision have more marketisation, the greatest inequalities in access, lack of coverage, and highest out of pocket payments because market models operate on the basis of risk selection and risk avoidance.

We conclude that the decision to have a universal public health care system is political. Many countries have decided that universal health care is the hallmark of a civilized society and that it is both necessary and affordable for governments to legislate for its citizens to that end. The question of how much any country should spend is inextricably linked to the chosen model of funding and provision, the degree of marketisation and how much risk selection and denial of care a government is prepared to tolerate in its health system.

Introduction

Among many high income countries, health care spending has been in relative decline since 2007, when the latest economic recession began. According to the Organisation for Economic Cooperation and Development (OECD), a grouping of the richest countries in the world,[121] a third of developed world governments reported a “real term cut in overall health spending in 2013”. In Italy, Portugal, and Greece real reductions have been taking place for several years. At the same time, checks on future spending levels are being discussed throughout the European Union. A common claim is that advanced economies can no longer afford universal health systems, that is, systems that guarantee a right of access to health care for everyone in need of it. What should higher income countries spend?

The relative decline in health spending has been accompanied by a growing tendency to treat this question as a technical and non-political issue. According to the International Monetary Fund (IMF), reform is needed because public health spending is “an important macro-fiscal issue”: “Public spending on health care has been a key driver of aggregate increases in public spending over the past 40 years. […] [S]pending is projected to continue rising as a share of gross domestic product (GDP) unless reforms are undertaken to help break these trends.” (Clements et al, 2012) Both the European Commission (EC) and the IMF have advised or forced some of the countries worst affected by the recession and the aftershock of the banking crisis in 2007-08 to cut health spending, and Greece to abandon universal health care, in return for financial assistance.

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[121] The OECD consists of the following high income countries:
Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Japan, Luxembourg, Netherlands, New Zealand, Norway, Poland, Portugal, Republic of Korea, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom of Great Britain and Northern Ireland, United States of America.

Throughout the developed world this technical rationale for what has become known as “austerity” is bolstered by the hypothesis that rich countries are victims of their own success in improving the life expectancy of their citizens. A longer-lived population will contain a higher proportion of elderly than a shorter lived one and this, it is argued, has created public budgetary pressures that threaten economic wellbeing. The proffered solution to an “ageing society” is to cap or reduce public health budgets so that they take up a declining (or no greater than at present) share of national wealth.

However, decisions about future levels of spending on health care are fundamentally political, or normative, just as are decisions on public expenditure on defence or international development. Today, most governments of the wealthiest countries spend between 7% and 10% of their national wealth on health care - the USA is an outlier at almost 18% - (see figure 1), and judging how much they should spend in the future is now a pressing political question. To address it we examine, first, the political basis of austerity policy. Secondly, since all normative claims have testable elements or can be reframed so that they are testable, we examine the concepts and empirical evidence that can be used in debates about future levels of spending. To simplify matters we look at the role of politics and austerity through four research lenses, namely, public health, law, finance, and economics and trade.

The role of politics and austerity in determining health care expenditure

Austerity policy is based on claims that are no less political than those that inform alternative spending policies.

This is because the econometric models that underpin the policy of reducing public expenditure and public services involve implicit and contestable value judgements about the benefits of free markets and of a diminishing role for government or relatively low public expenditure. Standard economic theory, according to Paul Krugman, prescribes increased public spending during a recession in order to stimulate demand, even at the expense of growing public deficits (in which governments spend more than they collect).

However, the dominant international political policy position known as the “Washington consensus” has been to support the adoption of private markets and small government in place of tax funded public services.

Following the banking crisis in 2008 many governments pursued the policy of reducing health expenditure. Those EU countries worst affected by austerity - Italy, Greece, Spain, Portugal, and Ireland - all experienced severe reductions in total and public and private per capita spending on health care. The EC and the IMF have required some countries to reduce health care spending substantially in exchange for financial assistance. Since 2008, the UK government has opted for substantial cuts in public expenditure, provoking criticism from some leading economists that this was less conventional economics than ideological commitment to the private sector and markets (Krugman, 2012).

Since 2000, alternative hypotheses about economic development have been used to generate testable questions about or rebut claims that public spending on health care is an economic burden that impairs future rates of economic development. There is now a large body of research that shows that growing inequalities in income and health status themselves create economic burdens that retard growth and that investing in health care can stimulate the economy.

In the last five years a number of studies have examined the costs of high levels of inequality for developed economies. Wilkinson and Pickett's *The spirit level* (2009) and Thomas Piketty's *Capital in the twenty-first century* (2014) challenge the hypothesis that health spending is an economic burden. Adding weight to the analysis is the World Health Organization's (WHO) *Macroeconomics and Health Commission* final report (2003) and the European Union's (EU) *Investing in health* (2013), the authors of which argued that investing in health is a desirable economic goal because it "contributes to the Europe 2020 objective of smart, sustainable and inclusive growth." Contrary to the IMF, the EU maintains that health spending is now "recognised as growth-friendly expenditure."

In a further sign of a changing policy arena, the United Nations Conference on Trade and Development suggested in 2014 that a more flexible approach was needed to public spending and government institutions than allowed under the Washington consensus (UNCTAD, 2014).

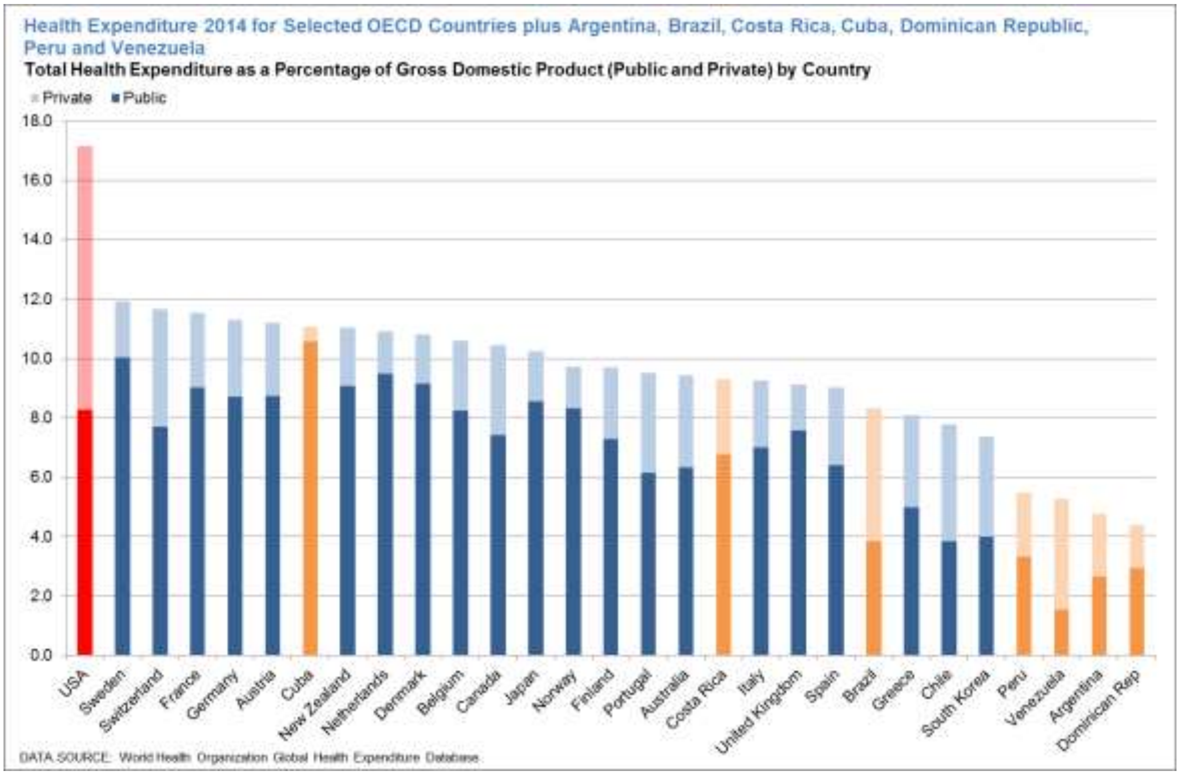
A second argument for the political basis of austerity policy arises from findings that economic forecasts have proved to be badly wrong. In April 2014, IMF research staff published an acknowledgement that their econometric models had proved to be wide of the mark after it was found that those countries that had implemented the deepest public spending cuts subsequently experienced the lowest levels of economic growth.

Thirdly, whilst the ageing society hypothesis has taken on a mythical status among politicians, it has been rebutted in a series of studies around the world. Ageing, it turns out, is too gradual to explain anything more than quite marginal changes in total health spending. This is because most people's health care costs are incurred in the last six months of life at whatever age they die. Additionally, there is a body of research which shows that not only do older people contribute more financially and in kind than they take out of the system but they are living longer and healthier and productive lives (the compression of morbidity). In any event, the ageing hypothesis lacks plausibility when used to suggest that a finite population has infinite health care needs.

In the UK, for example, older people have accounted for a relatively small proportion of the increase in spending on health care and while overall spending on health services between 1965 and 1999 grew by 3.8% a year in real terms, demographic change (ageing) accounted for a real increase of just 0.5% a year in sharp contrast to the cost of pharmaceuticals and technology which rise well above inflation.

1. Background – trends in health spending in richer and some middle income countries (OECD area plus some Latin American countries)

Figure 1. Health expenditure for OECD countries plus some Latin American countries



Health Expenditure 2014 for Selected OECD Countries plus Argentina, Brazil, Costa Rica, Cuba, Dominican Republic, Peru and Venezuela

Total Health Expenditure as a Percentage of Gross Domestic Product (Public and Private) by Country

DATA SOURCE: World Health Organization Global Health Expenditure Database

Table 1. Health Expenditure 2014 for Selected OECD Countries plus Argentina, Brazil, Costa Rica, Cuba, Dominican Republic, Peru and Venezuela as a percentage of Gross Domestic Product

Country	Public	Private	Total
USA	8.3	8.9	17.1
Sweden	10.0	1.9	11.9
Switzerland	7.7	4.0	11.7
France	9.0	2.5	11.5
Germany	8.7	2.6	11.3
Austria	8.7	2.5	11.2
Cuba	10.6	0.5	11.1
New Zealand	9.1	1.9	11.0
Netherlands	9.5	1.4	10.9
Denmark	9.2	1.6	10.8
Belgium	8.2	2.3	10.6
Canada	7.4	3.0	10.4
Japan	8.6	1.7	10.2
Norway	8.3	1.4	9.7
Finland	7.3	2.4	9.7
Portugal	6.2	3.3	9.5
Australia	6.3	3.1	9.4
Costa Rica	6.8	2.5	9.3
Italy	7.0	2.3	9.2
United Kingdom	7.6	1.5	9.1
Spain	6.4	2.6	9.0
Brazil	3.8	4.5	8.3
Greece	5.0	3.1	8.1
Chile	3.9	3.9	7.8
South Korea	4.0	3.4	7.4
Peru	3.3	2.2	5.5
Venezuela	1.5	3.7	5.3
Argentina	2.7	2.1	4.8
Dominican Rep	2.9	1.4	4.4

Figure 1 and table 1 show total spending on health care as a proportion of GDP for 2013.

Poor quality data on private spending

It is important to note that the quality of data on private spending in both rich and poor countries is limited by the fact that they are based on household surveys, are not comprehensive, and often lack comparability. Moreover, most data reflect spending by or on those who use services, not those who are excluded, and data on the poor and workers in informal economies might not be collected. The reliability of data about unmet need and inequality remains a critical issue in all countries.

Allowing for these limitations, the spending data show:

1. That there are political differences among all countries in the total health expenditure as a proportion of GDP across all countries and in the relative spending on public and private health care. The USA is an outlier among all countries, with the highest public and private expenditure.
2. That national (non-insurance-based) health systems (UK, Norway, Denmark, Italy, New Zealand, Sweden) have similar levels of total spending to insurance-based countries but relatively higher levels of public spending, expressed as a proportion of GDP, while private spending on health is relatively low in these countries.
3. Countries with high levels of private spending may have multiple public and private insurance systems.
4. Latin American countries also show major differences in public and private expenditure which are related to the health system design. For example Costa Rica and Cuba both have high levels of public expenditure and universal tax funded public health systems whereas Brazil, the Dominican Republic, and Chile have mixed funding and private insurance systems which are non universal.

Spending levels: the perspective of public health

Public health sciences seek to understand, among other things, the best ways in which to maximise population health status and meet public health needs through fairness of funding and services. Within the international public health community, universal access to health care has been adopted as the preferred goal of rational health systems for the last forty-five years (World Health Organization, 1978). This is the case because it is now accepted that although health care is only one of several factors contributing to population health universal access to it makes a measurably greater contribution than more limited access.

In 2015, the two major international health agencies, the WHO and the World Bank Group, jointly announced that universal health care "is a critical component of the new Sustainable Development Goals (SDGs)", which have replaced the Millennium Development Goals as the standard against which to measure policy progress in population health. Included among SDGs is a target to "Achieve […] access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (World Health Organization and World Bank, 2015). The agencies declare: "Supporting the right to health and ending extreme poverty can both be pursued through universal health coverage."

Thus goals such as the SDGs provide a framework based on public health science for normative debate about health spending. From them it follows that governments committed to the public health goal of maximising population health status should spend sufficient to ensure universal access to health care.

Spending levels: the perspective of laws and conventions

National laws, constitutions and international conventions on human rights provide a second framework for debate.

Legal analysis can be used to determine to what extent domestic laws may influence governments' health care budgets. In most developed countries, governments are required by primary legislation to fund public health care of some description and within reason to vote through sufficient money to discharge that duty. For example, the parliamentary act of 1946 which brought in the NHS throughout the United Kingdom committed the UK government to funding and providing key listed services for everyone throughout the UK, a duty that was abolished by the Health & Social Care Act 2012.

Similar laws can be found in other countries with universal systems. The Danish Health Act (amended June 2010) requires the government to meet, among other things, “the need for […] free and equal access to health care”; the objective of Sweden’s health act (the Health and Medical Services Act 1982:763) is “care on equal terms for the entire population”; and Italy’s national health service law requires that health benefits must be guaranteed to all citizens. The EU, which shares with member states responsibility for health care, has adopted “principles of equality of access and solidarity in funding arrangements, whether that is primarily through taxation or through regulated social insurance.” (Mossialos et al, 2010) These principles are applied through the European Court of Justice, the judgments of which are superior to national courts.

National laws can be amended and revoked, however, and simply describing them may provide insufficient guidance about duties. Spain abolished its national health service by royal decree in 20010. England’s NHS legislation was changed in 2012 so as to absolve the government of the day from the duty to meet specific service requirements for everyone throughout England. Legal analysis was crucial to show the scale and nature of the proposed changes and the ways in which the government can now reduce public expenditure and withdraw entitlements to health care and restrict access to public services without fear of legal challenge. However, the implications of the repeal is still not widely appreciated, and for political reasons the government claims still to be committed to universality.

Apart from duties and responsibilities set out in national legislation, high income countries are also subject to provisions of international conventions on human rights to which they are signatories. These, though not always enforceable in domestic courts, are relevant to normative debate. Among the most important human rights instruments are the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination Against Women, and the Covenant on Economic, Social and Cultural Rights. All, according to the WHO, provide “a legal and normative framework for the respect, protection and fulfilment of the right to health and other related rights of women, children and adolescents.” It is generally accepted that the instruments place national governments under a duty (although not necessarily enforceable) to “ensure that health facilities, goods, and services are of good quality, are available in sufficient quantity, and are physically accessible and affordable on the basis of non-discrimination.”

There is therefore a range of legal or quasi-legal provisions that can guide decisions about future spending.

Spending levels: the perspective of financing

Financial analysis derives from both public health and legal analyses, for if there is an obligation to fund universal health care how should money be raised and distributed so that the duty can be discharged most successfully and at least cost? In general, this question bears on the extent to which there is equity in resource distribution across society, and particularly on the role of publicly-financed health spending in redistributing resources from the rich to the poor and from the well to the sick. It resolves itself into three testable questions. The first is the extent to which low incomes are barriers to access, that is, the extent to which patients are required to pay at the point of use (so-called out-of-pocket payments or user charges) for the services that they need instead of paying in advance through taxes or insurance. The second is the extent to which advanced payments (instead of user charges), are equitably calibrated and collected either through insurance premiums or taxes, that is, are in line with earnings or income. The third question concerns the extent to which health care funds are allocated according to health care needs.

Solutions to the first two questions depend largely on the way in which governments raise money to pay for health care, that is, on which type of financing maximises universality. Evidence shows that universality is more likely to be achieved when out-of-pocket payments are minimised and personal incomes cease to be a barrier to access. In many countries, user charges, or private spending, entail catastrophic costs for the household and the individual because of the way they redirect resources from other necessities of life and basic household expenses (absorbing more than 20% of mean household income). In the UK, most people who require medicines are exempt prescription charges, whilst in Scotland and Wales prescription charges have been abolished. However, in most countries the cost of medicines is borne by individuals. This is often very expensive for the patient and household expenditure. For example, in poorer countries a single course of medicines for common conditions such as malaria or diabetes may cost several days wages. Medical costs including medicine costs are a common cause of personal bankruptcy in all countries. In the USA they account for three fifths of all bankruptcies.

If money is raised in advance rather than at point of use it needs to be raised by methods that impinge least (or at least proportionately) on the incomes of the poor. (Since poverty and income inequality are the main causes of ill health it would be paradoxical to raise health funds by means that deepened or failed to address either.) The most equitable funding mechanism is progressive direct tax. The main alternatives, social or private insurance, both involve user charges, sometimes substantial, at point of use and have more limited capacity to address inequality by spreading costs across the whole of the population (a practice known as “risk pooling”).

In a public health care system, the optimal form of financing is progressive taxation with a maximum separation between the user and the caregiver to reduce any conflicts of interest.

How should money be distributed around the system? Selection versus inclusion

But raising money equitably is only half the battle; resources must be allocated according to need if universality is to be achieved. Clearly, if health care money is not allocated according to need or is siphoned off for non-health care purposes, health care budgets are likely to be underestimated for some parts of the population and over-estimated for others.

Whether markets or market-like bodies are capable of needs-based allocation is a testable question. One key measure concerns the extent to which the institutions within a health system that are responsible for securing health care and the institutions that provide it are inclusive, that is, are responsible for everyone in a geographical area and are not able to exclude more expensive population groups such as the elderly and the chronically sick. Were selection of this type to occur the universal goal would be more expensive to achieve or might not be achieved at all. Systems based on private insurance or privately run provision are inherently selective. In these systems corporations manage their financial risks by excluding high cost patients or by limiting the range and nature of services available.

Risk selection and out of pocket costs: integrated universal systems and market models

Universal public systems must be designed so that they cannot exclude patients and citizens from care and are built on redistribution and solidarity and universal risk pooling. In contrast, commercial health insurers and providers select risks (cherry picking). They seek to exclude unprofitable patients such as the chronically ill and elderly, either directly by refusing coverage, or indirectly by charging very high premiums, often restrict coverage for pre-existing medical conditions and frequently leave patients with unaffordable out-of-pocket costs. These insurance practices explain why in the US, mainly unprofitable patients' groups are covered by public programs namely, the poor (Medicaid) and the elderly (Medicare).

Solidarity mechanisms which are integral to the design of public integrated systems cannot operate in commercial health insurance or among private providers, because their objective is profitability and solidarity among the wealthy (Price et al, 1999). Private insurers and private providers tailor coverage to purchasing power, not to need, often leaving patients with the most expensive conditions uncovered. Premiums generally rise with age (Rosenbaum, 2009) and high co-payments often restrict the use of medical services. Bureaucratic administrative procedures are necessary to select out patient who require high cost care and those who are at high risk. This can lead to patient and system delays. These problems have been observed not only in the US, but also in middle-income countries that have adopted market-oriented health policies (Starfield, 2008).

A second key measure of the wisdom of utilising market bodies in the pursuit of a population's health provision is the extent to which commercial pressures to consume more may inflate total (public plus private) health care costs so that more is spent than required from a public health perspective. This brings us to economic analysis.

Spending levels: the perspective of economics and trade

All governments want their nation's economies to grow faster, and health spending is often conceived as a factor in economic growth. But both increases and reductions in spending can be supported by different economic analyses. In 2014, for example, a measurable drop of 1.2% in the USA's economic growth forecasts was attributed to steps taken by the Obama government to increase access to health care and reduce costs and waste, reductions that were hotly contested by the health care industry.

Similarly, attempts by the UK government in 1957 to control pharmaceutical profits were successfully opposed by the companies affected. The industry body, the Association of the British Pharmaceutical Industry, argued, and the government ultimately accepted, that generous profits from proprietary medicines sold to the NHS subsidised standard drugs, funded export marketing, and supported research and development (Webster, 1998, p225). That principle survived until 2008.

Thus health spending can be conceived, economically, as a beneficial component of growth or as aid to industry. Alternatively, as we show above, under the austerity project it can be seen as an economic burden, at least so far as public spending is concerned. But as we show next, public and private spending are linked.

The cost of markets

Economists frequently consider the determinants of spending levels in the form of the structural arrangements that lie behind prices and how some structures lead to higher prices than others (Anderson et al, 2003). The evidence shows that publicly run systems based on geographic areas of administration are cheaper to run. By contrast, markets are relatively expensive. For example, before market elements were introduced, the UK's NHS had administration costs of around 6% of total expenditure. These costs now exceed 15% of total expenditure whilst in the USA, since 1974 one of the most heavily marketised health systems in the developed world, they exceed 30%.

Critiques of the role that markets play in inflating costs have been a staple of American economists for a number of years. In 2012 the USA's Institute of Medicine published a report in which it reproduced findings showing that in the US, wasted expenditure [approximately $765 billion] made up a large part its uniquely high level of spending on health care:

> "a substantial proportion of health care expenditures is wasted, leading to little improvement in health or in the quality of care. [The table below] contains estimates of excess costs in six domains: unnecessary services, services inefficiently delivered, prices that are too high, excess administrative costs, missed prevention opportunities, and medical fraud." (Institute of Medicine, 2012)

Table 3. Estimated sources of excess costs in health care in the USA, 2009

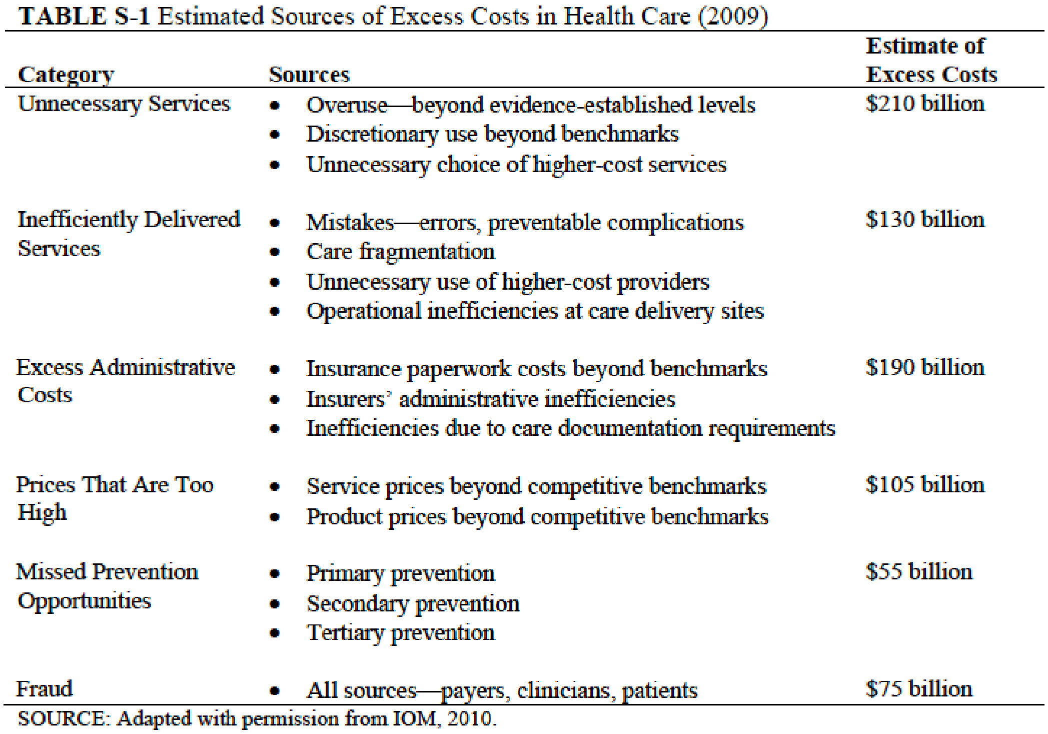


TABLE S-1 Estimated Sources of Excess Costs in Health Care (2009)

Category	Sources	Estimate of Excess Costs
Unnecessary Services	• Overuse—beyond evidence-established levels • Discretionary use beyond benchmarks • Unnecessary choice of higher-cost services	$210 billion
Inefficiently Delivered Services	• Mistakes—errors, preventable complications • Care fragmentation • Unnecessary use of higher-cost providers • Operational inefficiencies at care delivery sites	$130 billion
Excess Administrative Costs	• Insurance paperwork costs beyond benchmarks • Insurers' administrative inefficiencies • Inefficiencies due to care documentation requirements	$190 billion
Prices That Are Too High	• Service prices beyond competitive benchmarks • Product prices beyond competitive benchmarks	$105 billion
Missed Prevention Opportunities	• Primary prevention • Secondary prevention • Tertiary prevention	$55 billion
Fraud	• All sources—payers, clinicians, patients	$75 billion

SOURCE: Adapted with permission from IOM, 2010.

From a public health perspective these excess costs are inefficient, for not only do they represent a huge loss of productive health capacity but to the extent that the wastage is publicly funded they also waste scarce tax resources. In the USA, high levels of private spending on health care have generated public spending levels broadly comparable to those of European countries with universal health systems. However, the USA does not achieve universality, or anything like it, because much of the public spending is devoted to the sort of market-driven costs and wastage listed in the above table and because commercial considerations dominate in resource allocation.

The US has the most expensive system in the world with around 60 million people uninsured and almost 120 million people underinsured at any one time. Over-treatment and over-diagnosis go hand in hand with the denial of care. Catastrophic health expenditure due to out of pocket health charges is very high.

Case study of *cost of markets*: medicines

One of the biggest drivers of catastrophic costs and health care costs in most countries is pharmaceuticals.

On average 25% of a country's total health expenditure is spent on medicines with a wide range from 7.7% to 67.6%, but the source of spending varies enormously. In many low income countries medicines can absorb as much as 50% of the public health care budget annually, compared with 12% in the UK NHS. But most expenditure on medicines is due to out of pocket costs and charges with pharmaceutical costs accounting for 64% of all out of pocket payments on health care in some countries.

Since 1995, the private share of total pharmaceutical expenditure has increased across the world. According to the WHO, across all income groups, private spending by households in 2000 was the principal source of pharmaceutical expenditure, at 57.8% in high income, 70.9% in middle income, and 71.6% in low income countries.

But most of the money that the pharmaceutical industry makes is not spent on producing medicines. It is estimated that 60% of all pharmaceutical revenues are diverted from health care to profits, administration, and marketing costs.

According to one analysis of the Forbes 500 drug companies in 2003, of all revenues, 30.8% was spent on marketing and administration, 17% on profits and 14% on research and development (R&D). In the UK, the Association of the British Pharmaceutical Industry estimated that R&D was 33% of sales compared with 3.7% in the manufacturing industry, and company profits as a percentage of sales ranged from 20% to 43% in 2014.

Economists will argue that ‘waste’ such as the diversion of funds to market bureaucracy including marketing and billing and invoicing is nevertheless beneficial in a broader sense because, being economic activity, it contributes to employment and economic growth.

The cost of free trade agreements

Free trade is another economic perspective which has a bearing on spending. Economists frequently point to the importance of international trade for economic growth and to the role of health care, health insurance, and related goods, principally pharmaceuticals, in generating export-led growth. However, the promotion of free trade (the international equivalent of free markets) can have major implications for spending levels when it is associated with extending health care markets and diluting government controls.

For example, free trade treaties can prevent governments applying price controls, the logical approach to containing inflationary pressures on public health care budgets. Today, more rigorous pharmaceutical price controls continue to be opposed by the industry and are under assault by governments of pharmaceutical producing countries through trade treaty negotiations such as those involving the Trans-Pacific Partnership (TPP) and the Transatlantic Trade and Investment Partnership (TTIP). Both these draft treaties could outlaw or restrict the use of pharmaceutical price controls in centrally administered health systems. Such measures threaten the use of global budgets where governments set annual limits to health spending. Rates of expenditure growth are lowest in countries that cap health budgets under central oversight rules, such as England, Italy, Japan, and Sweden, and do not allow the market, consumer demand, and provider price-setting to determine global expenditure, such as in the USA.

The TPP and TTIP are only the most recent of a series of trade treaties with implications for health spending. In the 1990s, a WTO treaty known as the General Agreement on Tariffs and Trade was exploited by the US insurance industry and the US government as a means of opening up new markets for the then struggling, multibillion dollar business of health-maintenance organisations. Profits had fallen after 1997 because of market saturation, government and employer strategies to contain health-care costs, and high-profile scandals. To restore profitability, the industry sought to capture new markets abroad by acquiring publicly run facilities, converting public funds into profits, and repatriating the profits to the USA. In this, it received influential backing for its foreign acquisitions policy in Latin America from the US government, the World Bank, and multilateral financial institutions such as the Inter-American Development Bank. The universal health systems of Europe are the latest target of health care corporations with international trade strategies.

As can be seen, the above analyses lead to contradictory findings for health spending using a market model. The branch of economics that deals with supply and demand, microeconomics, is not relevant to our question if universal health care is adopted as a goal. This is because microeconomics is built on a principle of efficiency in which maximising individual utility not access is the desideratum and in which health care is defined as a private commodity not an essential public service. The USA offers practical lessons into the effects of the market model which relies on commercial insurers and providers. The inhumanity of that system is a warning to other rich nations. And yet it is rapidly becoming the alternative model to the integrated public health system that the UK once had.

Conclusion

We conclude that the decision to have a universal public health care system is political. There is strong evidence that universal health care is sustainable. In contrast, the US shows that the more marketised and privatised the systems the higher the costs, the waste and the greater the risks of being denied care. The question of how much any country should spend is inextricably linked to the chosen model of funding and provision, the degree of marketisation, and how much risk selection and denial of care a government is prepared to tolerate in its health system.

Further reading

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This is a very important document outlining the challenges facing countries and international organisations in enabling access to medicines for all.

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Towards National universal health care systems

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In this paper I will argue that we need a paradigm shift to ensure that public health care needs are put at the heart of our health care systems. Markets have singularly failed to deliver universal health care on the basis of need. The best example of this is the US with its highest expenditure on health care, high user charges (co-payments), and high administrative and transaction costs, which account for 30-50% of costs.[122] The US is one of the most marketised, inefficient and unequal systems in the western world and yet US health care is rapidly becoming the model maker for health care systems across the world. According to an Institute of Medicine report in 2012

"The costs of the system's current inefficiency underscore the urgent need for a system-wide transformation. The committee calculated that about 30 percent of health spending in 2009 -- roughly $750 billion -- was wasted on unnecessary services, excessive administrative costs, fraud, and other problems. Moreover, inefficiencies cause needless suffering. By one estimate, roughly 75,000 deaths might have been averted in 2005 if every state had delivered care at the quality level of the best performing state."[123]

Public health need is not at the heart of the US health care system, and neither is universal health care, and thus the goal of universal health care and coverage will never be achieved. The US health care marketised system fails its citizens because public health needs are uncoupled from the very systems that are supposed to respond to them. In the USA, public spending on health care is broadly comparable to public spending by most countries with universal health systems. However, the USA does not achieve universality, or anything like it, because much of the public and private spending is absorbed by market-driven costs and wastage, and also by the private sector's ability to determine and control how resources are spent. From a public health perspective this is plainly inefficient. Not only does it represent a huge loss of productive health capacity, but to the extent that the wastage is publicly funded it also wastes scarce tax resources.

In 2015, the two major international health agencies, the WHO and the World Bank Group, jointly announced that universal health care "is a critical component of the new Sustainable Development Goals (SDGs)", which have replaced the Millennium Development Goals as the standard against which to measure policy progress in population health. Included among the SDGs is target 3.8 to "Achieve […] access to quality essential health care services and access to safe, effective, quality and

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[122] Yong P, Olsen L. Lowering costs and improving outcomes: workshop series summary. The Healthcare Imperative. National Academies Press 2010; Available at: http://www.ncbi.nlm.nih.gov/books/NBK53942/

[123] Committee on the Learning Health Care System in America. Best care at lower cost: the path to continuously learning health care in America. National Academies Press 2012; Available at: http://iom.nationalacademies.org/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx

affordable essential medicines and vaccines for all”. The agencies declare: “Supporting the right to health and ending extreme poverty can both be pursued through universal health coverage.”[124]

In this lecture I will show that if we are to restore, protect, and implement access to universal health care as the goal of all countries, we need first to understand how the principles of public health need, redistribution, and risk-pooling or social solidarity are alienated by markets and marketisation. Markets operate through selection and exclusion, transferring risks and costs back to the users of services and denying care to those that need them most. Risk selection and exclusion is built into the design of market bureaucracies; inclusion and redistribution must be built into the systems of public administration for universal health systems. When the law sets out what a government has committed itself to do for its citizens, it is the task of the administrative bureaucracy to determine how the functions will be implemented and whether the goals will be achieved.

Three general questions for an administration committed to universal health care

The social movements mobilising for universal health care and welfare in the early 20th century argued for and experimented in different forms of collective ownership and accountability. The first and second world wars of the 20th century exposed the great gulf between those that had and those that did not have. Municipal socialism, while it was an improvement on philanthropy or charity, could not remedy regional and national inequalities in access and funding. The early Bismarckian systems of insurance for workers did not work because they excluded the old and women and children; ie, selection was taking place. For this reason Beveridge systems were premised upon using a general tax base to cover the whole population and are deemed the most efficient.

Where countries have pledged to provide universal health care they must raise the money accordingly. The question they must address is: what is the best way to raise money and distribute it so that the duty can be discharged and at least cost? This question bears on the issues of resource equity in society and particularly on the role of health spending in redistributing resources from the rich to the poor and from the well to the sick. The extent to which the laws of the country will allow any of its citizens or residents to be excluded from health care plays out in three testable questions. The first is the extent to which low incomes are barriers to access, that is, the extent to which patients are required to pay at the point of use (so-called out-of-pocket payments or user charges) for the services that they need instead of paying in advance through taxes or insurance. The second is the extent to which advanced payments (instead of user charges) are equitably calibrated and collected either through insurance premiums or taxes, that is, are in line with earnings or income. And the third concerns how health care funds are allocated according to health care needs.

Financing to maximise universality and social solidarity

Solutions to the first two questions depend on the way in which governments raise money to pay for health care, that is, on which type of financing maximises universality and equity. Evidence shows that universality is more likely to be achieved when out-of-pocket payments are minimised and personal incomes cease to be a barrier to access. In many countries, user charges, or private spending, entail catastrophic costs for the household and the individual because of the way they redirect resources from other necessities of life and basic household expenses. User charges pass risk back to the individual and penalise those most in need. Medical costs are a common cause of personal bankruptcy in all countries. In the USA they account for three fifths of all bankruptcies.[125]

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[124] World Health Organization. Sustainable Development Goals. https://sustainabledevelopment.un.org/?menu=1300

[125] CNBC. Medical bills are the biggest cause of US bankruptcies: study. http://www.cnbc.com/id/100840148

If money is raised in advance rather than at point of use, it needs to be raised by methods that impinge least on the incomes of the poor. (Since poverty and income inequality are the main causes of ill health it would be paradoxical to raise health funds by means that deepened or failed to address either.) The most equitable funding mechanism is progressive direct tax. The main alternatives, social insurance or private insurance, both involve user charges, sometimes substantial, at point of use and have more limited capacity to address inequality by spreading costs across the whole of the population (a practice known as "risk pooling"). In voluntary and private insurance, although financial risks are pooled in the group and across members, the system is not comprehensive, allowing insurers to select out those they will insure and to price risks and excluding those who cannot pay.[126]

In a public health care system, the optimal form of financing is progressive taxation with a maximum separation between the user and the caregiver to reduce any conflicts of interest. There are concerns that adoption of the phrase "universal coverage" for "universal access" is a coordinated attempt to promote private insurance over direct taxation. Coverage is a term that derives from insurance systems. (A tax-financed national health system cannot be described as "insurance cover" because a country cannot insure itself against itself.)

Global health NGOs, including those funded by Gates and western governments, have displaced the state in the funding and provision of health care in many parts of the world, especially the poorest countries. It is well established that global PPPs promote and actively implement the US model of managed health care, ie, mixed payment schemes including user changes, social and private health insurance, and corporate ownership through fragmented, selected, targeted, vertical health systems programmes with little or no direct public or political accountability and with incomplete care, in effect displacing what remains of public health care.

Allocating resources to meet health care needs

But raising money equitably is only half the battle; resources must be allocated according to need if universality is to be achieved. Clearly, if health care money is not allocated according to need or is siphoned off for non-health care purposes, health care budgets are likely to be underestimated for some parts of the population and over-estimated for others.

Whether markets or market-like bodies are capable of needs-based allocation is a testable question in practice. One key measure concerns the extent to which the institutions within a health system that are responsible for securing health care and the institutions that provide it are inclusive, that is, are responsible for everyone in a geographical area and are not able to exclude more expensive population groups such as the elderly and the chronically sick. Were selection of this type to occur the universal goal would be more expensive to achieve or might not be achieved at all. Systems based on private insurance or privately run production of provision are inherently selective. In these systems corporations manage their financial risks by excluding high cost patients or by limiting the range and nature of services available.

The difference between market-driven health care and universal health services underpinned by public health needs is in the approach to need through risk sharing and redistribution. Public health services oriented towards the goal of universal health care must collectivise and pool risk across the whole population in order to ensure everyone is covered comprehensively and to prevent any selection. The healthy and the wealthy pool their risks with the poor and the sick. No one should be

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[126] Pollock AM, Price D. The breakup of the English NHS: the new market bureaucracy needs information systems based on members and not geographic populations. Michael Quarterly 2011;8:460–75.

excluded or denied care on the basis of need. It is the government's responsibility to manage the risks and costs of care. Money should be raised on the basis of ability to pay, ie, progressive taxation, usually from healthy and the wealthy. Services must be funded and delivered on the basis of need, which means the old, the sick, and the poor receive most care because they have greatest needs. Equity or fairness and accountability must be designed into the whole system whether it be for patients or staff through salaries and wages and national terms and conditions of services, or in the design of information systems for monitoring and planning and meeting public health needs.

Just as risk and profit are not part of the lexicon of public health systems, neither are needs and equity in a health care market.

In a marketised system and market bureaucracy, the management of financial risks is paramount. A market can only work if it can select the risks it is prepared to take and choose the services it wishes to provide. Providers require freedom to operate, to pick and choose, to create niche markets, and to apply exclusion criteria and deny care. A market requires complex systems to manage risk. Risks must be anticipated in a market, identified, measured, quantified, and allocated. Services must be unbundled, risked, and priced so they can be selected. Risk allocation occurs through a contract. Risk 'sharing' means passing risks back to the purchaser or to the consumer. Selection on the basis of risk has to be built into the design of the information systems and the bureaucracy. Risk management involves risk selection methods, risk segmentation, risk identification, and risk stratification methods, which are then built into pricing. These tools inform the information requirements and are the tools of market bureaucracies.

When a system is designed on the basis of public health need and equity it naturally follows that social solidarity or redistribution is required, ie, that access should be on the basis of need. But the design does not happen by chance. It requires careful planning and a technocratic apparatus underpinned by a state bureaucracy. A market bureaucracy needs information to support selection, through risk segmentation and risk allocation through risk pricing. Budgets must be set aside to pay for commercial contracting, for advertising, for marketing of goods, and for performance management in order to ensure shareholder returns.

In a market, money leaks out of the system in a variety of ways, and is distributed away from public health care and needs. Markets incur costs that an integrated public health care system does not, namely administration, marketing, transaction costs, and profits. All of these additional costs channel money away from services to support shareholders' interests. In a market, money saved by so-called improvements in efficiency and service redesign is channelled away from staff and services. In the US these costs are at least 30% of the total health care budget, but in a public system as little as 5%. But markets can also have other consequences including creating unnecessary demand that is not reflected in need, and under-consumption, over-consumption, and the denial of care. They also result in decreased public accountability and loss of direct control and loss of trust, for reasons I will show later.

Redistribution, inclusion, and need are not central concerns in a market bureaucracy. It is possible to understand the degree of marketisation in a system by looking to see the extent to which there are mechanisms for risk selection in the bureaucracy and to compare these with the mechanisms for risk pooling and redistribution (Table 1).

Table 1 Comparison between public and marketised health care systems in approach to risk and redistribution and selection

	Universal access **Risk pooling and social solidarity** **Inclusion**	**'Market Systems'** **'Targeting' and selection on basis of risk**
Methods of funding / financing	**Progressive taxation** • Social Insurance • Central taxation	**Regressive taxation** • Private insurance • Local taxation • Charges
Resource allocation	**Risk pooling – geographic area** • Allocations on basis of population needs	**Individual** • Capitation payments based on risk • Membership -based
Organisation	**Planning authorities** • 1, 2, 3 levels of service within a geographic population • Not - for- profit	**Providers/ companies** • Regulators • Enrolees/ members • Combine insurance + provider
Services provision	**Direct management of services and integration** • Block budget, salaries, state ownership • Public –direct management	**Service unbundling** • Pricing and competition • DRG
Accountability	• National and local electorate, users, staff • Public information	• Shareholders, boards

How should the service delivery system be designed to promote universality?

A great deal is written about how to achieve redistribution in financing but far less attention has been paid to fairness in resource allocation and health service delivery. Politicians claim that it doesn't matter who delivers the services so long as they are publicly funded, ignoring how the uncoupling of services from consideration of funding, redistribution and risk pooling is deeply problematic. If the function is to meet needs as fairly as possible, then everyone must be automatically covered, and no one can be excluded or left out. So steps must be taken to prevent risk selection and wasteful diversion of funds. The most common approach in a public system is to allocate funds to contiguous geographic area based authorities that have the responsibility for meeting the needs and planning for all people in the area through a duty to provide. Resource allocation formulae are developed on the basis of need so that funds should flow on the basis of the population needs for services in a geographic area. When funds shift away from geographic areas to insurance pools or funds, the terms of coverage change to membership or eligibility. Insurers or commissioners can pick or choose their members, selecting them and offering services on the basis of financial risk. The population is unstable due to high levels of enrolment and disenrollment and not representative of the general population.

In a public system, services are usually directly administered and managed through integrated geographic area based management structures, or, where services are put out to tender, through a purchaser-provider split. But this split devolves financial risk to providers and undermines redistribution and the ability to plan for need. It also increases administrative costs and overall control and public accountability is diminished (as I will show later). This is because loss of public control leads to changes in the management and allocation of risks in the system. When services are integrated and directly managed through an area authority, financial risk is held collectively at national or regional level for the geographic population, ie, it is pooled and everyone is covered. When provider organisations are created as firms with their own duties to break even or make a surplus, financial risk is devolved to them. The risk pool is further fragmented and segmented when providers are free to decide which services and patients they will tender for and which they will not, ie, risk select in the market place. The effect is to undermine planning and to disrupt services and information systems and public control[127].

Private operators with a primary duty to boards or to shareholders, not their local community will engage in risk segmentation and risk selection strategies focusing on profitable treatments, goods and patients, so that their interests may no longer align with the area authority or even the purchaser, especially when they have power to lobby independently. This activity can lead to rigged trade, known as adverse selection and moral hazard. Over time, buyers and sellers have access to different information which is often incomplete, known as asymmetric information. Providers will selectively participate in trades which benefits them the most, but needs are not necessarily aligned with those benefits.

Public accountability and strong information systems

It goes without saying that public services require a strong degree of democratic control and public accountability, and must be underpinned by strong information systems if they are to respond to public needs. A less explored feature of public health care systems is the way in which information systems and integrating mechanisms that are essential to meeting public health needs are stripped out and altered as part of the trend to marketisation and use of private providers. Market systems use different types of activities and tools to support their goals. Commercial contracting is the mechanism for risk transfer in a market but it is also the main mechanism for deciding and determining control. When information on contracts is concealed from the public and is no longer in the public domain (because it is either a trade secret or commercial in confidence) the public interest is no longer served. This is the case for commercial contracts when services for long term care, pharmaceuticals, and public private partnerships (PPPs) in infrastructure are contracted out.[128]

Public trust

In the UK, public support for the NHS is very high, higher than in many other countries.[129] This has been achieved without marketing strategies - simply by providing universal care and services – on the basis of high trust. In contrast, in highly marketised systems such as the US public support and trust is low, although marketing costs are high. US surveys show the majority of people think health care

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[127] Pollock AM, Price D. The break-up of the NHS: implications for information systems. In: Watson P, editor, Health care reform and globalisation: the US, China and Europe in comparative perspective. London: Routledge 2012. 25–39.

[128] Pollock A, Macfarlane A, Godden S. Dismantling the signposts to public health? NHS data under the Health and Social Care Act 2012. BMJ 2012; 344:e2364.

[129] Commonwealth Fund. 2010 Commonwealth Fund International Health Policy Survey. http://www.commonwealthfund.org/publications/surveys/2010/nov/2010-international-survey/

needs fundamental change and reform.[130] In a market, where denial of care goes hand in hand with overtreatment and fraud, people must be persuaded to buy goods and services they do not need or to choose from competing providers. This involves creating a bureaucracy to support marketing or setting aside funds to buy in public relations and marketing support to persuade people to buy services they do not need and to screen out the people the market does not want to provide for.

In order to convince the public that a move from a public service to an unaccountable marketised system is necessary, the government must convince the public that the risks of keeping public health care are too great and that the public sector is failing and cannot be brought to account. Information must be suppressed and concealed. Myths and false information also confuse the record. Examples of these myths include the myth of infinite demand, the myth of consumer choice, the myth of demographic time bomb, and the myth of unaffordability and spiralling health care costs. These myths divide the population against itself into the deserving and the undeserving, instead of focusing on those who need care.

The private sector is presented to us as a virtuous solution. The argument is that the private sector will give the consumer competition and choice, add additional capacity, decrease red tape and bureaucracy, and lead to increasing innovation and efficiency. And as for loss of public control and direct accountability – the government makes a virtue of this too, telling us that the role of government is to steer, not row, and that it doesn't matter who owns and operates the system so long as it is funded by the taxpayer and regulation is in place to deal with market failure.

In the following three case studies I will examine what happens when public services are marketised, and the ways in which public health needs for those services are dislocated from the planning and provision of health services. I will show the shift to risk selection instead of inclusion, and how funding is diverted away from care instead of being pooled and redistributed; how information is lost; and, ultimately how the risks and costs of care are passed to the patient as the goals of redistribution and equity of access are peripheralised. The first two examples, privatising elective surgery and PPPs for health care infrastructure, look at what happens when public services are uncoupled from an integrated public health system and marketised. I have written about these at length elsewhere and so have summarised key findings; the main literature is referenced and in the public domain at www.allysonpollock.com

The third case study of medicines and vaccines is a study of global market failure. Traditionally, pharmaceutical production has always been a private sector domain activity and the key role of the government is regulation of the industry using marketing authorisations, pricing, quality standards, and financial incentives. Many middle- and low-income countries have had public production of medicines to address local needs for essential medicines and vaccines and reduce their dependence on imports, but little is written about this.

In 1997, the WHO published a report. *Public-private roles in pharmaceutical sector- implications for equitable access and rational drug use* highlighting that many public production initiatives were not successful and outlining the options for the government to regulate and control private industry in specific instance of market failure.

> *"Brazil, China, Egypt, India, Indonesia, Nepal, Sri Lanka and a number of former centrally-planned economies are examples of countries which had large state-owned and usually state-*

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[130] How SKH, Lay J, Schoen C. Public views on U.S. health system organization: a call for new directions. The Commonwealth Fund: http://www.commonwealthfund.org/~/media/files/publications/data-brief/2008/aug/public-views-on-u-s--health-system-organization--a-call-for-new-directions/how_publicviewsushltsysorg_1158_db-pdf

> *managed production. A number of other governments have started and then discontinued government production or are attempting to upgrade existing state production facilities."*[131]

So it seems timely to examine the extent to which market production and government regulation is meeting public health needs in the context of the Sustainable Development Goals of universal health care and access to medicines.

Case study 1: Private elective surgical treatment centres: creating additional capacity to meet 'unmet need' and long waiting times

Hip arthroplasty has been described as the operation of the 20th century, as it is one of most common elective surgical procedures. In Europe and in Canada, long waiting lists and waiting times for the procedure in the public sector are used by governments as a major justification for bringing in the private sector. Governments argue that the private sector is additional to the public sector and will also reduce the problems of legal challenges from patients and ensure that individuals get access to access to health care they need.[132] [133]

In England, waiting lists and waiting times were invoked by the UK government as a major justification for inviting large multinational corporations to bid for £5.6 billion worth of government contracts to provide NHS funded surgical treatments to patients. Since 2003, the English government has, in effect, opened up public services to the market by requiring that elective surgery and associated diagnostics are unbundled and priced for the market place. It did this by top-slicing national budgets and requiring or incentivising area authorities to unbundle elective surgery, price the procedures, and place contracts at local level.

Public accountability and information

i) public expenditure

There has been no systematic scrutiny of the policy of using the private sector in England, as business cases and contracts for independent sector treatment centres (ISTCs) have been withheld or redacted by the Department of Health (DH) on grounds of commercial confidentiality, making independent scrutiny, even by the House of Commons Health Select Committee (HSC), impossible.[134] The National Audit Office has yet to assess the performance of ISTCs despite the parliamentary HSC recommending it to do so in 2006.[135] [136] As private sector organisations performing public functions,

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[131] World Health Organization. Essential Medicines and Health Products Information Portal http://apps.who.int/medicinedocs/en/d/Jwhozip27e/

[132] Quigley HL. Cross-border healthcare in Europe: clarifying patients' rights. BMJ 2011;342:d296. Available at: http://www.ecabeurope.eu/PDF/BMJ%2011Feb11.pdf

[133] Treatment Abroad. Your rights to treatment in Europe.Intuition 2011. Available at: https://www.networks.nhs.uk/nhs-networks/cross-border-healthcare-network/documents/EU%20Treatment%20Guide.pdf

[134] Select Committee on Health. Written evidence. Further supplementary memorandum submitted by the Department of Health (ISTC 1E) March 2006. Available: http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/934/934awe09.htm

[135] Select Committee on Health. Fourth Report. Conclusions and recommendations. Available: http://www.parliament.the-stationery-office.com/pa/cm200506/cmselect/cmhealth/934/93410.htm

[136] Naylor C, Gregory S. Briefing. Independent sector treatment centres. 2009. Available: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/briefing-independent-sector-treatment-centres-istc-chris-naylor-sarah-gregory-kings-fund-october-2009.pdf

ISTCs are not subject to the Freedom of Information Act 2000, so that around £5 billion paid by the NHS to the private health care sector has remained essentially unaudited.[137]

From the available information on some projects we do know that in England, DH figures show that of the initial £1.7 billion paid out to the private sector for treatments and diagnostic procedures under the ISTC programme from 2003 to 2010, £252 million (14.8%) was given for work that was not carried out. In one contract alone, the company Netcare did not perform 40% of the work it had been contracted to do, receiving £35.1 million for patients it never treated.[138]

ii) additional capacity

When the government stated that the private sector would bring in additional capacity including beds and staff, doctors maintained that diverting funds to the private sector would accelerate loss of public sector provision. In February 2006, after four years of the market experiment with private sector contracts, Bernard Ribeiro, president of the Royal College of Surgeons of England, wrote to the HSC that ISTCs were leaving "NHS facilities under-utilised with a concurrent deleterious effect on fragile NHS Trust financial balances".[139] In the event there was no record of additional capacity being provided by the private sector as data on beds and staff were not collected. Meanwhile public sector bed provision continued to contract against rising bed occupancy rates and deficits. Staff were simply displaced from the public to the private sector. The private sector substitution came at the cost of the public sector. The finite pool of doctors and nurses (trained and employed by the public sector) was switched to the private sector, undermining integration and hollowing out public sector capacity.[140]

As for numbers and rates of treatment, our work in Scotland on the use of the private sector showed that the private sector did not create additional capacity for beds, staff, or treatments. Moreover it did not fulfil its contracts and was paid for work it did not do.[141] Private sector activity substituted for the public sector as activity in the public sector fell and inequalities in access among older people increased.[142]

Market segmentation and risk selection

The private sector had carefully designed the contracts to allow it to select out low risk, and select in healthier patients with no complications. This was necessary as it didn't have intensive care facilities for more complex cases.

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[137] Information Commissioner's Office. What is the Freedom of Information Act? Available: https://ico.org.uk/for-organisations/guide-to-freedom-of-information/what-is-the-foi-act/

[138] Moore A. NHS out of pocket as contract ends for cataract treatment centre. Health Service Journal 14 May 2009. Available at: http://www.hsj.co.uk/news/policy/nhs-out-of-pocket-as-contract-ends-for-cataract-treatment-centre/5001278.article#.U-3XYmPVX5M

[139] Select Committee on Health. Written evidence. Evidence submitted by the Royal College of Surgeons of England (ISTC 39) http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/934/934we41.htm

[140] Pollock A, Godden S. Independent sector treatment centres: evidence so far. BMJ 2008;336:421–4.

[141] Pollock AM, Kirkwood G. **Independent sector treatment centres: learning from a Scottish case study.** *BMJ* 2009;338:b1421. Available at: 10.1136/bmj.b1421

[142] Kirkwood G, Pollock AM, Howie C et al. **NHS Scotland reduces the postcode lottery for hip arthroplasty: an ecological study of the impact of waiting time initiatives.** *J R Soc Med* 2014;107(6):237-245.

The Royal College of Ophthalmologists stated that the diversion of funds for elective surgery away from NHS hospital eye services to ISTCs threatened the provision of comprehensive ophthalmic care for whole communities – emergency care for injuries or retinal detachments, and the management of chronic blinding conditions such as diabetic retinopathy, glaucoma, macular degeneration, and children's eye problems. As a result, publicly run NHS eye units are now closing (instead of replacing ophthalmologists who retire) and as they become unviable, this will require patients – mainly children, the elderly, and visually impaired people – to travel further for care.

The Royal College of Surgeons has stated

"Imbalances are occurring with destabilisation of existing NHS facilities. There has been no evidence of innovative technical advance in the ISTCs established in the First Wave programme. Significant sums of public money have been paid for surgical procedures which have not been taken up. There is clear evidence from a number of areas that triaging arrangements has diverted patients into ISTCs leaving existing NHS facilities under-utilised with a concurrent deleterious effect on fragile NHS Trust financial balances. There is also evidence to show that training of surgeons in adjacent NHS hospitals has suffered."[143]

The contracts ensured that the NHS takes back the risks when things go wrong including legal liability, revisions, readmissions, emergency treatments and clinical follow-up.

Innovation: safety and training concerns

The private sector claims of innovation are not supported by evidence. Netcare's medical director Dr Dinesh Verma resigned (after only six months in post in October 2004), having "repeatedly raised concerns about on-call cover, continuity of care and access to complete outcome data for audit", as reported by Hospital Doctor. Local NHS hospitals are also accommodating patients who suffer adverse incidents at the ISTCs, often requiring months of ongoing care, such as cataract surgery that resulted in blindness and necessitated further surgery to prevent blindness. The Royal College of Ophthalmologists had also told the government in 2006 that it had evidence of outdated practices with adverse results for patients. They warned that ISTC procedures by overseas visiting teams had to be raised to UK standards, and that there was also a complete lack of training in any ophthalmic ISTC. The programmes had limited training responsibilities and only accepted the "simplest cases".

Impact of marketisation can be more easily shown in public systems

In our research we were able to show the impact of the policy because we had data on beds, staffing, funding, activity, and treatments, we had the contracts, and we could follow the money, the patients, the resources (beds and staff), and the activity. The strong systems of public accountability underpinned by public information allowed scrutiny of the policy.

But in more privatised systems it is much more difficult to show what is happening. For a private company it is impossible to follow the money and the decisions taken. In Brazil, for instance, although there is a constitutional right to health care and a public health care system, it is underfunded. An analysis of publicly available data show almost a 70-fold difference in treatment rates in the public sector compared to those in Scotland with a similar demographic profile and a not dissimilar supply of

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[143] http://www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/934/934we41.htm

physicians. The lack of the data on the private sector and activities of physicians in the private sector in Brazil is a major issue.[144]

Summary

Uncoupling the funding and the provision of elective surgical services involves unbundling services, pricing them for the market and allocating risks. The risk pool is disrupted as risks are identified and reallocated through a commercial contract. Selecting out of services and patients occurs. Services were fragmented and segmented, and inequalities in access increased, especially for older people. Ie. those with highest needs. The policy of shifting elective surgery to the private sector hollowed out the public sector in five ways. First, it switched some services, activity and resources including capital budgets, staff and funding to the private sector, to transaction costs and profits. Second, it broke up and destabilised public services, leaving them with the risks of more difficult patients and complicated patients and having to deal with risky patients and complications. Third, the claims of innovation were not supported. Fourth, efficiency and value for money did not occur, and the private sector was paid for wok it did not do. Fifth, the lack of information on contracts, which were not published and which were deemed commercial and in confidence, on contract performance, and on staffing, provision, and activity, undermined parliamentary systems for public accountability. Public health needs were not central to the policy of privatisation.

We published our analysis in Scotland, and on 18 October 2009 Nicola Sturgeon, the first Minister of Scotland, said that from January 2010 the private sector treatment centre would revert to being provided in and by the NHS.[145]

> "This government is committed to ensuring Scotland has a health service which is truly publicly funded and delivered. This is another step towards achieving this goal. Currently the private sector provides the service at Stracathro but the NHS pays for it – which means, of course, that the NHS pays not just for the service provided but for the profit margin as well… from January, it will be delivered in and by the National Health Service."

Responding to public health care needs a political affirmation, as it is a political decision. The policy of using the private sector was abandoned in Scotland but continues in England as part of market driven ideology.

Case Study 2: Public Private Partnerships in infrastructure

My second example is the use of private finance in public infrastructure, in which government cedes control over public buildings and land to the private sector through a commercial contract that is the mechanism for allocating property rights for periods of 30 to 60 years. In my view, this is the engine for privatisation and one of the major drivers of market driven health care, allowing global markets access to public funds and is a mechanism for liquidating public land and ownership. After the Second World War, when private capital was bankrupt, and land and buildings had little or no value, a programme of state nationalisation or indeed state capitalism was required. Today the situation is different. Public land value has been inflated and property is seen as a safe haven for investment, especially with interest rates low. Increasing property prices have resulted in lucrative returns especially where the private sector is involved in the delivery of public services through public private partnerships infrastructure. Public services and infrastructure built for the delivery of public services

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[144] Jonathan Filippon, personal communication

[145] The Scottish Government. Stracathro hospital returns to NHS. 18 October 2009. http://www.scotland.gov.uk/News/Releases/2009/10/16165310

are a new safe haven for foreign direct investors to invest and to extract returns and accumulate capital. When public services are delivered through public private partnerships under long term contract, the government acts as tax collector, channelling public money as unitary payments to the private sector. This has been described as rent extraction or rent seeking behaviour. Just as patents confer property rights and on pharmaceutical companies for 20 years, under public private partnerships the public sector awards 30 to 60 year contracts to the private sector.

As with the example of elective surgery, public land and buildings are unbundled and transformed to a stream of services. There are four preconditions. First, the rules that govern public expenditure should make it difficult for government to borrow directly and invest directly in capital projects, ie, reductions in capital budgets for capital projects. Second, capital controls should be loosened to allow foreign investors. Third, there needs to be a mechanism to transfer property rights from the public sector to the private sector, and to transform those property rights into a stream of payments for services payable through a contract. Finally, the private sector requires protection of those property rights in the event of a change in government policy or reductions in public expenditure.

The impact of the private finance initiative (PFI) has been devastating – the high costs of paying the annual lease charges have drained public sector budgets, diverted funds to corporations, legal firms, management consultants and shareholders, and created major affordability problems, pushing local hospitals into deficit. The result of diverting the money has been to reduce numbers of beds, reduce levels of service provision, reduce numbers of staff and treatments, and disrupt information systems and planning.[146] [147]Services are closed to pay the PFI debts, reducing access and entitlements. Servicing the PFI debt has been at the cost of patient care.[148] It was possible to research this and show the devastating effects because the NHS was a public system and had good data on beds, staff, treatment, and money, and it was possible to follow the money and the activity to look at the consequences.[149] However, the private sector property rights trump public health needs. When public expenditure is reduced, the contracts are ringfenced and guaranteed and must be paid. The contracts ensure the revenue to the private sector behaves in effect like a hypothecated tax, and so, when faced with budget reductions, the public authority and the provider has no choice but to reduce services and cut staff.[150] But the problem is that, rather like pharmaceuticals, the export of PFI and PPPs for infrastructure is big business and there are many vested interests including politicians, lawyers, management consultants, and accountants.

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[146] Pollock AM, Price D, Kondilis E, Freitag A, Harding-Edgar L. Planning for closure: the role of special administrators in reducing NHS hospital services in England. BMJ 2013;347:f7322–f7322.

[147] Pollock AM, Dunnigan M, Gaffney D, Macfarlane A, Majeed FA. What happens when the private sector plans hospital services for the NHS: three case studies under the private finance initiative. BMJ 1997;314:1266-1271.

[148] Hellowell M, Pollock AM. The private financing of NHS hospitals – politics, policy and practice. Economic Affairs 2009;29:13-19.

[149] Pollock A, Price D, Liebe M. Private finance initiatives during NHS austerity. BMJ 2011;342:d324 - See more at: http://www.allysonpollock.com/?page_id=11

[150] Pollock AM, Price D. PFI and the National Health Service in England. 2013. http://www.allysonpollock.com/wp-content/uploads/2013/09/AP_2013_Pollock_PFILewisham.pdf

Case Study 3: Pharmaceuticals and global market failure

Medicines are big business. In 2014 the revenues of the industry were estimated at around US$1.3 trillion.[151] According to the WHO, 10 drugs companies control over one-third of this market, several with sales of more than US$10 billion a year and profit margins of about 30-40%. Six are based in the United States and four in Europe.[152]

Providing essential medicines is one of the core obligations of the 164 states that have agreed to recognise the international human right to health (General Comment 14). Providing immunisation against major infectious diseases, taking measures to prevent, treat, and control epidemic and endemic diseases, and ensuring reproductive, maternal, and child health care are also among their priority obligations.

Yet, the market in medicines continues to fail many millions of people throughout the world. Millions of people's lives are saved by medicines, millions of people go without the medicines they need, millions of people take ineffective or harmful medicines, and millions of people are harmed by taking medicines they do not need. According to the WHO, over one third of the developing world's people are unable to receive or purchase essential medicines on a regular basis.[153]

Currently, sixteen percent of the world's population living in high-income countries account for over 78% of global expenditures on medicines and there is a singular lack of alignment between the top 20 therapy areas, which account which account for 42% of spending and public health needs worldwide.[154] [155]

Industry is not required to develop and produce medicines to meet public health needs nor to make medicines universally available. The tension between economic growth and trade and public health need are well known. The pharmaceutical industry maintains that it drives economic growth as a major employer, investing in research and development and innovation, and that economies of scale are required to ensure efficient and high standards of production and high quality and safe medicines through investment in capital and equipment, which is far more than most countries could afford.[156]

According to the WHO however there is "an inherent conflict of interest between the legitimate business goals of manufacturers and the social, medical, and economic needs of providers and the

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[151] Deloitte. 2015 Global life sciences outlook: Adapting in an era of transformation. 2015. Available at: http://www2.deloitte.com/content/dam/Deloitte/global/Documents/Life-Sciences-Health-Care/gx-lshc-2015-life-sciences-report.pdf

[152] Statista. Statistics and facts about top pharmaceutical drugs: Available at: http://www.statista.com/topics/1497/top-pharmaceutical-drugs/

[153] World Health Organization. Trade, foreign policy, diplomacy and health. Access to medicines: http://www.who.int/trade/glossary/story002/en/

[154] Kaplan W, Wirtz VJ, Mantel-Teeuwisse A, Stolk P, Duthey B, Laing R. Priority medicines for Europe and the world 2013 update. http://www.who.int/medicines/areas/priority_medicines/Mast erDocJune28_FINAL_Web.pdf

[155] World Health Organization. Global status report on noncommunicable diseases 2010. http://www.who.int/nmh/publications/ncd_report_full_en.pdf

[156] IFPMA. The pharmaceutical industry and global health- facts and figures 2012. IFPMA: http://www.ifpma.org/fileadmin/content/Publication/2013/IFPMA_-_Facts_And_Figures_2012_LowResSinglePage.pdf

public to select and use drugs in the most rational way". [157] The question for governments is, given that the funding, research, and production of medicines is uncoupled from public health needs and the delivery systems, how is universal access to be ensured?

Does the financing of medicines maximise social solidarity and inclusion?

Globally medicines are impoverishing the world's poor and are a key driver of inequalities in health care. The financing of medicines is highly regressive and non-transparent. On average 24.9 % of a country's total health expenditure is spent on medicines, with a wide range from 7.7% to 67.6%, but the source of spending varies enormously.[158] In general the more marketised the health system, the higher the overall share of total health expenditure and the costs to the individual. The financing of drugs is highly regressive and comes from three main sources.

i) private expenditure
Since 1995, the private share of total pharmaceutical expenditure has increased across the world. According to the WHO, across all income groups, private spending by households in 2000 was the principal source of pharmaceutical expenditure, at 57.8% in high income, 70.9% in middle income, and 71.6% in low income countries.

User charges are highly regressive and a barrier to access.[159] When coupled with weak health systems, user charges are a major cause of patients not receiving the medicines they need, and of financial hardship. A single course of medicines for common conditions such as malaria or diabetes in many countries may cost several days wages.[160] In low, middle, and high income countries drug bills can be a cause of personal bankruptcy. For example, in the US, health care costs, including medicine costs, account for three fifths of all bankruptcies.[4] The private sector argues that user charges are a means of demand management and solve the problem of moral hazard, ie, the problem of someone taking more risks or over-consuming because someone else is paying.

High prices and lack of availability of medicines in the public sector are a common feature of health systems with high public expenditure on medicines, especially in low income countries. In one study, average public sector availability of generic medicines ranged from 29·4% to 54·4% across WHO regions while private sector patients paid nine to 25 times international reference prices for lowest priced generic products and over 20 times international reference prices for originator products across WHO regions.[161]

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[157] World Health Organization. Trade, foreign policy, diplomacy and health. Pharmaceutical industry. http://www.who.int/trade/glossary/story073/en/

[158] Lu Y, Hernandez P, Abegunde D, Edejer T. The world medicines situation 2011. Medicine expenditures. World Health Organization Geneva 2011. http://www.who.int/health-accounts/documentation/world_medicine_situation.pdf

[159] World Health Organization. Access to affordable essential medicines. http://www.haiweb.org/medicineprices/23092009/MGD8E_EMs.pdf

[160] Cameron A, Ewen M, Auton M, Abegunde D. The world medicines situation 2011. Medicines prices, availability and affordability. World Health Organization. Geneva 2011. http://www.who.int/medicines/areas/policy/world_medicines_situation/WMS_ch6_wPricing_v6.pdf

[161] Cameron A, Ewen M, Degnan D, Ball D, Laing R. Medicines prices, availability, and affordability in 36 developing and middle-income countries: a secondary analysis. The Lancet 2009;373(9659)240-249. http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(08)61762-6.pdf

ii) other health system expenditure

Government funding and social insurance and private insurance are the other sources of financing. While money for medicines is part of the budgets for public health systems, because the production of medicines is not integrated into services the money flows back out through commercial contracts to buy pharmaceuticals (as with PFI and elective surgery above). Pharmaceuticals account for around 15% of public health care expenditure and as much as 31% in low income countries, and still many needs for essential medicines are still not met (see below) because medicines are not available or the prices are too high.

One additional source is donor financing through global financing mechanisms such as PEPFAR (the US President's Emergency Plan for Aids Relief), the Global Fund, GAVI, and development loans, which redistribute money mainly from taxpayers in developed countries to patients in low and middle income countries. These have been shown to increase access to essential medicines. The distribution of benefits however depends on the terms negotiated and the long term financing implications.

iii) tax breaks

Further distortions are introduced into financing by the fact that global drug companies protect their profits through tax breaks and tax incentives and locating their companies to minimise corporation tax.[162] [163] The UK reduced corporation tax to 10% on drugs with patents approved by the European Medicines Agency under its 'patent box' scheme.[164]

Worldwide, corporation taxes for the pharmaceutical industry have fallen dramatically over time as countries race to compete against each other and offer tax incentives and as companies seek to minimise taxes paid. [165] [166] On its accession to the EU, Poland gave favourable tax incentives to companies.[167] In the 1980s, research by the US General Accounting Office found that pharmaceutical companies saved $15 billion by registering for tax purposes out of Puerto Rico: "17 of the 21 most prescribed drugs in the U.S. in 1990 were authorized for manufacture in Puerto Rico." [168] [169]

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[162] Corporate tax reform. Part IIB: The taxation of innovation and intellectual property. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/81506/corporate_tax_reform_part2b_innovation_and_intellectual_property.pdf

[163] Baker D. To overhaul the corporate tax code, start with drug companies. The New York Times 13 Apr 2011. http://www.nytimes.com/roomfordebate/2011/02/01/the-trouble-with-corporate-taxes/to-overhaul-the-corporate-tax-code-start-with-drug-companies

[164] HM Revenue and Customs. Corporation tax: the patent box. 2007. https://www.gov.uk/guidance/corporation-tax-the-patent-box

[165] ABPI. Research and development. http://www.abpi.org.uk/industry-info/knowledge-hub/randd/Pages/expenditure.aspx#1

[166] Willert P. Assessment of the pharmaceutical market in Poland after accession to the European Union European Journal of Health Economics 2007;8:347-357.

[167] Hall K, Kitto L. Industry issue report: taxation in the pharmaceutical industry. 2011. https://kelley.iu.edu/CBLS/files/Courses/Hall-Kitto%20Pharma%20Tax%20Issues.pdf

[168] Merrill PR. Corporate tax policy for the 21st century. National Tax Journal 2010;63(4):623-634.

[169] Devereux M, Griffith R, Klemm A. Corporate income tax reforms and international tax competition. Economic Policy 2002. Figure 24

Are the funds for medicines distributed according to public health need?

Overall, almost 60% of all pharmaceutical revenues are not spent on medicines production, and billions of pounds intended for health services, voted for by parliaments, are thus diverted away from care. According to Public Citizen's analysis of the Forbes 500 drug companies in 2003, of all revenues, 30.8% was spent on marketing and administration, 17% on profits, and 14% on R&D.[170] In the UK, the Association of the British Pharmaceutical Industry estimated that R&D was 33% of sales compared with 3.7% in the manufacturing industry, and company profits as a percentage of sales ranged from 20% to 43% in 2014.[171]

The companies claim that the high profits (17% to 43% profits) are rewards for marketing or for innovation. Across the world corporation taxes for pharmaceutical industry have fallen dramatically while in many countries personal taxation for individuals has risen. OECD figures show that personal income tax rose in 24 out of 35 countries over three years to 2010.[172]

Drug companies also claim that the high prices for patent drugs are a reward for innovation and that it costs around US$2.5 billion to develop a new drug and to bring a new drug to market.[173] Patents or monopoly property rights are a reward for the costs and time spent on innovating and developing new medicines.[174] These claims are contested, but even if true, it is important to remember that the costs of research are recouped through the prices charged to governments and patients, through the high costs of patents, and through tax breaks, tax credits, and tax incentives; the public has no say.[175]

It is difficult to compare private vs. public costs of administration due to lack of data and the fact that there is little public production. Administration costs of 30.8% in the pharmaceutical industry compare with 6% administration costs in a fully public health care system like the UK, but are comparable to administration costs in private health care companies. Vogel (2007) compared the top ten major pharmaceutical producers with the top ten generic manufacturers based on Kaiser Family Foundation data. Major pharmaceutical producers spend a higher percentage of total current costs on marketing and administration and R&D than generic producers.[176]

Risk selection and exclusion to protect market share

Risk selection and market segmentation is key to the industry operations. Much of the research carried out by industry is into ways of keeping prices high and protecting market share. For example, most expenditure on research is on developing products for western markets in order to protect

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[170] Public Citizen. 2002 Drug Industry profits: hefty pharmaceutical company margins dwarf other industries. Congress Watch 2003. https://www.citizen.org/documents/Pharma_Report.pdf

[171] ABPI. Value of the pharmaceutical industry in the UK. http://www.abpi.org.uk/industry-info/knowledge-hub/uk-economy/Pages/voi.aspx

[172] OECD. Tax burdens on labour income continue to rise across the OECD. 11 Apr 2014. https://www.oecd.org/tax/tax-burdens-on-labour-income-continue-to-rise-across-the-oecd.htm

[173] Mullin R. Cost to develop new pharmaceutical drug now exceeds $2.5B. Scientific American. 24 Nov 2014. http://www.scientificamerican.com/article/cost-to-develop-new-pharmaceutical-drug-now-exceeds-2-5b/

[174] Tufts Center for the Study of Drug Development. Cost to develop and win marketing approval for a new drug is $2.6 billion. http://csdd.tufts.edu/news/complete_story/pr_tufts_csdd_2014_cost_study

[175] Adams CP, Brantner VV. Estimating the cost of new drug development: is it really $802 million? Health Affairs 2006;25(2)420-428. http://content.healthaffairs.org/content/25/2/420.full.pdf+html

[176] Vogel R J. Pharmaceutical economics and public policy. Haworth Press, New York, 2007.

market share, and not on the major causes of death and disease. Light and Lexchin have summarised the problems as follows. The number of new drugs licensed remains at the long term average range of 15 to 25 a year. However, 85-90% of new products over the past 50 years have provided few benefits and considerable harms. The pharmaceutical industry devotes most research funds to developing scores of minor variations that produce a steady stream of profits in a process known as evergreening (see below). Heavy promotion of these drugs contributes to overuse and accounts for as much as 80% of a nation's increase in drug expenditure. Overinflated estimates of the average cost of research and development are used to lobby for more protection from free market competition.[177]

For example, oncology drugs, offering little survival advantage while accounting for almost a tenth of all industry revenues, are an area of enormous growth in approvals and research with more than 1,682 products in development compared with a few handful for common infectious diseases, which are the major causes of death and disease worldwide.[178]

The practice of evergreening is used to develop extra patents on variations of the original drug by advocating new forms of release, new dosages, new combinations or variations, or new forms, not necessarily with any therapeutic advantage, ie, incremental innovation.[179] Insulin, with an estimated value of US$32 billion in 2014, has been kept under patent for more than 90 years. The market in insulin has consolidated so that most production is limited to four major companies.[180] [181] The additional costs caused by delays to generic entry can be very significant for the public health budgets and patients. The European Commission estimated a loss of around €3 billion due to delays in the entry of generic products caused by misuse of the patent system.[182] In many countries, including the US, people are dying because cheaper generics are not available and because the patent system is not linked to efficacy, need, and therapeutic advantage.

Marketing costs are also directed towards protecting prices and market share and revenues.[183] The practice of product branding and product placement has been shown to lead to increased health expenditure for drugs. Health Action International research shows that, in low and middle income countries in the private sector, the prices of branded medicines are not only higher but more likely to be stocked than generics, further penalising the poor.[39] Patients choose to buy branded drugs because they are concerned that generics drugs may not be of the same quality or may be spurious. So they would rather pay for higher priced medicines. Some of this may be due to the well

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[177] Light D, Lexchin J. Pharmaceutical research and development: what do we get for all that money? BMJ 2012;345:e4348. http://www.bmj.com/content/345/bmj.e4348

[178] IFPMA. The pharmaceutical industry and global health. Facts and figures 2014. http://www.ifpma.org/fileadmin/content/Publication/2014/IFPMA_-_Facts_And_Figures_2014.pdf

[179] Vernaz N, Haller G, Girardin F, Huttner B, Combescure C, Dayer P. Patented drug extension strategies on healthcare spending: a cost-evaluation analysis. PLOS Medicine 2013. http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001460

[180] HAI Global. Life-saving insulin largely unaffordable. http://www.haiweb.org/medicineprices/07072010/Global_briefing_note_FINAL.pdf

[181] Luo J, Kesselheim A. Evolution of insulin patents and market exclusivities in the USA. The Lancet Diabetes and Endocrinology 2015;3(11)835-837. http://www.thelancet.com/journals/landia/article/PIIS2213-8587(15)00364-2/fulltext

[182] European Commission 2009

[183] EFPIA. The pharmaceutical industry in figures. Key data 2014. http://www.efpia.eu/uploads/Figures_2014_Final.pdf

documented marketing and drug promotion activities of industry and their targeting of patient groups and doctors.

At the same time, governments' opportunities to put in place more rigorous pharmaceutical price controls continue to be opposed by the industry and are under assault by governments of pharmaceutical producing countries through trade treaty negotiations such as those involving the Trans-Pacific Partnership (TPP) and the Transatlantic Trade and Investment Partnership (TTIP). Both these draft treaties could outlaw or restrict the use of pharmaceutical price controls in centrally administered health systems. Such measures also threaten the use of global budgets where governments set annual limits to health spending. Rates of expenditure growth are lowest in countries that cap health budgets under central oversight rules, such as England, Italy, Japan, and Sweden, and do not allow the market, consumer demand and provider price-setting to determine global expenditure, as in the USA.

Public health needs, medicines, and health care costs

Medicines are a key driver of health system behaviour and health care costs. Pharmaceuticals account for around 15% of public health care expenditure and as much as 31% in low income countries, and yet many needs for essential medicines are still not met.[184]

While lack of availability of medicines or lack of ability to afford medicines results in increased morbidity and mortality and late and delayed treatment and medical care, so too does over-medicalisation, overtreatment and over-diagnosis.

On the one hand many medicines are considered to be a cost-effective intervention because they allow the task of administration to be shifted to health providers with shorter training and fewer qualifications, or to reduce the need for health care. [185] [186]

On the other hand, deaths and illness due to adverse drug reactions and iatrogenic medicines are a major cause of death worldwide, a cause of unnecessary admissions ,and a significant cause of health expenditure.[187] In Europe adverse drug reactions account for around 7% of patient admissions to hospitals, and in the UK NHS about one in ten of all bed days at a cost of hundreds of millions of pounds.[188]

Public health needs and the medicines approval process

Governments today have little say in the research and production activities of the global pharmaceutical industry. However, in theory they do have power to control or limit the entry of

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[184] MDG Gap Task Force Report 2008: Delivering on the global partnership for achieving the Millennium Development Goals. United Nations 2008, Sales No. E.08.I.17.

[185] World Health Organization. Health systems. First global conference on task shifting. http://www.who.int/healthsystems/task_shifting/en/

[186] WHO recommendations. Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting http://apps.who.int/iris/bitstream/10665/77764/1/9789241504843_eng.pdf

[187] Null G. The Center for Sustainable Medicine. Death by medicine – iatrogenic illness. 06 Oct 2008. http://www.sustainablemedicine.org/un-sustainable-medicine/death-by-medicine-iatrogenic-illness/

[188] Bandolier Extra. Adverse drug reactions in hospital patients. June 2002. http://www.medicine.ox.ac.uk/bandolier/extraforbando/adrpm.pdf

medicines into their own country's market place through the drug approval system and to put strict controls in place over the marketing of medicines and use in the public system. This power over approvals is shifting to regional level through harmonised centralised approval systems or national regulations. The European Medicines Agency now has a centralised approval system for new and innovative medicines which allows industry to bypass individual countries approval systems. This shift has been argued for on grounds of efficiency and limited regulatory capacity and the need to get medicines into the market and to patients faster. Speed however needs to be balanced against a country's own sovereignty to decide what is in the public interest and public health needs.

The goal of the company is to get a licence to sell its product in the marketplace. The role of the regulator is to grant an approval or marketing consent to the company. The licence is granted on the basis of safety, efficacy, and quality. However the drug approval system does not require industry to show that there is a public health need for the medicine, or that the medicine is effective, or that there is a therapeutic advantage over another medicine, let alone an alternative sort of intervention.

Moreover research has highlighted how companies lobby governments to water down the regulatory standards that govern efficacy and to accelerate market approval times, and even the most stringent regulatory authorities including the FDA have responded. The weakening of regulation for the conduct of trials and proof of efficacy can lead to the creation of false needs, a process known as pharmaceuticalisation or medicalisation, and to disease mongering. There is now a wide and growing body of literature demonstrating that the trial itself has become degraded and that efficacy claims are leading to the creation of false needs for the medicine. This degradation includes the use of surrogate measures which have no strong relation to hard clinical outcomes. Statistical manipulation and grouping of endpoints to achieve statistical significance, use of single pivotal trials, small numbers of participants, highly selective patient subgroups, short trial duration, and over-powering of trials may overstate efficacy and understate harms. In addition, current critiques of evidence-based medicine have generated a new discourse that the clinical trial does not take sufficient account of the need for other types of evidence including observational data, and patient-oriented data. A key concern is that researchers and doctors participating in research have vested interests in the outcomes, but as opinion leaders they are important advocates. Another is the failure to publish and make the trials data available. Studies of efficacy rely on clinical trials data, but the data that underpins safety and efficacy is not freely available due to commercial confidentiality. This is another example of asymmetric information and has led to a worldwide campaign for publication of trials data and transparency.[189]

The consequences of withholding or manipulating vital regulatory data on evidence of harms and risks to patients and or marketing medicines outside of therapeutic indications are serious and costly to patients and the health care system. Merck's behaviour over Vioxx resulted in the deaths of hundreds of thousands of people prematurely from heart failure as a result of withholding evidence of harms from the regulator. Johnson & Johnson, GlaxoSmithKline, Abbott Laboratories, Pfizer, and Eli Lilly have each settled multi-billion dollar fraud cases in the US since 2009, involving in total at least 28 different drugs and arising out of, for example, marketing drugs for unapproved conditions – 'off-label' use - and lobbying and paying physicians and patients to use their drugs.[190] Law breaking is not uncommon, but these large out of court settlements are shrugged off as simply the "cost of doing business".

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[189] www.alltrials.net

[190] Krumholz HM, Ross JS, Presler AH, Egilman DS. What have we learnt from Vioxx? BMJ 2008;334:120.

Lack of data, information asymmetry, and concerns about conflicts of interest among researchers, clinicians, and industry has seen a decrease in public confidence and trust and questions about data and efficacy. In England the Chief Medical Officer has ordered a report into the effectiveness of statins and tamiflu because of a need to restore public confidence in medicines. There is a growing perception and awareness that public health needs are not being met. [191]

Do the post marketing requirements ensure that public health needs are met?

Under the medicines approval process a medicine can remain in circulation in the country without ever showing proof of effectiveness, ie, that it works, in the population for whom it was intended and that it has met the need. Although the regulator can impose post-marketing authorisation conditions, for example phase 4 studies, evidence from John Abraham's studies of the US FDA is that industry rarely complies.[192]

Studies of effectiveness should draw on patient data collected as part of disease surveillance and monitoring, but most public health care systems do not collect the data and information to show whether the intervention works. Medicine surveillance is not integral to the health care system, just as medicines are not. This situation is worse in countries where patients access medicines in the private market, where there is almost no data and we have to rely on commercial databases that collect data for sales and marketing purposes. Even in western countries with stronger public health care systems, the primary purpose of information systems is administrative, namely to support billing, invoicing, and performance management in the marketised bureaucracy. Insufficient attention is paid to the capacity of the system to monitor public health needs and effectiveness of interventions in a systematic and comprehensive way. The information required for monitoring public health needs is at best a by-product of the administrative system. Weaknesses in surveillance and monitoring have been articulated as a key concern in the international effort to tackle antimicrobial resistance.

Because need and effectiveness and therapeutic advantage have been uncoupled from the approval process and from patent approval, decisions to prioritise funding for medicines are made in isolation from knowledge about the effectiveness of other alternatives, whether they be medicines or alternative treatments or interventions. Decisions about research and production are not subject to public scrutiny, but are private matters mainly for industry or industry in partnership with academia.

Governmental responses to the public health needs gap in market driven medicine approvals

Governments have attempted to respond to the public health needs–effectiveness gap in the approvals system in a number of ways but always through a market paradigm.

i) Essential medicine lists

Since 1977 the WHO has been spearheading the international effort to ensure that people receive the medicines they need at the doses they need, for the length of time required – known as 'rational medicine use'. Many countries have adopted the essential medicine list (EML) concept and regularly updated EMLs are still used by most countries across the world accompanied by clinical guidelines development for prescribers and prequalification of producers. These lists are particularly important in

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[191] Brimelow A. Chief Medical Officer calls for medicines review to restore public trust. BBC News 16 Jun 2015. http://www.bbc.co.uk/news/health-33127672

[192] Davis C, Abraham J. Unhealthy pharmaceutical regulation: innovation, politics and promissory science. Health, technology and society. Palgrave Macmillan, Basingstoke 2013.

countries which do not have the regulatory capacity to judge safety and efficacy and have very small public health care budgets. But nevertheless, although the model lists have been in operation for nearly 40 years, many millions of people do not receive the essential medicines they need, and although every two years more medicines and vaccines are being added to the WHO model EML list, governments are not able to procure them or distribute them because their health systems are too weak and there is not the funding or capacity for local production or distribution, and people must turn to the private market.

ii) Health technology assessment bodies

Some countries use health technology assessment bodies to supplement or as an alternative means to achieve rational drug use through the public purse. The UK, Australia, and Canada assess comparative effectiveness and cost-effectiveness in the context of public health care systems funded through general taxation or public insurance, creating agencies to do this work for the public system. This has led to growing complexity, contestation, and confusion over guidelines and concerns that some pricing incentives may result in the development and delivery of unnecessary medicines to patients.

iii) Research and innovation

At the same time, specific incentive mechanisms designed to encourage research and development into rare and neglected diseases have been developed, often with government subsidies, using PPPs and other models. These include the US Orphan Drug Act, the Health Impact Fund, the Drugs for Neglected Disease initiative (DND*i*) a non-profit research and development organisation, Europe Innovative Medicines Initiative, and advance purchasing initiatives. Markets require financial incentives but all within the paradigm of the market.

iv) Local production initiatives

From the early 1960s the WHO called for local production, and many countries had their own state run or state owned local production facilities for vaccines and other medicines. WHO policy is now ambiguous as it points to the high costs of investment and the costs of complying with quality standards such as ICH and WHO GMP and multinationals are regionalising local production. The question of why states should not utilise their own local production for their patients and public health needs still remains.

v) Compulsory licensing as a response to lax standards on patents and unmet need

Governments may issue a licence to allow the use of an invention (eg, a patented drug) without the consent of the patent holder on grounds of public interest, such as a national emergency, anti-competitive practices, or for public, non-commercial use, but must pay compensation to the licence holder. Almost no low income countries have taken advantage of compulsory licensing.

vi) Human rights instruments to underpin Millennium Development Goals

Court challenges can be used to obtain access to medicines and treatments and to reverse patent approvals. However, litigation can exacerbate inequalities if the demands of individual plaintiffs or specific cases are prioritised over collective or wider needs, as is happening in Brazil. [193]

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[193] Wang DW. Courts and health care rationing: the case of the Brazilian Federal Supreme Court. Health Economics, Policy and Law 2013;8(1):75-93.

Summary

All of the above responses to global market failure are within the framework of the dominant free market paradigm and leave public health need outside the regulatory door. They do not ensure that public health needs are part and parcel of the regulatory drug approval process, and nor do they ensure that we have a medicines system that is built on risk and redistribution and premised on universality and equity. The medicines system needs an overhaul. As a first step all countries with an EML should review all medicines approved outside of the essential medicines lists from the perspective of public need, efficacy and effectiveness, and therapeutic advantage, withdrawing medicines that do not meet those criteria. The continuing FDA Drug Efficacy Safety Investigation (DESI) review, which aims to evaluate drugs approved prior to 1962 and before effectiveness rules applied, is a sort of precedent.

Second, as harmonisation of drug regulation proceeds, the regulatory approval system needs to be strengthened and linked to research for pubic health care needs. The medicine system must be linked to public health care systems and surveillance systems.
The questions which need to be addressed are as follows.

i) What is the public health need for the medicine - does it meet an unmet need?
ii) Does it show a therapeutic advantage over other medicines?
iii) Does it show a therapeutic advantage over other treatments and interventions?
iv) What was the basis of efficacy and how strong are the clinical endpoints- are they surrogates measures?
v) Are there surveillance systems in place to monitor need and effectiveness?
vi) What criteria should govern medicines that are not on the EML and their availability outside of the public health care system?
vii) Are there systems in place to monitor pharmaceutical revenues and expenditure?
viii) Who should control the decisions about research and prioritisation of medicines and their production and expenditure, and how does this link to the approval process and patents?
ix) Will the medicine be available to all on the basis of need – if not then why approve it?

Table 2 Risk selection and management for pharmaceuticals

Pharmaceuticals	Public health needs	Market driven medicines
Regulatory approval system	Not included	Marketing approval
Funding and financing	Government procurement of EML medicines Donor funds directed to EML medicines	Health insurance , charitable funds, user charges, taxation, tax relief Highly regressive, anti-redistributive No risk pooling Little public accountability
Resource allocation **Control over expenditure**	HTA Pricing controls	Pricing and price controls Health technology assessment (cost effective analysis) Profits, taxation
Control over research and production **Prioritisation**	Govt funding, financial incentives	Firm, industry PPPs with academia and others

Risk management		Commercial contract
Service	Not integrated	Fragmented, a commodity
Accountability	None	Shareholders Conflicts of interest between patients, doctors, and researchers
Information on need and effectiveness	Weak or absent surveillance systems	Commercial and confidential Efficacy: surrogate measures
Property rights	Compulsory licensing (for patented drugs)	Patents, licences, pricing

Epilogue

In this lecture I have shown how the principles of public health need, redistribution, and risk-pooling or social solidarity are alienated by marketisation. Markets operate through selection and exclusion. They transfer risk back to the users of services and deny care to those that need them most. Risk selection is built into the design of and tools used by market bureaucracies.

Markets bring new costs and inefficiencies including transaction costs, billing, invoicing, marketing, advertising, and excessive prices and profits, not experienced in public administrations. Regulatory capture and regulatory failure are commonplace as is fraud and risk selection, information asymmetry, and low trust. In the case of pharmaceuticals, where governments have ceded control over research priorities and over medicines production to the market, governments pay for innovation and medicines through patents and the prices that they agree. Lack of access and availability are the result. The medicines system needs an entire redesign. It is a system in crisis. The medicines approval process is not connected to public health needs, nor is it linked into the public health system or health care prioritisation for research and clinical practice, but it should be. Abandoning the market in medicines and in health care might seem like swimming against the neoliberal tide, but it is necessary if we are not all to drown in a sea of poisons or starve in a desert of neglect.

It will take political courage to admit that the market has failed and to take back control, if the goal of universal health is to be achieved. As public health systems are increasingly reduced, displaced and marketised, their ability to control costs, to remedy unmet needs, and to respond to need will be further undermined. The complex interplay between public health systems, the drug approval systems of each country, and research, innovation, and production need to be addressed and as a matter of urgency. The paradigm shift requires a complete reorientation in thinking away from market driven systems and market driven regulation towards public health needs, redistribution and risk pooling.

Designing public health care systems to meet public health care needs is not high risk and nor is it an experiment. It has been tried and tested in many countries, and shown to work well, not least in the UK NHS for 60 years. The public bureaucracies have done what was required of them by law and developed the expertise to do so. There is no country in the world that has delivered universal health care through a market. In order to ensure access to universal health care, the systems of public administration have to adhere to some common principles. A good starting place for public bureaucracy committed to the goal of universal health care would be to incorporate the following six principles: fairness of financing, fairness of resource allocation, risk pooling and social solidarity in service provision, political accountability and control, service integration through geographic units of administration, and public accountability through strong systems of information and surveillance systems. These are the necessary first steps towards the Sustainable Development Goals for universal health care and access to rational and essential medicines.
Adapted from Lecture given to CLAD Peru Lima in November 2015

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Ms. Róisín Shortall T.D.,
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11th January 2017

Dear Deputy Shortall,

I warmly welcome the establishment of the Oireachtas Committee on the Future of Healthcare and I greatly support this initiative to bring some long term vision and planning into our health services. When our services are under such critical day to day pressure, this is the very time we should be raising our vision and thinking about where we are going and what kind of services we require and can afford.

I have led a number of change initiatives in recent years – the Health Innovation Hub Ireland (2016), the Establishment of Hospital Groups report (2013), the Reconfiguration of Services in Cork and Kerry (2010), and the amalgamation of the Cork Maternity Hospitals (2007) – these projects have given me an insight into how we run our acute health services and how often sound planning comes to naught through a lack of consultation with our staff, our patients and their families and a failure to implement agreed change. The result is a widespread disillusionment over unfulfilled or half fulfilled promises, that is the true enemy of reform.

For example, the publication of the Hospital Groups report was followed by a visit to every hospital in the country to explain the recommendations and answer questions. New governance for each Hospital Group with greater autonomy and better alignment with the education sector was promised. While the organisational benefits of Hospital Groups are becoming increasingly apparent, three years on we still have no Boards, no MoU with the university sector and a perception of diminished rather than enhanced autonomy.

We simply must break this cycle if we are to face the challenges that are coming down the road. We must deliver better governance, better management, sustainable services and a deep cultural change that embraces openness, welcomes criticism and supports learning at every turn.

I am aware that the Hospital Groups have been the subject of some discussion at committee hearings. If you thought it would be useful, I would be happy to provide any context and background that would better explain the composition of and the rationale for the Hospital Group structures. I would also be happy to share my on-the-ground experience of communication and public engagement when reconfiguring services.

Yours sincerely,

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cc Members of the Oireachtas Committee on Future Healthcare in Ireland

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The provision of good healthcare is well recognised as a significant challenge to all countries. Ireland is facing this challenge as well as its own demographic and other challenges but is, in addition, carrying its own historic and negative burdens of variable financing and questionable decision making. A response on the Future of Healthcare will necessarily be in part a root cause analysis of the problems and in part the solutions.

Starting with politics, one would have to ask, has political advocacy served Ireland well? Many good things have been done but also many bad decisions have been made, not helped by party political point scoring. The electoral cycle fosters short-termism. A cross party moratorium on health with a ten year strategy is therefore warmly welcomed.

There are some things (**dominant issues**) that have to be put right because, if they are not, they will continue to conspire to undermine our ability to change and deliver healthcare efficiently or even approach a universal single tier service where patients are treated on the basis of health need rather than on ability to pay:

- Administrative structures, governance and management are critical. Confidence in change, its clarity and purpose, can only exist in an environment of clear, well communicated and inclusive leadership. The prevalent top-down management style needs to reverse.
- There are many 'capacity' issues that have to be addressed across healthcare. With swelling patient numbers it is hard to see how this can happen without significant resource input but it requires judicious distribution.
- The national hospital configuration is not fit to meet present day needs.
- The current disposition of Hospital Groups and Community Healthcare Organisations is not supportive of cohesive patient pathways.
- There needs to be a singular national focus on Quality Improvement. (QI)
- Workforce and training needs to change to address deficiencies, be better tailored to meet our patients' needs and incorporate newer models and ways of working

Management focus at the coal face, buy in from healthcare professionals and integrated and co-operative working are all important ingredients for instituting the changes that are so critically required. Confidence and engagement will be re-enforced by an understanding that the 'dominant issues' are being addressed.

There are a myriad of examples of 'best practice'. Internationally, health quality improvement has become an industry in its own right. Many in Ireland are aware of and have already trained in these areas; but we need more. Where there are problems we commonly (or lazily) seek outside support and consultants. At this point, it is important that we start to manage our own affairs, identifying our own, often unique, problems, providing our own solutions and implementing the necessary changes. This is the only way that equity, transparency and sustainability will become imbedded – it has to be lived.

Report

This submission has focussed on the headings and questions set out by the Oireachtas Committee.

Strategy

What are the key priorities for inclusion in a ten year plan for the health service?

Politics and electoral cycle

1.11 Up to now there has been an ever changing strategy and no consistency. Within a cross party moratorium, politics and politicians should focus and participate on long term structural and strategic decisions for the greater good of patients in general.

1.12 There should only be operational interference at this level where structural or strategic aims are being contravened or the HSE is not meeting its stated objectives.

1.13 The Minister and his/her administrative instruments, the DoH and HSE, should eschew what appears to be a defensive mentality in which their focus is on their own organisations and their survival in a hostile financial climate. Instead, they should work with each other and their partners to use resources as effectively as possible, even if this means relinquishing a degree of sovereignty to allow space and opportunity for good, accountable and committed managers and clinicians to innovate and excel. This will not happen overnight but the aim must be to move towards improvements in patient care being led from the bottom up, rather than top down, within a clear national framework.

Structural and administrative

We need a clear national health strategy for the medium to longer term.

We need clear governance structures. The lines of demarcation, responsibility, accountability and communication regarding policy and operational issues are unclear and constantly changing. If the HSE is to be retained (as it must be, probably forever in some form) there must be a clear line of demarcation such that it is truly operational as distinct from the DoH and Minister's strategic/commissioning role.

The DoH must become more decisive, consistent and accountable in matters of policy and strategy, less submissive to political and vested interest and relate better to the HSE whilst abstaining from operational/granular issues.

An independent Commissioning Body needs to be set up, separate from (or, maybe an independent role within the DoH?). The main function should describe in broad strokes where resource are to be allocated, including services, procedures and technology, drugs etc. Increasing fiscal constraints into the future will make the reality of rationing more likely and it is not correct that this is left to the HSE and its component parts such as the HPO, PCRS, and Hospitals/Groups etc.

The HSE needs to become the effective, overarching, lean operational organisation. Currently, it consists of lines of administration, often ineffectual with poor management and poor internal or external communication systems. (The metaphor is in the buildings – contrast, for example Dr Steeven's and Hawkins House and Google offices, in terms of lay out, staff morale and team working)

- An effective HSE Board and independent chair should be re-instated; ideally with a well-resourced, fresh and new management team.
- Its top down management style is currently characterised by obscure programmes such as the National Transformation and Integrated Care that have become remote from clinical programmes and front line carers and repetitious (e.g. Flow and Quality Improvement). Their concepts have neither been discussed nor debated and have been largely ineffective to date; despite substantial resources spend on personnel and outside consultancies.
- PCRS is not an efficient organisation. It's Medical Card and Payment functions should be separated and managed independently.

Current policy thinking on the structures of the health services is inimical to good, coordinated and comprehensible pathways for patients and health workers.

- The principle of Hospital Groups is good; to devolve a large amount of fiscal and performance management away from the centre. But the precise role and responsibilities of Hospital Groups needs defining recognising that they will never become independent trusts i.e. truly independent or entirely self-sufficient. Ireland is too small and the Groups (and Hospitals) are too small. It is worthwhile reflecting that Royal Bolton Hospital (Bolton Hospital Trust, the second largest trust in the Manchester region) receives, in a year, Emergency Department attendances equal to those that attend St James's, the Mater and Beaumont put together! We need to be wary about transposing policy from other jurisdictions.
- The Dublin East Hospital Grouping unworkable: a Southeast Group should be reconsidered.
- Dublin has hospitals with too many replicated specialties in small units e.g. Plastics, Vascular, Colorectal, Urology, ENT etc.
- Dublin should be divided north, south and west for better integration of patient care.
- Letterkenny and Altnagelvin should work together providing joint services.
- Community Healthcare Organisations (9) and Hospital Groups (6 excluding children) should be more closely aligned. Currently there is the confusing potential for some hospital groups to share or be associated with more than one CHO; up to five CHOs in one instance.

Change and progress can commonly be confounded by employment and IR issues. These need to be challenged.

What are the key challenges, in your view, to achieving a "universal single tier health service, where patients are treated based on health need, rather than ability to pay"?

I strongly believe in the principles of a "universal single tier service based on health need". But there are advantages and disadvantages.

Some points in favour of Universal Health Care

a) The current 2-tier system is patently unfair.

b) Private health care is becoming increasingly unaffordable.
c) Profit motives, competition, and individual ingenuity could lead to greater cost control and effectiveness.
d) The private health care system would become more accountable than it is at present.
e) It would eliminate wasteful inefficiencies and duplication.
f) A centralized, national database together with the Unique Patient Identifier would make diagnosis, treatment and follow up easier for all.
g) Medical professionals could concentrate on treating patients rather than on insurance procedures, malpractice liability etc.
h) It would be conducive to better team-working with parity of contracts and a greater commitment by clinicians to participation in management.
i) Free medical services should encourage patients to practice preventive medicine and inquire about problems earlier when treatment will be more straightforward.

Some points against Universal Health Care

a) "Free" health care is not really free; better health care would have to be paid for with higher taxes or spending cuts in other areas.
b) UHC could lead to a decrease in patient flexibility.
c) The health-care industry may become infused with poor practice, gaming and vested-interest already prevalent in the public system.
d) Patients are unlikely to curb their drug costs and doctor visits if health care is free.
e) There is a danger that government-mandated procedures may reduce doctor flexibility and lead to a decline in patient care
f) Healthy people who take care of themselves will have to carry the burden of those who do not take care of themselves.
g) The potential for increased costs relative to a taxation financed system.
h) The dangers of competition between purchasing insurers.
i) In an effort to cut costs controls on salaries, drugs, medical equipment, and medical services are likely to be put in place, which may disincentive research, development, and investment.

Put simply, we are not ready. Any transition would be long and painful but, unfortunately, there are too many pieces in the public system to be put right – and this is what we need to start doing, in earnest. UHC will then evolve as it becomes affordable.

What actions are needed to plan for, and take account of, future demographic pressures (population growth, ageing population), and their impact on the health system?

This question cannot clearly be answered by a single solution but needs the many issues to be tackled systematically and at many levels including, and in part, by what has already been suggested and also by what follows.

Capacity issues that need addressing

Because we are facing Increasing numbers of patient presentations, increasing age, chronic diseases and complexity and we already have enormous hospital waiting lists of both outpatients and inpatients, there needs to be a planned and judicious increase in resources to be put into:

- Primary Care, with an expansion and greater incentives for Primary Care Centres, community care and access to diagnostics.
- Hospital Beds (Decreased from 5.26 in 2006 to 2.84 in 2012/100 population)), Critical Care, Diagnostics, Theatres.
- The workforce – there is a definite shortage of Doctors and Nurses (at primary and secondary level), and Allied Health, Social Care and other health workers.
- Ambulance services

Additional resource in these areas will be a fruitless exercise without also addressing the items under the following headings.

The national hospital configuration is not fit to meet present day needs

There are too many acute small hospitals - 29, with 9 receiving trauma that do not have T&O departments. Hospital reassignment will need to be addressed in the process of introducing a National Trauma Strategy.

Acute and elective patient flows should be separated and ring fenced either within hospitals or in separate institutions; mixed flows of acute and elective patients through the same hospital bed pool is inefficient and confuses demand and capacity planning. (Current patient ratios: Acute - 5 Medical to 2 Surgical; Elective - 1 Medical to 3 Surgical. Acute admissions are swamping Electives)

Small hospitals cannot cope with increasing specialisation: At this point there are roughly 16 Surgical and 25+ Medical specialties as well as many other clinical and non-clinical sub-specialties. Volumes in small units are insufficient to retain skills or interest; hence the inability to recruit and retain staff.

Smaller Hospitals should continue to be used for Day or short- stay surgery, minor injuries, differentiated medical care and some longer term care. (Older persons, convalescence)

There is a need for a greater national focus on Quality Improvement (QI)

There are many examples of poor and inefficient processes and performance within the Health Service. Their correction could dramatically reduce costs and provide capacity if addressed systematically. Within the hospital system alone some of these include:

- Poor Governance – hospitals mostly have no clearly defined operational strategy.
- There is, in many cases, poor acute floor/emergency department organisation, co-ordination and triage. There is poor integration between and with in-house specialist services.
- We admit too many acute patients. We know that half of all acute surgical admissions do not have a surgical procedure. Do they all need to be in hospital?
- Senior decision maker s (consultants or experienced doctors/nurses rather than junior or non-consultant doctors) are commonly not involved at the first patient encounter; their early involvement would expedite either admission or discharge and/or treatment

pathway facilitated by closer links with GPs and community care as well as with specialist front line staff.

- For this reason we have poor ambulatory care services at the acute front lines; currently it is easier, and more likely, for a junior doctor to admit patients because of their lack of experience.
- There is inadequate Demand and Capacity Management in many hospitals (works as a control hub within a hospital responding in real time and anticipating fluxes)
- In many hospitals there is poor, undisciplined, unregulated ward-rounding by consultants or senior decision makers. Home before 11 rates are woefully poor (<10-20%) If hotels operated in this way they would quickly close.
- There is often poor and unregulated discharge planning contributing in part to delayed discharges.
- Mixed specialty wards and poor ward cohorting is commonplace. This is unsafe for patients and very inefficient.
- Inadequate 7-day and extended day working leads to poor use of resources.
- There is a confusing confluence of acute from elective flows leading to poor planning and frequent cancellations.

There are enormous gains that could be made in providing better, safer, more efficient and cost effective patient care and flow by improving processes, performance and closer co-operation of providers at a service level. This requires local resource, expertise and a committed workforce working with fully committed management (trained in QI), notably:

- Within Primary and Community Care and Radiology to undertake greater volumes of out of hospital care.
- Between Primary and Community Care and hospitals to tackle hospital avoidance, shorter hospital stays and discharge planning.
- Within hospitals to tackle patient flow at the acute floor, within hospital wards and theatres and with greater flow management.

Process improvement (e.g. Lean) works in health care. Where it is applied properly its results have been remarkable. It will never take root in the HSE as it stands: it is management that needs to change, not the process improvement methodology. Presently hospital managers are unable to create the conditions for sustained local, front line improvement because they are overwhelmed by the directive driven, compliance orientated and target-obsessed approaches of central HSE management. This has to change.

Improvement should properly be supported and incentivised through more effective Activity Based Funding. (HPO under the oversight of the proposed Health Commissioning Body)
Full time, trained QI staff and data access and interpretation are key to QI; continuing expansion of QI and ICT skills and their availability is critically important.

This should define the continuing activity of Clinical Programmes. These have, by and large, been effective and should continue to be sustained with more visibility in support of Clinical Directors at the coalface. They require new and clearer TORs and should be supported directly from appropriate HSE directorates.

Irish QI should have a co-ordinated centre for training, learning and standardisation, as with the Scottish QI Hub – perhaps tendered for by an academic institution(s).

Workforce and training

As stated, there are shortages of Healthcare workers across the board – making more appointments is one answer but often finding replacements is an issue.

- The plight of General Surgeons in Model 3 Hospitals is a case in point. There are currently 76 and, of these, 19 (or 25%) are in locum posts. Of the current cohort of 76 surgeons, 41 (54%) have not undergone formal training in Ireland. If recruitment and retention fails to improve within the next five years then locum numbers could increase to 47% and those without formal training to 76%.

The issue of recruitment and retention is being addressed by the HSE (Committee commissioned by HSE under my chairmanship) addressing such issues as:

- Better job planning.
- A more transparent and efficient appointment process.
- The institution of an appraisal process – it is stark reality that, at present, unlike any other modern health service (or business) neither consultants nor managers currently undergo any kind of appraisal process.

There is a dependence on too many non-training NCHDs.

- Whilst often satisfactory there are also communication and quality of training issues and their short term appointments impacts on the quality and continuity of patient care.
- They should be phased out where possible and replaced by either role substitution by nurses, allied health professionals and others or by the rapid training and deployment of newer, internationally well -established roles such as Physician Associates, Operating Theatre Assistants etc.

Training is important and training bodies should be challenged to address their outputs to meet the requirements of Irish patients, the Health Service and its structural configuration.

Integrated Primary and Community Care

What steps are needed to move from the current model towards a model based on integrated primary, secondary and community health care?

What are the key barriers to achieving this, and how might they be addressed?

In your experience, what are the key roadblocks you encounter in your particular area of the health service?

My responses to questions 4.0, 5.0 and 6.0 are largely contained in my answers to questions 1.0 and 3.0.

Integration has to take place, not just by labelling departments within the HSE and having management/directorate/ leadership meetings at that level. It has to happen on the ground including managers and clinicians,

- Within primary and community care (CHOs)
- Between hospitals and Primary care and CHOs (fostering liaison groups as in Kilkenny)
- Within hospitals between departments and specialties

It has to take place within a Quality Improvement frame work.
Focus and ownership by local management and clinical engagement are key to sustained integration – the main road block at present.

<u>How would you ensure buy-in from health care professionals to progress towards an integrated health care model?</u>

This is important. Culture change will come with leadership, confidence in management, clarity within the working environment (which is confounded by many of the issues described above), job predictability and satisfaction, incentivisation and reward. It is a frustratingly long journey, not helped by many years of poor governance, management, leadership and financial recessions. Repeated reliance on waiting list initiatives and the NTPF and their poor track records demonstrates a case in point.

<u>Are there any examples of best practice that the Committee should consider? Please refer to any evidence you have to support this.</u>

Yes, there are many, many examples of which we are aware. Health care innovation and quality improvement is a worldwide industry/phenomenon. We, in this country, are constantly seeking the support of "Technical Partners/International Consultancies" who are happily feeding on our dysfunctionality. The problem is they are not accountable and they leave. It is imperative that we start to manage our own affairs in a mature manner by identifying our own, often unique, problems, providing our own solutions and implementing and sustaining the changes needed.
If this is what the Oireachtas Committee on the Future of Healthcare is setting about doing this has to be welcomed.

Funding Model

<u>Do you have any views on which health service funding model would be best suited to Ireland?</u>

The differential reimbursement of GPs, hospital consultants and public hospitals for public patients by fixed remuneration versus private patients by fee-for-service creates incentives to treat the latter category over the former is unfair and disruptive.

I believe we should maintain a tax-funded system, controlled by the government rather than a multi-purchaser, insurance-based system <u>until there is greater clarity</u>, for say ten years.

Health taxation should be ring-fenced.

Within this system there should be a purchaser (Healthcare Commissioner) and provider (DoH, HSE) split.

Private health insurance should be restricted to cover to private hospitals, so that the treatment of private patients would no longer have an impact on accessibility to public hospitals for public patients.

Private hospitals should be allowed to tender to treat public patients to meet public capacity issues.

A money-follows-the-patient (ABF) reimbursement system should be expanded and made more widespread.

Access to medical care could, in the meantime, be broadened to cover a gradually widening sector depending on fiscal flexibility

Only when there is sufficient data and costings should a multi-purchaser insurance system or social insurance system be introduced. We could not do this now.

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Chair of Working Group of Irish Hospital Redesign Programme 2014-2016.
Chaired the recent Expert Committee on Medical Cards and the Committee reviewing the consultant appointment process - “Towards Successful Consultant Recruitment, Appointment and Retention”

Professor Thilo Kroll

The thoughts for consideration and examples focus primarily on advancing partipatory, citizen- and community co-designed processes and services in health care. It encourages the Committee to entertain the notion of inviting non-traditional health care providers into a co-ordinated network of service delivery and to place the service user at the centre of any planning and delivery process to ensure adequacy, equity, accessibility, usability and affordability. Particular attention ought to be given to currently marginalised or excluded population groups from these processes. Harnessing personal and community assets would be one of the key challenges for health care in the future.

For consideration by the Oireachtas Committee on the Future of Healthcare

Mental health care provision and integrated person-centred pathways of treatment, care and support

Ireland is facing considerable challenges at the intersection of homelessness, mental health, and addiction. Pathways into either homelessness, addiction, or mental health problems are complex and in many cases interwoven. Policies such as Housing First are well intended but will not solve the underlying causes of homelessness, especially not for those who experience mental health and addiction problems. This requires an integrated, inter-agency approach and at the provider level coordinated pathways of care and support that place the individual service user at the centre. Services need to be designed in such a way that support is organised around the service user need at any given time to have a chance of success. Uniform ways of providing services will lead to unequal benefits and successes and ultimately reinforce the ‘revolving door’ situation that currently overburdens ineffective services. One of the solution may be found in connecting NGOs, microproviders and public and private service providers in a more effective way. Technology may play an important role in coordinating this process in terms of real time data on available services in a particular geographic locale feeding into coordinating platforms. A network can be designed around systems such as the SHINE project (see more below).

Inclusive design practices of all services, facilities and educational practices as well as in relation to funding applied health research

The UN Convention on the Rights of Persons with Disabilities (UN CRPD), which yet has to be ratified in the Republic of Ireland requires equitable access to and provision of high quality affordable health care services for people with disabilities. With a rising number of people living with more than one disabling long-term condition this is a challenge. The pre-requisite for designing and implementing truly accessible and inclusive practices and services is the involvement of end users in the process. Equally in health-related research we have to be mindful that current practices do not generate an ‘evidence base’ without representation of people with disabilities either as participants of research or as those who have a say in defining research agendas. We have demonstrated that in the UK many research practices in fact exclude people with disabilities with unknown consequences.

1. **Kroll T**, Jahagirdar D, Wyke S, Ritchie K (2012). If Patient Reported Outcome Measures (PROMS) are considered key Health Care Quality Indicators, who is excluded from

participation? *Health Expectations*. DOI: 10.1111/j.1369-7625.2012.00772.x.

2. Jahagirdar D, **Kroll T**, Wyke S, Ritchie K (2012). Patient reported outcome measures for COPD: The exclusion of people with low literacy skills and learning disabilities. *The Patient: Patient-Centred Outcomes Research*, *6*(1),11-21.

3. Jahagirdar D, **Kroll T**, Wyke S, Ritchie K (2012). Using Patient-Reported Outcome Measures in Health Services: A Qualitative Study on Including People with Low Literacy Skills and Learning Disabilities. *BMC Health Services Research, 12:431* doi:10.1186/1472-6963-12-431

Funders of primary research and evidence syntheses and practice guideline production need to be mindful of the importance of an inclusive research base. Equally, service designers should place the user at the centre and work closely in partnership.

1. *Shifting the power balance from professionally designed and led to participatory, person- and family centred processes of co-designing services to ensure citizen-designed services that are meeting their needs in a meaningful way*

Scotland has been quite instrumental in advancing participatory, citizen-led processes in re-designing policies and services. This implies a shift in power from professions to the public and includes innovative forms of using public funds such as participatory budgeting.

http://www.gov.scot/resource/doc/163759/0044572.pdf
http://www.gov.scot/resource/doc/216076/0057753.pdf
http://whatworksscotland.ac.uk/wp-content/uploads/2015/12/Participatory_budgeting_FINAL.pdf

A similar process may be considered in the Republic of Ireland, especially in relation to devolved budgets. This requires interagency working and close involvement of local partners in the planning process. However, a dialogue about the pros and cons of localised, citizen-involved, participatory processes and budgets would be desirable.

2. *Working towards integrating/connecting 'grassroots' level NGOs and microproviders with public or privately operated service providers*

In the UK there have been Health Foundation funded examples of improving local health care, such as the SHINE project which provides evidence for cost efficient local care delivery for older residents and earlier discharge from hospitals
http://www.health.org.uk/sites/health/files/ShineImprovingTheValueOfLocalHealthcareServices.pdf

Drawing on international experience such as the Alaskan Nuka project, the SHINE project in Scotland provides and innovative approach to connect grassroots level microproviders to statutory services provided by the NHS. The SHINE project successfully implemented *'a range of initiatives to support older people to live and thrive at home in ways that are safe and sustainable. This involves changing the nature of the conversation staff are having with older people and their* *families, harnessing community resources such as businesses and care cooperatives, and developing 'micro-enterprises'*. For more details on the SHINE project, please consult https://www.internationalfuturesforum.com/projects.php?pid=45

This notion may be explored in the Irish context as well.

3. *Adoption of an asset-based approach in health care in tackling health inequalities*

It is easy to focus simply of deficiencies and challenges without recognising the inherent assets that individuals and communities hold and which can be harnessed to prevent poor health, reduce inequalities and enhance community and individual wellbeing. Instead of striving for simply treating illness a greater focus on preventive conditions that help individuals and communities flourish while drawing on their inherent abilities for self management would be desirable.. Seligman (2011) has examined the key attributes for human flourishing, which include the desire to maximise 'positive emotions', feeling engaged in society, having constructive relationships with others, perceiving meaning in one's life and having a sense of achievement. Flourishing lives result when these attributes are addressed. In Scotland, a range of policy and practice initiatives have emphasized asset-based approaches, including the AfterNow project led by Professor Hanlon.

At the heart of the AfterNow project www.afternow.co.uk is the intention to make complexity visible and to move away from approaches that are purely designed around individuals' health behaviours but rather analyse and target environmental, cultural and economic factors in population health and wellbeing. (Hanlon & Carlisle, 2012).

References

Hanlon P & Carlisle S (2012). AfterNow. What next for a health Scotland? Argyll: Argyll Publishing.
Seligman M (2011). Flourish: A Visionary New Understanding of Happiness and Well-Being. Ny: Simon & Schuster.

The focus on community assets has been endorsed and promoted by the previous Chief Medical Officer Sir Harry Burns. The work developed on the basis of a review report by Sir Michael Marmot for the UK as a whole, entitled Fair Society, Healthy Lives (2010). Marmot says "*Effective local delivery requires effective participatory decision-making at local levels. This can only happen by empowering individuals and local communities*". A briefing paper on asset-based approaches in health can be found at the Glasgow Centre for Population Health (GCPH) http://www.gcph.co.uk/assets/0000/2627/GCPH_Briefing_Paper_CS9web.pdf

The current Chief Medical Officer in Scotland, Catherine Calderwood released a report, entitled **"Realistic Medicine"** (Chief Medical Officer's Annual Report 2014-15). The key areas of the report include 1. A more *personalised approach to care*. 2. Creating a style of *shared decision making*. 3 A challenge to reduce unnecessary variation in practice and clinical outcomes. 4 A challenge to reduce harm and waste created by current overinvestigation and overtreatment of patients. 5. Ways to manage risk better. 6 A challenge for *healthcare workers to become improvers and innovators.*

Rehab Group

The Rehab Group is one of Ireland’s biggest providers of health and social care services, supporting 10,000 adults and children with disabilities, people with mental health difficulties, older persons and their families and carers every year. The Rehab Group would like to acknowledge the opportunity afforded to us to make this submission. We are keen to be an active participant in this process and would welcome an opportunity to contribute further.

The 10 year strategy for the Irish health services should:

- Set an ambitious vision for world class, high quality health services
- Create a responsive, planned health services
- Community and acute hospital services must be equally valued and respected
- The Strategy should deliver parity of support between Section 38 and Section 39 agencies
- Invest in and fully support the development of mental health services
- Develop and invest in a credible, reliable community care sector
- Empower the person to manage their own their health in partnership with health professionals
- Promote the full and effective use of technology and innovation throughout the health services.

Introduction

The Rehab Group is one of Ireland’s biggest providers of health and social care services to children and adults with disabilities, people with mental health difficulties, older people and their families and carers. Every year, 10,000 people throughout Ireland are supported by the Rehab Group to live as independently as possible in their local communities. In many different ways, people who use our services are facilitated in accessing the essential supports they require within their local community.

The Rehab Group is very encouraged by the establishment of the Oireachtas Committee on the Future of Healthcare. By committing to a ten year strategy for health services, Ireland can plan for foreseeable demographic needs and build a health service which fully and equitably responds to and meets the needs of all of the people who use it. Through this process there is an opportunity to harvest the full value from our investment in demographic data and public health initiatives under previous strategies.

Despite some improvements in recent years, the health service’s focus has been almost exclusively on curative interventions for people who are acutely unwell rather than on maintaining people’s well-being and quality of life. The committee should consider setting a definite, ring-fenced percentage of health spending on health promotion and health protection to grow incrementally over a 5 year period.

By committing to a ten year strategy for health services, Ireland can plan for foreseeable demographic needs and build a health service which fully and equitably responds to and meets the needs of all of the people who use it. Through this process there is an opportunity to harvest the full value from our investment in demographic data and public health initiatives under previous strategies.

In placing an emphasis on acute health services, the Committee's focus may be too narrow. It is vital to also consider the role that community and social care services play in how the health services operate. Understandably, much public concern and media focus is on timely service access but resolving the challenges in the Irish health service is as much about egress as it is about entry.

Services must exist in the community to enable people to successfully transition out of acute services. Too often the service user is expected to navigate through complex, bureaucratic systems in order to extract very basic services to meet their needs. Once engaged, the continual feedback from Irish health service users is positive. Any State that fails to address the prevailing anxieties of its citizens will flounder. In Ireland there is now an urgent need to restore public confidence in the public health services.

Key points of this submission

The following points refer to priorities which should be reflected in the final 10 year strategy.

- **Set an ambitious vision for world class, high quality health services**

A ten year plan for Ireland's health service needs to set ambitious goals which stimulate reform to deliver a far more effective, better quality and more equal service than currently exists. Ireland needs a health system which, not only treats people equally, but equitably and, most importantly, effectively and with respect. A world quality health service is one that can reliably and consistently deliver access to effective and efficient services offering individual choice, including decisions which medical professionals might consider sub-optimal.

People using Rehab's services access the full spectrum of health and social care, acute, primary and community health services and they experience significant variation in availability and eligibility across geographic areas impacting on their ability to access essential services, in a timely and predictable manner. Variation is the enemy of quality. We believe that the viewpoint afforded by this cross party alongside multi annual initiatives can be a powerful agent for change and will instil hope for the future.

Following many years of reduction and retreat the Irish health system has had to retract back to acute care. It is now time to reinvest in our services in a careful and considered manner. In 10 years time it should be more than a service only available to people who are acutely unwell. It should have become a shared, cherished and community-mandated national resource that safeguards and promotes the health of the nation.

Private health services need to be disaggregated from public provision, the current two tier system introduces unhelpful turbulence, cross subsidies and inequity. A broad based public health and social care system will benefit all users equally. Where all citizens, avail of and depend upon a unitary health service, well-organised and articulate voices can be marshalled to advocate effectively, benefitting of all citizens.

Throughout the world, Irish healthcare professionals from all disciplines are highly regarded and sought after. The availability of intelligent and skilled practitioners, who can remain compassionate in traumatic circumstances shouldn't be taken for granted. If we wish to retain these professionals into the future, we must take active steps to protect against burnout and leak away by ceasing to expect highly valued staff operate in poorly designed facilities, systems and processes.

Across all health services, we need to develop attractive, sustainable and affordable career structures which respect and reflect the health professionals' life stage and work life balance and continuing development needs. In the past, attempts were made to financially compensate staff for working in poorly designed facilities and processes. This had created a perverse incentive which works against rational design and ergonomic career structures.

In creating a world class health service, there will be a need to let go of some long-established service models which have long since outlived their usefulness. Within the Strategy, the Committee must show leadership and make recommendations on how out-moded approaches and service models can be ethically and respectfully decommissioned.

The committee needs to challenge and test some underlying assumptions which may no longer be valid in modern Ireland; do the Irish people really care, do they want a vibrant public health service, and what will they forgo in order to make such a possibility a reality. If as a people we are really serious about providing world class health and social services then it is well within our grasp, but if we are in any way ambivalent about this ambition then we will continue to fall short, disappoint and ultimately fail.

We urgently need to restore and instil a collective sense of ownership. The symbolism of language is important to Irish people and it would be appropriate and helpful to always refer to '*our health service'* throughout the Committee' report. The prevailing belief that a functioning, fair and effective public health system is somehow impossible to achieve is a myth that has been fostered by well placed and powerful vested interests. There is no room for hopelessness in this debate.

Irish demographic trends clearly demonstrate a requirement for more creative responses to our aging population. The pre-mature and excessive uptake of captive, residential services like '*Fair Deal'* reveal a failure of ambition and imagination. That so many of our citizens have forsaken their homes, is a poor reflection on the balance of service provision and tragically harks back to an institutional past, the great confinement and block treatment. We need to be vigilant and not subject our older citizens to a segregated existence, denying them the opportunity to contribute to their communities in a meaningful way. Sleepwalking into institutional provision must be avoided at all costs. While the quality of care and accommodation has been greatly improved through the efforts of Regulators and providers the quality of décor is not at issue, As Lady Hale, Deputy President of the UK's Supreme Court, succinctly puts it, *"A gilded cage is still a cage"*.

Ireland's over reliance upon residential models of care only serves to illustrate a lack of confidence in the continuity, dependability and sufficiency of home based supports. The Department of the Environment should consider the provision of grants to adapt family homes so that an older person can retain their rightful place within their home communities.

- **Create a responsive, planned health services**

The story of Ireland's health service is punctuated by crises, many of which are entirely predictable. Every year, there is a seasonal trolley crisis. There are regular references to the demographic time bomb just waiting to explode as Ireland's population ages. Every year within disability services, there is a rush to provide for the needs of school leavers with disabilities.

The new 10 year strategy must fundamentally reform our current health system which is unduly driven by fire fighting. It must fully orientate itself towards a national health service that readily responds to needs that have been identified and planned for. This will not only improve the efficiency of the health services from a cost perspective, it will also improve the experience of the person using the services. Once plans are cast they should not be deviated from without significant cause, too often the urgent displaces the important and priorities become clouded and confused.

The health service needs to plan for everyone who uses its services. The focus is often on the needs of a person who attends at an emergency department in cardiac arrest but not for people who because of chronic condition will require frequent hospitalisations over the course of their lives. Service stratification and faithful adherence to care pathways and protocols have a central role in this instance.

For people with disabilities, this inability to plan for the future creates considerable inertia and difficulty in their lives. For example, a young person with a disability in school is going to have a disability when they leave school and require a disability but often options for ongoing support are not considered or provided for until the last minute. This causes needless anxiety and concern for families and is entirely unavoidable in a service that plans over a longer period of time.

Better planning will require significant capacity building across a health sector which is more used to fire fighting so the challenge of creating a better planned health service should not be underestimated. The pay-off in the long-run will be substantial though and the strategy should not shy away from this.

- **Community and acute hospital services must be equally valued and respected**

Members of the public must also be reoriented to appreciate and value community and outpatient clinic appointments. Elevated 'Did not attend' rates show an alarming loss of capacity and waste. The use of appointment validation and confirmation systems for OPD and community services by using SMS prompts and reminders can restore significant service capacity. While these services are provided free of charge, the wasteful opportunity cost of non-attendance should be charged for.

- **The Strategy should deliver parity of support between Section 38 and Section 39 agencies**

Agencies funded by the HSE are currently funded under either Section 38 or Section 39 of the Health Act 2004. Section 38 organisations are effectively quasi-state bodies whose employees are public servants who benefit from pay agreements and awards. Section 39 bodies are independent organisations which provide services for the HSE, employing their own staff with their own terms and conditions.

A fundamental disparity exists in relation to how these organisations are treated by the state and, by extension, how the people who use their services are treated**.** Section 39 organisations bring a necessary flexibility and agility to the HSE's service provision. They invest in training and infrastructure but are not fully compensated in their funding. National Pay increases do not automatically accrue to Section 39 organisations to pass on to their employees, but somehow pay cuts always do. Section 39 organisations are subject to labour market pressures and must therefore implement pay increases in order to retain talent and protect service continuity. It is time that this is recognised in government policy and that the services that people rely on in our communities are not funded at differing levels simply because of the nature of the legal arrangement with the state.

- **Invest in and fully support the development of mental health services**

There is no health without mental health. People with enduring mental health conditions are significant users of Ireland's health services, have foreshortened lives and yet the resources available to support them are significantly lower than they need to be. Ireland has experienced a pendular swing in acute mental health bed numbers from the World record in the 1950's (22,000 beds) to one of Europe's lowest bed to population ratios (20:100,000). With less than 7% of health spending (WHO recommends 12%) it is time to rebalance the allocation to a more rational degree. 90% of all mental health provision occurs in Primary Care with 35% or 5.6 million annual GP consultations relating to a mental health needs. GPs and Primary Care practitioners need to be in a position to offer a wide range of interventions. Improving access to counselling in Primary Care is to be welcomed, but GPs also need to be supported and to become more active in screening to protect the physical health of adults with disabling mental health needs.

The Rehab Group fully endorses community-based services for people with mental health difficulties but insists that such services are adequately resourced to full their ambition to support people outside of the acute health sector. Sustained recovery in mental health is as much an educational process as it is a therapeutic process and people who use mental health services must have options beyond acute care and treatment within the community. Shared activities, access to accredited education and real employment opportunities are clearly shown to reduce social isolation, promote integration and enhance mental health status. Flexible funding models need to be available that allow the individual 'a life beyond therapy' where they can regain their confidence, identity and place within their community.

People in distress, crisis and at risk of self-harm must enter the health system in the same way as everyone else, however overcrowded emergency departments which are ill-equipped to deal with the complexity of their needs. Additional alternative channels that can response to emotional distress and vulnerability are needed. The Strategy must remove the need for all to attend acute hospital unless their case is urgent. A range of innovative community-based initiatives including Living Room initiatives, drop-in cafes, Crisis Houses, SCAN (*Suicide Crisis Assessment Nurses)* and Self Harm nurse specialists in Emergency Departments. have been developed in the mental health field to provide social and therapeutic support to avoid hospitalisation.

- **Develop and invest in a credible, reliable community care sector**

Beyond the acute sector, there are areas of the health-funded services which are significantly under-resourced. Community-based services such as physiotherapy, speech and language therapy and occupational therapy are significantly under-developed. Demand-led schemes are always funded but for other services, particularly those based in the community, rationing is applied as soon as the allocation is exhausted. Waiting lists are closed once the resource is committed and this, stop-start model is ineffective and discouraging. People lose confidence in the availability of such services and can feel compelled to insulate themselves from under provision by migrating back towards acute sector.

The families of children with disabilities will often turn to private providers to get essential services that they should be entitled to receive for free of charge. This constrained access

has a real and degrading effect on those in urgent need and has a significant impoverishing impact on those affected, and particularly on people with a disability.

community based services were originally designed to cater for specific cohorts with acknowledged additional needs, Older persons, people with a disability, children, pregnant mothers, people with a mental illness. Recent attempts to widen the base of primary care has often caused these services to be extended to the wider community, this would be a welcome development if the requisite additional investment had been front loaded.

Unfortunately the recent economic crisis mitigated against this possibility and now many of the people with specific needs have been displaced by more assertive service users. Clarity on the eligibility to services would be helpful and universal access to adequately resourced community services would be the preferred outcome. Guarding the boundaries of eligibility has become a preoccupation and much administrative effort is expended on rationing service access and addressing appeals.

Early advocates of community services often considered community-based care as being a cheaper alternative to hospitalisation, but high quality community services bring an inherent inefficiency and so must be resourced accordingly if all members of the community are to be reached. The State must reserve the right to determine that in some instances it may not be feasible, appropriate or possible to sustain adequate service levels to all members of the community within their home context.

Another erroneous interpretation of *community care* is to attempt to recreate a hospital within the persons own home environment, bringing high tech interventions into a domestic setting. Unless such interventions can be extended to all members of the community, then the economics and equity of such initiatives must be questioned.

As mentioned earlier, community care is predicated on the base assumption that the community does indeed care. The Committee may wish to test the validity of this assumption.

- **Empower the person to manage their own their health in partnership with health professionals**

The disability sector has embraced person-centred approaches in recent years, placing the person at the centre of their service and empowering them to make decisions about their lives. A similar practice has been embraced in the mental health services where enabling people to manage their own recovery is understood as key to long-term, positive outcomes.

Chronic disease management is an educational process with shared learning, information exchange and shared responsibility. Modern information and communications technology lends an unprecedented opportunity to deliver confidential, individually tailored interventions directly to the service users. Enabling a person to understand and manage their own health needs has been demonstrated to have a profound health protecting effect.

These protocols work best when they are guided by best evidence, guided by universal protocols and operated by skilled professionals. These initiatives can preserve finite human resources and staff time and can guide their deployment to the point of greatest positive impact.

Often the way that individuals availing of health and social services are referred to can be depersonalising and unintentionally offensive. To be reduced to a '*patient', 'client'* or *'resident'* has almost become part of the healthcare transaction, an unspoken exchange to facilitate the needs of the system and can have a corrosive and hardening effect on staff members. A strategy which recognises this fully will lead to the development of a far more human, effective and quality health service in Ireland.

- **Promote the full and effective use of technology and innovation throughout the health services.**

Ireland's health service must be able to move with the times to adopt relevant international best practice and to develop its own best practice. The current system is often so overwhelmed by overcrowding that there is little space for innovation and this is something that must be provided for in the new Strategy. There are savings to be made within existing resources within the health service. Over the next decade, new technology and innovations will enable better use of available resources and identifying these should be a central recommendation of the Oireachtas Committee.

Ireland is recognized throughout the world, in taking a leading role in the development of computer hardware, applications and data mining. We now need to leverage this capability to the benefit of our own citizens. In relation to health technology and information systems it is now time to get past the trauma and embarrassment of the P-PARS experience

By utilizing the safeguards imbedded in data protection, assisted decision making (capacity and consent) and confidentiality, the Irish health system must introduce a unique identifier for citizens to interact with all health and social services. For individuals who elect to remain outside such a system they should be fully advised that the pace and effectiveness of their service access maybe be sub-optimal without their decision impacting on the service quality of others.

Moving beyond simplistic solutions to complex problems, this cross-party committee affords an opportunity to develop resilient and elegant solutions to meet our population needs.

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Rotunda Hospital

The Rotunda Hospital Dublin seeks to redevelop as a co-located hospital on the campus of Connolly Hospital, in order to continue its 270 year tradition of provision of world-class healthcare for women and children, locally in Dublin, regionally in the north east of Ireland, and nationally across the island of Ireland. The principles upon which the Rotunda model of service delivery is built are as follows:

- Using a mix of community and the hospital-based care, keeping services close to the woman where possible and ensuring care is delivered in the most appropriate setting by the most appropriate team
- Providing choice for women in the context of evidenced-based, safe, and high quality care, as described by the National Maternity Strategy 2016-2026
- Playing a national and international role in Education and Research, by collaboration with our RCSI Academic and RCSI Hospitals Group partners
- Delivering care from a physical infrastructure which is world-class, designed, built and operated to international standards, making the best use of space, adjacencies, and technologies
- Continuing to harness the efficiency and innovation associated with its voluntary status and independent governance model to provide highest quality care for women and children of Ireland

Introduction

The Rotunda Hospital Dublin, as the oldest Maternity Hospital in Ireland and with more than 270 years' experience in providing innovative and world-class healthcare to women and babies, welcomes the opportunity to provide input to the Joint Oireachtas Committee on the Future of Healthcare.

The Rotunda is one of the major stand-alone maternity hospitals in the state and is responsible for the healthcare needs of over 9,000 pregnant women per annum, delivering approximately 15% of the total births in Ireland. This makes the Rotunda one of the largest maternity hospitals in Europe, with an internationally recognised brand and reputation for excellence in Women and Infants healthcare. The Hospital also provides an extensive neonatal service to premature and sick babies, including those delivered in the Rotunda and those transferred in from other hospitals throughout the country.

The Rotunda Hospital is also the largest provider of benign gynaecology services to the north Dublin area as well as the geographic area extending from Dublin to the border. The success of the Rotunda is based on the governance provided through its voluntary status, with an executive management team comprising senior clinicians, together with the support of an independent voluntary Board of Governors. This voluntary model, with Executive and Board in such close proximity to the governance of service delivery, enables the hospital to be innovative and responsive to the developing needs of women and babies as well as encouraging clinical reflection, audit and research.

This 270 year history in the provision of excellence in maternity and neonatal care now needs to be progressed further by redeveloping the Rotunda Hospital adjacent to an acute general hospital, together with the availability of specialist paediatric hospital services. The development of this co-location of services presents an **unrivalled opportunity for Ireland to create an internationally renowned campus** providing world-class healthcare 'from cradle to grave'. **The Rotunda Board and Executive Management Team are fully committed to this development**, are fully engaged with the process, and wish to see it progress as quickly as possible.

The basic principles upon which the **Rotunda model of service delivery** is built are as follows:

- Using a mix of community and the hospital-based care, keeping services close to the woman where possible and ensuring care is delivered in the most appropriate setting by the most appropriate team
- Providing choice for women in the context of evidenced-based, safe, and high quality care, as described by the National Maternity Strategy 2016-2026
- Playing a national and international role in Education and Research, by collaboration with our RCSI Academic and RCSI Hospitals Group partners
- Delivering care from a physical infrastructure which is world-class, designed, built and operated to international standards, making the best use of space, adjacencies, and technologies
- Continuing to harness the efficiency and innovation associated with its voluntary status and independent governance model to provide highest quality care for women and children of Ireland

The Rotunda favours a model of **fully integrated normal and high-risk care with a consistent standard of facilities** for all women attending, with women's care led by the most appropriate professionals across all relevant disciplines.

Healthcare Structure

We believe that health is a continuum and the focus of the ten year plan should be on a wellbeing model rather on a disease model. We believe that maternity services are a critical link in the progression of this model as they are ideally placed to engage with the family and promote wellness from pre-conception throughout life. This can be addressed through the provision of services largely in community settings that encourage individuals to:

- optimise their health status when considering pregnancy
- avail of screening and intervention during pregnancy to ensure optimal health of their baby
- breastfeed their baby to achieve the well-recognised health benefits for later life are maximised
- avail of early intervention programmes to support parents in the management of their family

Health and wellbeing must be integrated to reflect the lifetime needs of individuals. The health service structures must be integrated to a single commissioning model that accommodates the needs of the individual at all stages of their life, rather than being provided in the current "silo" model of primary, acute, long-term illness and psychiatric care programmes.

Much time has been devoted to discussions on the funding of the healthcare system by comparing funding models of one country against another. We believe that this approach is not optimal. Funding comparisons against other EU countries are not reflective of the current Irish healthcare system and do not provide an accurate reflection of the investment and funding required for the current and future demands of the Irish system.

We believe that some of the funding concerns within our healthcare system would be addressed through specific changes in the current healthcare financing structure:

- Funding should reflect actual costs of providing agreed services in line with patient needs and patient centred ("money follows the patient"), with all such costs being benchmarked
- Good performance outside of agreed parameters should be financially rewarded while poor performance should be managed through an agreed remedial process
- An independent commissioning unit of healthcare providers should be established, which would help secure better outcomes for service users, better match services to the needs of the population and secure greater efficiency from services
- Commissioning of services should be available from public, voluntary and private healthcare providers

Healthcare Demographics and Person-Centred Care

Demographic statistics show that Ireland's population is increasing and forecast to grow even further in the coming years. Relative to other EU countries the Irish death rate is falling, with Irish people living longer than the average in Europe. This increase in longevity together with a younger than average population, explains our low death rate in recent times.

While this demographic change is positive for the individual, these evolving demographics pose challenges for the healthcare service:

- A requirement for increased coordination of health education, awareness programmes and effective public health measures spanning the pre-conception period, through pregnancy, birth, childhood and into old age
- The expansion of the Healthy Ireland initiative to incorporate healthcare advice into education, capital development, social welfare provision and where good compliance with health and wellbeing initiatives is rewarded. The maternity and paternity benefits could be enhanced if there is evidence of compliance with well-designed health care programmes that promote wellness

Investment for the Future

Investing in effective public health measures and awareness campaigns will improve the general health of the population and place less demands on acute health services into the future.

A world class healthcare system demands world class talent. It is vital that the health sector retains and attracts workers at all skill levels. It is critical that the talent pool is trained to adapt to a rapidly changing healthcare environment. This will require:

- Adequate funding for up-skilling of staff, with a strategic education plan for current healthcare workforce to allow better recruitment, improved career pathways and maximising retention of staff
- Investment in the development of an IT infrastructure within the healthcare system which will support new connected healthcare solutions, allowing healthcare providers gain full advantage of the technical advances which are transforming the healthcare environment. Such connected IT

infrastructures will facilitate greater information-sharing without creating unnecessary regulatory burdens

- Conducting a future skills need analysis for the healthcare sector, being mindful of the changing business environment, in particular the impact of technology on skills requirements of the future
- Encouraging business and healthcare partnerships to promote specific healthcare developments and staff potential

The Rotunda Hospital and the RCSI Hospitals Group Network

The Rotunda's vision for the development of a world-class Women and Infants healthcare system places the new Rotunda Hospital at the heart of a major adult hospital on the site of the Connolly Hospital campus, co-located with appropriate paediatric facilities through a satellite hospital of the Children's Hospital Group.

This new, tri-located hospital campus would have the space, capacity and potential to:

- Be the major adult teaching hospital campus for the RCSI Hospitals Group on the north side of Dublin, by harnessing the joint expertise available at Connolly and Beaumont Hospitals

- Be the co-located site of a 10,000 to 12,000 birth per annum maternity hospital, functioning as a national referral site for complex obstetric and neonatal care

- Be the co-located site of a major paediatric satellite site of the Children's Hospital Group, providing subspecialist paediatric care as needed to the maternity hospital

- Be the site of major academic investment by the RCSI university as the principal clinical teaching site for medicine, nursing, pharmacy and allied health professionals

- Be the centre of a new healthcare-industry research and development hub, based at the junction of the M50 and M3, in close proximity to Dublin airport, maximising rapid access to hospital and related pharma, IT, and healthcare industry resources

The new Rotunda Hospital at Connolly would provide advanced maternal-fetal medicine services for the RCSI Hospitals Group, extending from Dublin as far north as the Border, including support for prenatal diagnosis, high risk obstetric care and fetal treatment for patients of the RCSI Hospitals Group network, such as Our Lady of Lourdes Hospital Drogheda and Cavan General Hospital.

The new Rotunda Hospital at Connolly would provide advanced gynaecologic services for the RCSI Hospitals Group, including leadership for gynaecologic oncology, reproductive medicine and urogynaecology services for the RCSI Hospitals Group network.

The new Rotunda Hospital at Connolly would provide advanced neonatal intensive care facilities for the most complex and premature babies in-born at the Rotunda, as well as select out-born babies from RCSI Hospitals Group network hospitals, such as Our Lady of Lourdes Hospital Drogheda and Cavan General Hospital.

The new Rotunda Hospital at Connolly would support the provision of localised care for women and infants services at community clinics throughout the RCSI Hospitals Group network region, provided by doctors, midwives, public health nurses, physiotherapists, social workers and dieticians, linked to the region's General Practitioner networks through an integrated IT system. A single, high-standard of care would therefore be available for all patients in close proximity to their home location, provided by local clinical teams, but with immediate access to the advanced facilities of the Rotunda Hospital at

Connolly. It is the hope of the Rotunda Hospital Dublin Executive Management Team that these observations on the future direction of healthcare developments in Ireland will be of assistance to members of the Joint Oireachtas Committee on the Future of Healthcare, in particular when considering the needs of Women and Children. We would be happy to expand on any of these areas if requested by the Committee member

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Royal College of Physicians of Ireland

The Royal College of Physicians of Ireland is a postgraduate medical training college dedicated to ensuring that doctors have the skills to provide patients with the best possible care**.** In addition to providing postgraduate training and ongoing professional education for Irish doctors, RCPI seeks to promote high quality patient-centred care and continuous improvement of the health service.

Recognising that sustainability of the health service depends on prevention of ill-health, RCPI advocates for public policy actions to address lifestyle risk factors associated with chronic disease.

Towards 2026: A Vision for patients, hospitals and doctors

In 2016, the College established *Towards 2026: A Vision for patients, hospitals and doctors*, a policy forum to deliver a vision for the future of hospital care in Ireland. Dr Tom Keane, the former National Director of the Cancer Control Programme, chairs this group which includes patients and carers, doctors from a range of specialities, hospitals management and representatives from the Department of Health.

Technical Briefing – November 2016

The forum will issue a report in late 2016. The College hopes that the work being undertaken as part of the Towards 2026 policy forum and its recommendations can inform the 10 year plan being developed by the Oireachtas Committee for Future Healthcare. While its work is still continuing we would like to offer a technical briefing to the Oireachtas Committee for Future Healthcare in November, which is the earliest opportunity we will have to discuss the recommendations and share the themes and issues emerging. This briefing will also give the Committee members an opportunity to discuss issues around hospital care for the next decade with our physicians who have led this important policy work.

Section 1 of this submission responds to the question ***What are the key priorities for inclusion in a 10 year plan for the health services?*** by providing information on themes emerging from the initial discussions of the Towards 2026 policy forum.

Section 2 responds to the same question ***What are the key priorities for inclusion in a 10 year plan for the health services?,*** by focusing on prevention, with reference to public policy interventions aimed at addressing lifestyle risk factors of alcohol consumption, obesity, smoking and physical inactivity.

Section 3 responds to the questions on **integrated care**, with reference to the National Clinical Care Programmes.

About the Royal College of Physicians of Ireland

The Royal College of Physicians of Ireland (RCPI) seeks to play a leading role in promoting and safeguarding the health of the nation through medical training, education, professional standards for high quality patient-centred care and continuous improvement of the health service. The value of clinical leadership is well established and it is the responsibility of the medical profession to provide a strong voice on the development of healthcare service delivery.

While our role in society has undergone profound changes since our foundation in 1654, we remain first and foremost a college – dedicated to the education and training of doctors. We are committed to helping doctors enhance their skills, competencies and professionalism throughout their working lives.

We house six of the 13 postgraduate specialist training bodies in Ireland:

- The Irish Committee on Higher Medical Training
- Faculty of Occupational Medicine
- Faculty of Pathology
- Faculty of Paediatrics
- Faculty of Public Health Medicine
- Institute of Obstetricians and Gynaecologists

International Clinical Fellowship Programme

With the support of the Health Service Executive National Doctors Training and Planning (HSE NDTP), RCPI has developed a programme offering clinical training to doctors from outside of Ireland who are sponsored by their government, hospital or national training body. This programme is an opportunity for experienced doctors who have completed their medical degree through English to learn advanced skills that are especially beneficial for the health services in their home country.

Quality Improvement and National Clinical Programmes

RCPI manages a number of initiatives designed to empower doctors and other health workers to lead improvements in healthcare services. Many of these initiatives involve close collaboration between RCPI and the Health Service Executive. Healthcare workers who have trained with us have seen theory and methodology translate into tangible, measurable outcomes such as quicker access to care, fewer adverse events, cost-savings, reduced length of stay and more prudent use of resources.

Policy and Advocacy

The Royal College of Physicians, recognising that many of the determinants of ill-health lie outside of the healthcare system, has a longstanding record of leadership in the area of public health policy. We have a policy groups comprised of members, fellows and trainees from a range of medical specialities within RCPI, representatives from other medical and healthcare professions, and relevant advocacy organisations.

These groups work together to review evidence and to develop recommendations to prevent illness and to promote wellbeing amongst the public. In recent years there has been a focus on alcohol, obesity and tobacco, and policy groups have also been established on physical activity and ageing.

RCPI also houses the Faculty of Public Health, which is also a strong advocate for public health policy, and which has been a driving force behind the establishment of many of the RCPI policy groups.

Towards 2026: A vision for patients, hospitals and doctors

This section responds to the question: What are the key priorities for inclusion in a ten year plan for the health services?

In 2016, RCPI established *Towards 2026: A Vision for patients, hospitals and doctors*, a policy forum to deliver a vision for the future of hospital care in Ireland and to examine the role of the doctor in a more responsive and dynamic healthcare system. This group is continuing its work so this submission does not contain recommendations regarding future hospitals care as they have not been developed at this stage. We are mindful of the work and timelines the Committee is working towards and are open to sharing this information at the earliest opportunity to inform its work.

The College would like to offer the Committee a technical briefing on the recommendations and emerging themes in November 2016, which is the earliest opportunity for us to share this information and facilitate discussions with our physicians in light of this important policy work. The Towards 2026 final report and recommendations will be published in late 2016.

The Towards 2026 forum is currently examining how best to deliver patient-centred care based on the best available evidence on population and disease projections. The group also hopes to generate debate within the professions and inform wider political and public discourse on the future of our healthcare system.

Composition of the Policy Group

Dr Tom Keane, the former National Director of the Cancer Control Programme chairs the policy forum. Members represent a range of medical disciplines, professional bodies and healthcare organisations.

Representatives from the Department of Health's Acute Hospital Policy Division are also members of this forum.

Towards 2026: The case for action

The population of Ireland has grown and continues to grow. Acute hospitals have seen a corresponding increase in day cases and inpatients. While length of hospital stay has reduced, we have seen a fall of a quarter in inpatient beds and only a small rise in day-case beds. A significant proportion of Emergency Department attendances are aged 65 or over - 22% in 2014 of which almost 12.5% were aged 75 or over.

Between 2007 and 2020, it is estimated that the number of adults with chronic diseases will increase by around 40%.[194] Patients with a chronic disease are more likely to present with multiple other comorbidities[195] which require continuous long-term care delivered by a multidisciplinary team.

Advances in new healthcare technologies and medications have raised professional and public expectation regarding treatment. This progress is now threatened by our incapacity to deal with the increased demand. All of the evidence points to the need to shift to disease prevention.

There is a clear need for sustainable consensus on a health agenda and multi-annual budgets to enable long-term health system planning based on population need.

Towards 2026: Discussions and emerging themes

The aim of *Towards 2026* is to create a collective vision for the future hospital in the context of an evolving healthcare system based on current and future policy decisions. This frame will be supported by peer-reviewed evidence where possible.

Assumptions underpinning this process are as follows:

1. The Primary Care Model will evolve.
2. The Integrated Care Model will develop progressively over the next ten years.
3. ehealth will play a central role in the delivery of all future models of care.
4. The population will continue to age and chronic disease rates will continue to increase.
5. The typical future patient will be elderly with multiple chronic diseases.

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[194] Balanda KP, Barron S, Fahy L. Making Chronic Conditions Count: Hypertension, Coronary Heart Disease, Stroke, Diabetes. A systematic approach to estimating and forecasting population prevalence on the island of Ireland. Executive Summary Dublin: Institute of Public Health, 2010.

[195] O'Shea et al. BMC Health Services Research 2013, 13:23 http://www.biomedcentral.com/1472-6963/13/23

6. Open disclosure will be introduced.

Initial emerging themes from this policy forum include:

‘A Caring Environment’

- A culture that values and maintains wellness
- A bipartisan approach to healthcare in the political sphere
- Healthcare planning based on population-level needs assessment.

‘Caring Systems’

- Universal access to appropriate services based on clinical need and not ability to pay
- Sufficient capacity to meet demand particularly in community services
- Integrated ICT systems incl. EHR, UPI and eHealth
- A transparent system for prioritisation and allocation of resources and a culture of continuous quality improvement.

‘Citizen Empowerment’

- Self- and shared-management of healthcare
- Education and access to medical information
- Personalised care

‘Role of Healthcare Providers’

- Integrated care
- A culture of shared accountability and governance
- Multidisciplinary support at community level
- Clinical leadership
- Expansion of roles
- Level and location of care according to complexity of care required (with specific focus on older people and people with mental health conditions)

Throughout the forum discussions to date, there has been clear recognition of the significant impact social demographics have on access to care, level of education and ability to take on responsibility for one’s own health.

Towards 2026: Evidence

There is an abundance of international literature on the evolution of hospital care in different geographic, economic and cultural settings. Consistently recurring recommendations on the theme of future healthcare delivery include:

- Focus on health, wellbeing and disease prevention
- Universal Health Care
- Clinical Leadership
- Integrated models of care
- Patient-centred care
- Patient empowerment
- Good Governance, accountability and transparency
- Strong Primary Care Model
- Competency-based training for doctors
- Expanded Roles for non-physicians

Primary Prevention through public policy

This section responds to the question: What are the key priorities for inclusion in a ten year plan for the health services?

Summary of recommendations:

- We will be in a position to outline key priorities and recommendations regarding the future of patient-centred hospitals care at a technical briefing in November 2016.
- The ten-year plan for the health services should explicitly acknowledge the role of prevention and should describe how prevention will be funded and prioritised.
- Immediate and full adoption of the Public Health Alcohol Bill and all of its measures
- Ensure excise duties on alcohol products increase year on year in line with inflation.
- Introduce a 20% tax on sugar sweetened drinks in budget 2017.
- Introduce traffic light labelling on food products.
- Publish and adequately resource the implementation of the National Obesity Strategy
- Introduce a ban on the marketing of unhealthy foods to children.
- Increase excise duties on cigarettes and roll your own products in budget 2017
- Fully implement the National Physical Activity Plan, with adequate resourcing for all actions defined in the plan.

Prevention and keeping people well

Chronic diseases are major drivers of healthcare costs. Ninety per cent of our total healthcare costs are spent on the 30% of the population with chronic diseases. [196] Many of these diseases are caused or worsened by risk factors such as tobacco use, overweight and obesity, alcohol consumption and physical inactivity. Prevalence of chronic conditions and accompanying lifestyle factors are also strongly influenced by socio-economic status, level of education, employment and housing.

The healthcare and economic burden associated with some of these risk factors is alarming:

- Smoking related healthcare costs were estimated at €466 million in 2013.[197]
- Healthcare costs of alcohol- related illness were estimated at €1.2 billion in 2007, with a total economic cost of €3.7 billion. [198]
- Estimated cost of overweight and Obesity was €1.13 billion in 2009, of which direct healthcare costs were €400m. [199]
- The cost of physical inactivity is estimated to be approximately €1.5 billion annually. [200]

A sustainable healthcare system will not be possible unless prevention and self-management is prioritised, resourced and rewarded.

Already prevention is emerging as a theme from the discussions of the Towards 2026 policy forum. Among the forum members, there is widespread support for prioritisation of action on preventing ill-health and disease and keeping the population healthy.

Healthy Ireland has established a vision for keeping people well and has highlighted the need for cross-sectoral actions to advance this vision. Sustained political support is necessary to make progress on reaching specific targets defined in the Healthy Ireland framework. **The ten-year plan for the health**

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[196] HSE (2016) Planning for Health: Trends and Priorities to Inform Health Service Planning.

[197] IFC International (2016) An assessment of the economic cost of smoking in Ireland.

[198] Byrne S (2011) Costs to society of problem alcohol use in Ireland. Dublin: Health Service Executive.

[199] Safefood. The cost of overweight and obesity on the island of Ireland. Safefood; 2012.

[200] Department of Health and Department of Transport, Tourism and Sport (2016) Get Ireland Active-National Physical Activity Plan for Ireland.

services should explicitly acknowledge the role of prevention and should describe how prevention will be funded and prioritised.

RCPI's policy groups have published recommendations aimed at reducing the burden of disease and the costs associated with the above risk factors, with a focus on public policy recommendations. They have also published recommendations for action within various settings including within healthcare settings.

The following actions are immediate public policy actions for primary prevention that can address many of these risk factors at population level. Many of the actions below represent 'quick-wins' for public health policy in that they are based on evidence of what works and they have widespread public support. They will save lives, reduce long term healthcare costs and reduce economic costs associated with lost productivity and other costs associated

Alcohol

Every day in Ireland 3 people die as a direct result of alcohol use. It is a major factor in suicides and increases the risk of 7 types of cancers. Alcohol is associated with 900 new cancer cases in Ireland

every year and 500 cancer deaths. At least half of all alcohol related cancers could be avoided by drinking within recommended limits. [201]

We recommend full and immediate adoption of the Public Health Alcohol Bill

The public health alcohol bill was published in 2015 and contains a range of evidence-based measures that target the pricing, availability and marketing of alcohol products – factors that are known to have the greatest impact on harmful drinking. Adoption of this bill would reduce alcohol consumption and would save lives.

Minimum Unit Pricing will have a significant and immediate impact. In British Columbia, Canada a 10% increase in minimum price saw consumption decrease by 3.4% overall and there was a 32% reduction in alcohol attributable deaths within a year. [202]

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[201] Laffoy M, McCarthy T, Mullen L, Byrne D, Martin J. Cancer incidence and mortality due to alcohol: an analysis of 10-year data. Ir Med J. 2013 Nov-Dec;106(10):294-7. PubMed PMID: 24579406.

[202] Zhao et al (2013) The relationship between changes to minimum alcohol prices, outlet densities and alcohol attributable deaths in British Columbia in 2002-2009. Addiction, 108: doi: 10.1111/add.12139

The bill also provides for labelling of alcohol products. There are no health benefits from consuming alcohol; it is high in calories and may contribute to excess weight gain. Better labelling can help consumers to make better and more informed choices around alcohol, and has widespread public support. Over 95% of people support better labelling of details of alcohol-related harms. There is also strong support for labelling on alcohol strength, the number of calories and ingredients.

The bill will also protect children from alcohol marketing. More than 90% of Irish children reported that they were exposed to traditional, or offline, alcohol advertisements and more than half saw four or more alcohol advertisements per day.[203] Current systems of self-regulation are ineffective in terms of protecting children from exposure to alcohol marketing, and will in the bill be replaced by statutory regulation.

We also recommend increasing excise duties in line with inflation in budget 2017 and successive budgets.

Obesity

Ireland's obesity levels have reached a crisis point. One in four Irish children are overweight or obese. Two out of every three adults are overweight or obese. [204] By 2025 it's estimated that 37% of Irish women and 38% of Irish men will be obese.[205]

The determinants of obesity are complex and no one measure alone will reverse the trends. The National Obesity Strategy will describe a range of measures to reduce obesity.

We recommend that this strategy is adequately resourced and implemented in full.

We also recommend:

- Introduction of a 20 per cent tax on sugar sweetened drinks, including juices and sports drinks, in the 2017 budget.

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[203] K. A. Fox, C. Kelly & M. Molcho, Health Promotion Research Centre, NUI Galway. (2015) Alcohol Marketing and Young People's Drinking Behaviour in Ireland

[204] RCPI Policy Group on Obesity (2013). The Race We Don't want to win. Royal College of Physicians of Ireland, Dublin.

[205] NCD Risk Factor Collaboration. Country Profile: Ireland. www.ncdrisc.org/country-profile.html

- Introduction of a front-of-pack, traffic-light, food labelling system in addition to the 'Reference Intake' (RI), previously 'Guideline Daily Amount' (GDA) as allowed for under the new EU regulation (Regulation No (EU) 1169/20111) on the provision of food information to consumers.
- A ban on the marketing of unhealthy foods (High Fat Salt and Sugar – HFSS foods) to children.

Tobacco

Smoking is a major health hazard in Ireland. With the aim of reducing smoking prevalence to less than 5% by the year 2025 (the target set by Tobacco Free Ireland 2013) we recommend the following: [206]:

- Introduction of standardised packaging.
- A licensing system for the sale of tobacco products
- Stricter enforcement of tobacco legislation
- Publishing of details of retailer outlets in contravention of tobacco sale legislation
- A ban on sale of electronic cigarettes to children
- Removal of VAT on nicotine replacement patches
- Price cap regulation on tobacco industry profits
- A ban on the sale of tobacco products at events/locations primarily intended for persons under 18 years of age
- Increase in excise duties on cigarettes and roll-your-own products in Budget 2017

Physical Activity

In Ireland physical inactivity is responsible for 8.8% of the disease burden from coronary heart disease; 10.9% of type 2 diabetes; 15.2% of breast cancers and 15.7% of colon cancers. [207] In the case of all of these major diseases, Irish statistics are worse than both European and global averages.

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[206] RCPI Policy Group on Tobacco (2014). Policy Statement- Towards a Tobacco Free Society. Royal College of Physicians of Ireland, Dublin.

[207] Lee, I.-M., Shiroma, E. J., Lobelo, F., Puska, P., Blair, S. N., & Katzmarzyk, P. T. (2012). Impact of Physical Inactivity on the World's Major Non-Communicable Diseases. Lancet, 380(9838), 219–229. http://doi.org/10.1016/S0140-6736(12)61031-9

Regular physical activity has appropriately been described a 'wonder drug' and offers health improvements far greater than for many drugs. Despite this, neither the adult nor child population in Ireland is active enough. Two thirds of adults to not meet national physical activity guidelines; 1 in 10 adults are sedentary. [200]

The National Physical Activity Plan was published in 2016 and should be supported and fully resourced. An increase of 10% in the proportion of the population undertaking regular physical activity could result in economic savings of up to €135 million annually. [208]

The Policy Group on Physical Activity was established in 2016 and is due to publish recommendations later this year and will provide the committee with a copy of these recommendations. These will cover the following areas:

- Planning and transport
- Workplace
- Education and Schools.
- Promotion of physical activity within clinical practice
- Medical training and education

National Clinical Programmes

This section responds to the questions from the committee that relate to integrated care.

The National Clinical Programmes (NCPs) are a series of clinician-led evidence-based service design initiatives set up to provide guidance on how to optimise patient care and services within the Irish healthcare system. The NCPs are a joint initiative established by the HSE and the professional clinical bodies, including RCPI. The programmes design and support models of care that optimise access, quality and value of healthcare services. The first programmes began in 2007 and there are now over 30 NCPs in place.

Achievements

Adoption of the NCPs coincided with a profoundly challenging period for the Irish economy and consequently for publicly-funded health services. Large funding and staffing cuts were imposed on the

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[208] Woods C, Murphy N, Mac Donncha C, Murphy MH. *The Case for a National Physical Activity Action Plan*. Available online at https://www.dcu.ie/shhp/downloads/NPAP.pdf.

Irish healthcare system since 2009. Despite this, evidence indicates that services have been maintained or enhanced since the cuts. Between 2009 and 2013, efficiencies within the health system achieved more day cases in the hospital sector (increase of 13.6%) and despite an increase in demand for acute services, slightly lower average lengths of stay (from 5.96 days in 2009 to 5.42 days in 2013)[209]. There were also some improvements in reducing wait times for elective public hospital care between 2011 and 2012.[210]

Some specific successes and achievements of the programmes include:

- Stroke Services: Inpatient mortality has been reduced by more than one quarter and there has been an increase of more than one third in patients discharged home rather than directly to a nursing home. The national thrombolysis rate has increased more than tenfold.[211] [212]
- Acute Coronary Syndrome: 92% of patients receiving reperfusion following a major heart attack are getting Primary Percutaneous Coronary Intervention which is evidenced as the most effective treatment, compared to 55% in 2011.[19]
- Rheumatology: the Musculoskeletal Physiotherapy Initiative has resulted in over 60,000 people being taken off rheumatology and orthopaedic outpatient waiting lists since 2012[213].
- Diabetes: Over 76,000 patients have undergone screening for retinopathy as part of the National Diabetic Retinopathy Screening Programme. Patients with diabetes have substantially improved access to an integrated podiatry service developed around the Diabetes Model of Care with 22 new podiatrist posts in acute care and a further 9 in the community this year.[214]

The success of these programmes show the significant potential that they can have in terms of improving access to the health services, developing standardised models of care and improving outcomes for patients.

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[209] Department of Health, 2014. Health in Ireland - Key Trends 2014 [WWW Document]. URL http://health.gov.ie/wp-content/uploads/2014/12/JD605-DHC_Key-Trends_2015_WEB.pdf (accessed 1.13.15).

[210] Burke, S., Thomas, S., Barry, S., Keegan, C., 2014. Indicators of health system coverage and activity in Ireland during the economic crisis 2008–2014 – From "more with less" to "less with less." Health Policy 117, 275–278. doi:10.1016/j.healthpol.2014.07.001

[211] Irish Heart Foundation, 2016. *Stroke Audit 2015*

[19] National Clinical Programme for Rheumatology, 2016

[20] National Clinical Programme for Diabetes, 2016

The continued support and development of the NCPs should underpin all future health service reform and ongoing improvement in patient care and outcomes.

Responses to committee questions on integrated care

Lessons learned through the NCPs provide useful direction for the delivery of integrated care.

What steps are needed to move from the current model towards a model based on integrated primary, secondary and community health care?

- Population planning around demographics (particularly ageing and frailty), disease prevention and early management of chronic disease are required to inform service design and capacity planning.
- Meaningful engagement between doctors, including GPs, multidisciplinary healthcare professions, HSE management, patients and Department of Health representatives.
- Investment in community & primary care services, and where required, within acute services, based on population needs.
  Careful development of KPIs based on system-wide quality indicators

What are the key barriers to achieving this, and how might they be addressed?

- There are substantial gaps in many community based health and social services which has resulted in an excessive shift in the burden of care towards acute health services and it is only when this is addressed that the process of integration of these services across the various settings will be possible.
- Funding must be **sustainable** and provided **across** the system to ensure patients are being seen in the appropriate setting and at a timely point in the disease process.
  Investment in IT is required to ensure sustained integration and flow of information across settings and to ensure patient flow.

How would you ensure buy-in from health care professionals to progress towards an integrated health care model?

The experience of the NCPs shows that change of work practice and service design are possible, where there are clear targets, inputs across disciplines, and a shared vision for improving patient outcomes.

Physicians will buy into integrated care if they believe that:

- Integrated services will optimise patient outcomes (there will be a requirement for clinicians to provide leadership on the service design)

- These services will be underpinned by sufficient and sustainable funding and workforce planning.

Examples of best practice

- The NCPs have produced evidence-based models of care and guidelines which consider international and national best practice. Many of these have not been implemented due to austerity and structural limitations.

Role of the NCPs in a new funding model

- Commissioning of services should be aligned to the implementation of models of care and guidelines designed by the NCPs and based on integration of services across settings.
- NCPs should continue to develop models of care and clinical guidelines and other decision-making tools, develop performance measures and support audit, in addition to providing advice regarding service alignment with evidence based models of care.

https://www.rcpi.ie/

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Appendix

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WHO (2015). WHO global strategy on people-centred and integrated health services – Interim Report. http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/

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Royal College of Surgeons of Ireland

RCSI welcomes the opportunity to make a submission and offers the following recommendations:
Develop the Hospital Groups: Good structures drive good outcomes. Enact legislation to underpin the agreed hospital groups and reforms to deliver on Group potential to better support patient care and hospital sustainability – e.g. all hospitals to develop long-term service plans that best structure services within their Group and leverage the competencies of their wider group.

Change Where we Provide Healthcare by Reducing Dependence on Acute Care Services:

1. Increase investment in primary care significantly and align primary and acute care networks. To deliver complex care in a variety of settings, we need a cross-organisational, care pathway approach to the management of chronic disease, the elderly, mental health, etc.
2. While the need for surgical care is growing, data highlights that we can manage surgery much more efficiently in the public sector if elective patients (and their surgical teams) have protected space (e.g. surgical facilities, beds). Hospital Groups also need to develop better protocols to deliver efficient, integrated and high quality care (e.g. referrals, communications with GPs). Long waiting lists should be addressed through targeted investment and reform – rather than short-term initiatives that do not tackle the underlying challenges.
3. We need continued targeted investment in wellness under ‘Healthy Ireland’ as many of our health issues stem from unhealthy lifestyles (e.g. lack of exercise, unhealthy diets).

Embed an Evidence Based Focus on Patient Outcomes: We need to progress our emphasis from budget management to delivering high quality care efficiently. This requires better data to track performance across all hospitals and to drive change. Ireland’s legal infrastructure (Health Information and Patient Safety Bill) to collect, manage and utilise information needs to be progressed urgently. We need to implement a structured National Quality Assurance Strategy.

Create One Step Up: Redesign professional roles (e.g. nurses, pharmacists, physician associates, physiotherapists, nutritionists, social workers) to enable all to work to the top of their abilities.

Improve Clinical Management and Executive Management Skills: Structured investment in Clinical and Executive healthcare leadership education and development is needed.

Retain and Develop World Class Healthcare Professionals in Ireland: We must provide good career paths and a better working environment to attract and retain talented people in Ireland.

Reform Clinical Indemnity: High insurance costs contribute to healthcare costs and a loss of healthcare professionals. In tandem with continued actions to improve surgical practice, we need to reduce the increasing costs of insurance.

Facilitate Work Permits For Non-EU Graduates Educated In Ireland: Enabling and supporting non-EU graduates who are educated here to work in Ireland post-graduation, where needed, would provide the Irish healthcare system with highly qualified and ready to practice healthcare professionals with the necessary technical, language and cultural skills.

Invest in Translational Health Research: It is essential that the Government support the embedding of research activities in the hospital groups.

Sustainable funding model: The funding model must ensure that everyone has access to high quality affordable healthcare by supporting long-term investment and reform.

While the funding model is important, we believe that the key challenge is to reform service delivery:

- Structural reform including significant investment in primary care, secondary care reform to deliver working hospital groups and more productive surgical facilities, and a stronger focus on health promotion and translational health research.
- Reform to how healthcare professionals are recruited, managed and empowered.
- System reforms to ensure that we adopt an evidence based approach to achieving high quality outcomes and protocols to deliver efficient, integrated and high quality care to patients with complex needs.

Introduction

RCSI welcomes this Oireachtas Committee Review of the Future of Healthcare in Ireland.
Given the importance and complexity of healthcare provision, the goal to achieve a cross-party consensus on a ten-year strategy for health care and health policy in Ireland a challenging and worthwhile endeavour. We are delighted to submit this paper to the Committee.

The RCSI, since its foundation in 1784, has remained dedicated to its core mission of educating and training doctors, surgeons and other healthcare professionals (including nurses, pharmacists, and physiotherapists) to the highest standard.

Enabling health care professionals, through high quality teaching and research, to support people to live long, healthy and productive lives is central to our mission. In that context, our investment in research is growing significantly. With our Institute of Leadership and other initiatives, RCSI is also increasingly supporting the development of healthcare management capacity in Ireland.

Today, our mission extends across the globe, exemplified by RCSI's undergraduate and postgraduate campuses in Dublin, Bahrain and Malaysia, which produce high quality healthcare professionals, equipped with the knowledge and skills required to deliver the highest quality healthcare to patients in Ireland and worldwide.

We are an independent, not-for-profit, international health sciences institution – one of nine independent degree awarding institutions in Ireland. Headquartered on St. Stephen's Green, we are the only specialist health sciences educational institute in Ireland and one of the most global in the world.

Future of Healthcare

As a specialist health sciences educational institute, understanding the future of healthcare is essential to meeting the sectors future skills needs. A wide range of trends are influencing the way that healthcare is delivered in Ireland and internationally.

Briefly, while the pace of progress differs across the world, key trends include the following:

Changing patient demographics: increasing life expectancy across the world, driven by better healthcare, means that people are living with multiple chronic diseases or disabilities, which is creating a complex and growing cohort of patients. Significant organisational changes are underway, particularly as the locus of care shifts away from acute care in hospitals to the long-term management of chronic conditions in ambulatory and community settings.

Cost pressures: national expenditure on healthcare has been growing across the board. A difficult financial position, exacerbated by rising demand, will drive reforms to the way healthcare services are delivered.

Technology, data and digital health: Significant medical, technological and scientific advances will be incorporated into practice. Investment in digital health continues to rise as more focus is seen in the wearables and personal health tracking tools.

Consumerism: the expectations and demands of patients in healthcare will increasingly mirror that of the consumer in coming years. Patients are increasingly looking for better access, convenience and speed in the healthcare system. There is also a greater need for disease prevention and the challenge of engaging patients in their own care.

Key Priorities

RCSI provides a practice focused educational experience for health professionals, which is delivered by health professionals, who teach what they practice daily in healthcare provision and research. While healthcare is complex and multi-faceted, our recommendations naturally are influenced by our perspective on education, training, teaching, healthcare management and research. We would like to highlight a range of policy areas where action would support the delivery of a future healthcare system that is fully fit for purpose.

Develop the Hospital Groups

In 2013, following extensive consultation, the Government announced the welcome re-alignment of Irish hospitals with the medical school partners to create six Academic Health Centres in order to bring practice, teaching and research together.

Good structures drive good outcomes. Delivering the Hospital Groups remains a fundamental first step in the re-design of acute care in Ireland. Strong functioning groups, by working together, support the provision of high quality healthcare in individual hospitals (and therefore the sustainability of smaller hospitals) and the optimisation of services in their region.

They can do this by developing intra and cross network operating models across specialities based on already developed models of care. This is a key step to planning care delivery, determining work force requirements, devolving budgetary responsibility and the development of standardised operational and quality performance metrics.

Recommendations:
Enact legislation to underpin the agreed hospital groups.
Enact reforms to deliver on Group potential to better support patient care and hospital sustainability – e.g. all hospitals to develop long-term service plans that best structure services within their Group and leverage the competencies of their wider group.

Change Where we Provide Healthcare by Reducing Dependence on Acute Care Service
As highlighted earlier, changing patient demographics and preferences is shifting the locus of care away from acute care in hospitals to the long-term management of chronic conditions in ambulatory and community settings.

Recommendation:
Increase investment in primary care significantly and align primary and acute care networks. To deliver complex care in a variety of settings, we need an integrated, cross-organisational, care pathway approach to the management of chronic disease, the frail elderly, mental health, etc.
While the need for surgical care is growing, data highlights that we can manage quite complex surgery much more efficiently in the public sector if elective patients (and their surgical teams) have protected space (e.g. surgical facilities, beds). Hospital Groups also need to develop better protocols to deliver efficient, integrated and high quality care (e.g. referrals, communications with GPs). Waiting lists should be address through targeted investment and reform – rather than shorter-term initiatives, which offer poorer value for money and support the continuation of existing inefficient practices rather than those seeking to drive reform.
We need continued targeted investment in wellness under 'Healthy Ireland' as many of our health issues stem from, or are exacerbated by, unhealthy lifestyles (e.g. lack of exercise, unhealthy diets).

Embed an Evidence Based Focus on Patient Outcomes
The primary goal of our healthcare system should be to support people to live healthy lives and to support those facing ill health. It is self-evident that we cannot increase healthcare spend in line with projected health care demand. We need to progress our emphasis from budget management to delivering high quality care efficiently. This requires better data to track performance across all hospitals and to drive change.

Atul Gawande, surgeon and New York Times bestselling author, notes that '*our ever changing world of modern medicine challenges us with 13,000 diseases, 6,000 drugs and 4,000 surgical procedures. …*

to rescue a critically sick patient, 178 tasks must be carried out correctly each day of critical care management. Failure to perform these correctly may lead to a patient safety incident...'

We need clear evidence in order to understand what is working and what is not. The healthcare system needs to be able to demonstrate objectively that the care provided is of high quality, to identify where there are deficiencies in the quality of care, and ensure that deficiencies are addressed.

Reliably measuring the quality of care is difficult. RCSI has worked closely with specialist surgical associations, the HSE and other stakeholders to establish the National Office of Clinical Audit, which has developed and provides robust governance for a growing range of clinical audits. We are currently in the process of establishing a Process Improvement Centre, which will implement LEAN initiatives within RCSI and our Hospital Group.

Big data offers the potential to transform the delivery of healthcare. Better data and analysis will transform management decision support, clinical decision support, population management, patient empowerment, personalised care, quality, and safety and coordination across providers. Specifically, the use of big data in a national, programmatic approach to clinical audit will allow us to determine what delivers results for patients, how we can improve knowledge and redesign systems to deliver better outcomes for patients in an efficient manner. It offers significant potential to enhance patient safety and patient services, to reduce costs, to progress new innovative initiatives (e.g. hot spotting).

Achieving these benefits is dependent on implementation of a national approach to health information. This requires the development of an electronic healthcare record to link patients' details across healthcare settings in order to provide a fuller picture of their health needs (achieved in the Health Identifiers Act 2014), and the development of legal standards to guide the use of this sensitive data. These standards, contained in the Health Information and Patient Safety Act, have not yet been enacted. We advocate the prioritisation of this legislation.

From a research perspective, big data offers significant potential to utilise large datasets to progress research (scientific and systems research) that supports improvements in healthcare and human health. It is essential that the new Health Information and Patient Safety Act provides:

- Protection of clinical audit data and participants from disclosure - under current law, we cannot ensure that data collected for the purposes of clinical audit can be held confidentially and not disclosed. This has a huge impact on clinician willingness to disclose information for the purposes of confidential peer review and shared learning.
- Clinical Data Sharing provisions - as a key requirement for learning from past practice and patient outcomes is to be able to access and share clinical data. The current lack of provision for data sharing in healthcare leads to very burdensome processes which works

against national audit and other quality initiatives and research. Given the international nature of healthcare research, it would also be helpful if data sharing was international in nature.

Recommendation:
Ireland's legal infrastructure (Health Information and Patient Safety Bill) to collect, manage and utilise health information needs to be progressed urgently.

Building on the need to develop an evidence based focus on patient outcomes, quality assurance must be embedded in the way we deliver healthcare to deliver strong patient outcomes, to fix our processes, to leverage resources, and to retain and motivate staff. Quality assurance needs to underpin a management approach that is integrated and has senior management sponsorship.

The approach can leverage and integrate several validated but, to date, disparate initiatives including lean healthcare, separation of planned and acute surgery, average length of stay programme, productive theatre programme, etc.

Recommendation:
Implement a structured, National Quality Assurance Strategy.

Create One Step Up

We need to re-imagine clinical staffing models based on our ambition for the future of the Irish healthcare system.

As healthcare delivery models evolve, the future roles of healthcare professionals will change, as will the characteristics, attributes, and competencies that determine success. Innovation in the workplace is essential if we are to deliver excellent services, manage resources effectively, and encourage skills development and its full exploitation for societal gain. For example, it is well documented that on the one hand, we remain critically underserved in consultant numbers across many surgical and medical specialties and on the other, excessively dependent on junior doctor grades, many in non-training posts. The predictable bi-annual medical staffing crisis requires an innovative re-design of staffing models.

We are fortunate to have highly educated, talented and caring healthcare professionals. We need to make best use of their skills by ensuring that their job roles suit the healthcare system we want to create. It is essential that employers and other stakeholders, particularly in the public sector where roles can be more restrictive, work to promote the more effective use of skills.

Recommendation:

Redesign professional roles (e.g. nurses, pharmacists, physician associates, physiotherapists, nutritionists, social workers) to enable all to work to the top of their abilities.

For example:

- Increase the number of Advanced Nurse/ Midwife Practitioners and to broaden their roles from very specific areas of practice to embracing a more systems approach/ chronic disease model, with primary care being a key focus.
- The role of pharmacy is evolving rapidly. New skills development, provided through the IIOP, will enable pharmacists to support the evolving needs of patients and the health system and to provide important face-to-face health professional engagement with the public.
- Over the past four decades, physician assistants (called physician associates in Ireland) have emerged as an important component of the clinical healthcare workforce in the United States. Over 180 programmes have produced a workforce of circa 80,000 PAs working in both hospital and primary care settings.
- Driven in large part by the implementation of the "European Working Time Directive", and compounded by growing and/or aging populations, emigration of higher skilled medical workforce, and fiscal constraints in national health systems, the PA profession is now establishing a strong foothold across Europe[215].

- RCSI has commenced the first Irish PA training programme, a 2-year Master of Science in Physician Associate Studies degree, in January 2016. In tandem, the Department of Health approved a two-year pilot project with four North American PAs working in surgical specialties in Beaumont Hospital, commencing in July 2015. This project aims to establish the feasibility and value of introducing a PA career structure into Irish healthcare.

- PAs can provide a stable workforce to complement the medical NCHD training career grades in Irish hospitals – adding value for the clinical workforce as well as patient care. What is needed to benefit from a rapid growth in this potential workforce is a focus on enabling the establishment of a PA career grade in the HSE system.

Improve Clinical Management and Executive Management Skills

The integration of both executive and clinical leadership is a key enabler to the redesign of efficient, patient centred healthcare. The increasing complexity of care pathways, the potential transformational impact of medical and device innovation and the step-change in demand will

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[215] Over 1,000 PAs work in hospitals mainly in the Netherlands. In the UK, the discipline has grown rapidly from 2 to 15 training programmes since 2013. This is in part responding to a call from the British government for 1,000 PAs in primary care alone by 2020.

require excellence in healthcare leadership with the capacity to design and deliver transformational change initiatives that have the support of patients, staff and funders.

Recommendation:

Structured investment in Clinical and Executive Healthcare Leadership education and development is needed.

Retain and Develop World Class Healthcare Professionals in Ireland

Healthcare is remarkably globalised – from the importation of new drugs and medical equipment, to the adoption of medical techniques and processes developed overseas, and particularly, the flow of healthcare staff across borders.

The net outward migration of healthcare professionals from Ireland presents serious health, social and economic implications. It risks the amplification of skills deficits in healthcare delivery (e.g. specialist roles, rural positions), challenges in rolling out primary care and enhancing our hospitals, and from an education perspective, a risk of having a poorer capability to train the next generation of healthcare professionals. We need an honest assessment of what is required to attract and retain clinical staff at all levels.

From our experience and research[216], is it notable that many aspects of the Irish healthcare system are not conducive to attracting and retaining talent in Ireland. Numerous studies have reported that Irish health professionals are demoralised and dissatisfied with working conditions in Ireland and are leaving in increasing numbers. The RCSI Doctor Emigration Project highlights that understaffing, limited career opportunities, a lack of flexible training options, high levels of non-core tasks, long hours and better pay overseas are driving doctors to consider practicing medicine abroad.

Recommendation:

Cognisant of fiscal pressures, we must provide good career paths and a better working environment to attract and retain talented people in Ireland.

Reform Clinical Indemnity

As a person centric profession, healthcare is labour intensive. The consequence of errors can also be severe – for patients and their healthcare providers. In recent years, the cost of medical indemnity insurance for health care professionals has increased significantly to the point where it is threatening

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[216] In addition to our role as educators, researchers in RCSI are engaged in workforce planning studies and participate in relevant Government groups. For example, in May 2014, RCSI began a Health Research Board-funded research project into the emigration of doctors from Ireland, which will run until December 2016.

the viability of some surgeons. More generally, it can be expected that these costs will affect health expenditure by the State and private customers.

The best solution is to support doctors in developing and maintaining good surgical practice that reduces error and ensures where error leading to harm does occur that it is managed appropriately through education.

Recommendation:
Mirroring the insurance challenges faced in other sectors, we recommend that actions are taken to reduce the increasing costs of medical indemnity insurance (e.g. tort reform, more competition, use of alternative dispute resolution, etc.)

Facilitate Work Permits for Non-EU Graduates Educated in Ireland

Mirroring many EU countries, Ireland is facing a shortage of qualified healthcare professionals. Ireland already has the second highest level of dependency in the OECD on foreign-trained doctors and over half of Ireland's junior hospital doctors (NCHDs) are non-Irish. The ageing of the Irish population will increase the demand for health workers. The ESRI notes that even if there is a continuous supply of Irish born health workers, Ireland will undoubtedly rely on the support of foreign-born health and social care workers in the future.

Where specific skills are difficult to source in Ireland, employers can hire nationals from non-EEA countries with an employment permit. Of the 2,160 employment permits issued in Q1 2016, almost one quarter came from the 'medical and nursing' sector. The medical and nursing sector accounted for almost 40% of employment permit renewals in the same period[217]. However, as there is an international shortage of nursing and medical manpower, competition with other English speaking countries (including the UK, Australia, and Canada) for international talent is strong.

At the same time as the Irish healthcare system is searching globally for scarce talent, Ireland's current rules do not support non-EU but Irish trained healthcare professionals to work here following graduation. Irish medical schools produce just over 700 publicly funded EU medical graduates annually and approximately 400 international students. Many of these international students would value early career training opportunities in Ireland – while Irish graduates and the health system have traditionally valued the opportunity to go overseas for part of their early postgraduate career training.

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[217] Source: www.djei.ie/en/Publications/Employment-Permit-Statistics-2016.html (sourced on 18/04/2016)

The current situation with just over 700 places for medical graduate interns (Irish and EU) means that, in effect, international graduates cannot complete their registration in Ireland – and so must leave after medical school. After registration, since many Irish graduates go abroad, there is a shortage of early career physicians who are then sourced overseas.

Not being able to complete internship (i.e. registration) in Ireland makes Ireland less attractive as a destination for undergraduate medical education in an increasingly competitive international market, and requiring almost all of our international graduates to leave before registration means we lose many excellent graduates trained – and 'service ready' - in our healthcare system . A means to enable early career international graduates trained in Ireland to stay and complete registration would thus benefit both our medical schools training and our health service workforce planning.

Recommendation:

We would support measures that facilitate work permits for non-EU graduates educated in Ireland. Enabling and supporting non-EU graduates who are educated in Ireland to work in Ireland post-graduation, where specific skills prove difficult to source within the EEA, would provide the Irish healthcare system with highly qualified and ready to practice healthcare professionals with the necessary technical, language and cultural skills.

Invest in Translational Health Research

Strategic investment in healthcare research is necessary to move towards a data informed and systematic approach to system and service design.

Long term health policy needs to sponsor a data and quality based approach to service re-design and lead a reversal of the culture of service design in support of interest groups. In this regard, the strategic support of the Academic Health Care model underpinning the hospital groups is critical.

Recommendation:

It is essential that the Government support the embedding of research activities in the hospital groups.

Sustainable funding model

The costs of funding healthcare have increased rapidly in recent years with implications for the levels of service provision, fiscal policy (spending decision and taxes) and individual’s decisions to purchase health insurance.

Recommendation:

A multitude of models have been proposed to fund healthcare in Ireland and each has its merits and faults. The RCSI does not offer a view on the best model for Ireland. However, we believe that it is essential to everyone has access to high quality affordable healthcare when needed.

Conclusions

We believe that the key challenge is to reform health service delivery. This paper sets out a range of proposals that entail:

- Structural reform including significant investment in primary care, secondary care reform to deliver working hospital groups and more productive surgical facilities, and a stronger focus on health promotion and translational health research;
- Reform to how healthcare professionals are recruited, managed and empowered; and
- System reforms to ensure that we adopt an evidence based approach to achieving high quality outcomes and protocols to deliver efficient, integrated and high quality care to patients with complex needs.

What is the future for General Surgery in Model 3 Hospitals?

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Introduction

Over recent years medical consultant recruitment and retention has posed considerable challenges for many hospitals in Ireland. This issue is multifactorial in nature as it relates to salary reductions imposed on new entrants to the consultant body introduced during the financial recession and to poor morale within the medical workforce leading to an unwillingness of medical graduates to return from abroad. Within smaller hospitals (Model 3 Hospitals), general surgery as a specialty has become particularly unpopular because of the onerous rotas, reduction in the number of high calibre non-consultant hospital staff and permanent consultant colleagues and the inability for surgical trainees to practice their chosen subspecialty on appointment. This latter point has been compounded by the cancer strategy, which while appropriate and timely removed the management of many surgical cancers to tertiary referral centres (Model 4 hospitals). The current trauma review is also likely to further remove a cohort of complex patients from peripheral hospitals to tertiary referral centres.

The provision of general surgical care particularly in the acute setting plays an important role not only in the care of surgical patients but also in support of other specialties including emergency departments (ED), acute medicine, critical care and obstetrics and gynaecology. Furthermore, there is an increasing realisation that patients who fall within the sphere of acute surgical care can be critically ill and evidence from abroad indicates that outcomes are frequently poor and vary greatly between different centres[1]. Hence, there is a pressing need to examine acute surgical care provision within the smaller hospital network in Ireland and identify policies which may allow sustainable service provision particularly within the emerging hospital groups.

The aim of this paper is to examine the general surgical workload and consultant staffing in Model 3 Hospitals providing acute surgical care. In addition, the results of a survey of current general surgery trainee's attitudes to working in Model 3 Hospitals are presented. The purpose of this report is to initiate discussion which may aid in designing sustainable solutions to the provision of acute surgical care in Model 3 Hospitals.

The organisation of general surgical services in Ireland.

The Report of the Acute Medicine Programme[2] defined four generic hospital models. Model 1 hospitals are community/district hospitals and provide no surgical care. Model 2 hospitals admit low acuity medical patients and have a range of ambulance bypass protocols in place. They may have a daytime Medical Assessment Unit (MAU) may have a minor injuries unit and day care surgery may be performed. These hospitals have evolved from those mentioned as a consequence of the Health Information and Quality Authority (HIQA) reports in Ennis and Mallow[3, 4]. In addition to Ennis and Mallow these include Dundalk, Roscommon, Nenagh, Ennis, St. John's Hospital in Limerick, Navan, St. Colmcille's Hospital Loughlinstown and Bantry. The design of these smaller hospitals was set out in 'Securing the Future of Smaller Hospitals: A Framework for Development', published by the Dept. of Health in Feb. 2013[5].The Midlands Regional Hospital, Portlaoise is currently undergoing a transformation to a Model 2 hospital.

St. John's Hospital Limerick and The South Infirmary Cork are sometimes referred to as Model 2S hospitals as the complexity of surgery is above that of day case surgery and patients may be admitted for a number of days. Model 3 hospitals admit undifferentiated acute medical and surgical patients. They have an Acute Medical Assessment Unit (AMAU), 24 hour ED and Intensive Care Unit (ICU) facilities. Model 4 hospitals also admit undifferentiated acute medical and surgical patients, accept tertiary referrals from other hospitals and have Category 3 ICU facilities that offer multi-organ and multispecialty support.

All hospitals that provide surgical care in Ireland are listed in Table 1 below.

Group	Hospital Name	Model
Dub MidL	ST. JAMES'S HOSPITAL, DUBLIN	M4
Dub MidL	Tallaght Adult	M4
Dub MidL	MIDLAND REGIONAL HOSPITAL, PORTLAOISE	M3
Dub MidL	MIDLAND REGIONAL HOSPITAL, TULLAMORE	M3
Dub MidL	NAAS COUNTY HOSPITAL	M3
Irl Est	MATER MISERICORDIAE, DUBLIN	M4
Irl Est	ST. VINCENTS UNIVERSITY HOSPITAL	M4
Irl Est	MIDLAND REGIONAL HOSPITAL, MULLINGAR	M3
Irl Est	ST. LUKE'S HOSPITAL, KILKENNY	M3
Irl Est	WEXFORD GENERAL HOSPITAL	M3
Irl Est	OUR LADY'S HOSPITAL, NAVAN	M3
Irl Est	ROYAL VICTORIA EYE & EAR, DUBL	M2
Irl Est	ST. COLMCILLE'S, LOUGHLINSTOWN	M2
Irl Est	ST. MARY'S HOSPITAL, CAPPAGH	M2
Irl Est	ST. MICHAEL'S, DUN LAOGHAIRE	M2
MidWest	REGIONAL, (DOORADOYLE) LIMERIC	M4
MidWest	ENNIS COUNTY HOSPITAL	M2
MidWest	NENAGH COUNTY HOSPITAL	M2
MidWest	REGIONAL ORTHOPAEDIC, CROOM	M2
MidWest	ST. JOHN'S HOSPITAL, LIMERICK	M2
Pead	OUR LADY'S HOSPITAL, CRUMLIN	M3
Pead	Tallaght Child	M3
Pead	TEMPLE ST. CHILDREN, DUBLIN	M3
RCSI	BEAUMONT HOSPITAL, DUBLIN	M4
RCSI	CAVAN GENERAL HOSPITAL	M3
RCSI	CONNOLLY HOSPITAL, BLANCHARDSTOWN	M3
RCSI	OUR LADY OF LOURDES, DROGHEDA	M3
RCSI	LOUTH COUNTY HOSPITAL, DUNDALK	M2
RCSI	MONAGHAN GENERAL HOSPITAL	M2
RCSI	ST JOSEPHS HOSPITAL RAHENY	M2
Saolta	REGIONAL (UCHG), GALWAY	M4
Saolta	LETTERKENNY GENERAL	M3
Saolta	MAYO GENERAL HOSPITAL	M3
Saolta	PORTIUNCULA, BALLINASLOE	M3
Saolta	SLIGO GENERAL HOSPITAL	M3
Saolta	ROSCOMMON COUNTY HOSPITAL	M2
SouthSW	CORK UNIVERSITY HOSPITAL	M4
SouthSW	WATERFORD REGIONAL (ARDKEEN)	M4
SouthSW	KERRY GENERAL HOSPITAL	M3
SouthSW	MERCY HOSPITAL, CORK	M3
SouthSW	SOUTH TIPPERARY GENERAL HOSPITAL, CLONMEL	M3

SouthSW	BANTRY GENERAL HOSPITAL	M2
SouthSW	MALLOW GENERAL HOSPITAL	M2
SouthSW	ORTHOPAEDIC HOSPITAL, KILCREEN	M2
SouthSW	SOUTH INFIRMARY/VICTORIA, CORK	M2
SouthSW	ST. MARY'S ORTHOPAEDIC, GURRAN	M2

Table 1. Model 2, 3 and 4 Hospitals in Ireland providing surgical care, listed according to hospital group.

Activity analysis of General Surgery managed patients in Model 3 Hospitals.

Surgical activity carried out in Model 3 hospitals is listed in Table 2. Seventeen hospitals provide both elective and acute general surgical services. Activity data presented is from the validated 2014 HIPE database.

Group	Hospital Name
Dub MidL	MIDLAND REGIONAL HOSPITAL, PORTLAOISE
Dub MidL	MIDLAND REGIONAL HOSPITAL, TULLAMORE
Dub MidL	NAAS COUNTY HOSPITAL
Irl Est	MIDLAND REGIONAL HOSPITAL, MULLINGAR
IrlEst	OUR LADY’S HOSPITAL, NAVAN
Irl Est	ST. LUKE'S HOSPITAL, KILKENNY
Irl Est	WEXFORD GENERAL HOSPITAL
RCSI	CAVAN GENERAL HOSPITAL
RCSI	CONNOLLY HOSPITAL, BLANCHARDSTOWN
RCSI	OUR LADY OF LOURDES, DROGHEDA
Saolta	LETTERKENNY GENERAL
Saolta	MAYO GENERAL HOSPITAL
Saolta	PORTIUNCULA, BALLINASLOE
Saolta	SLIGO GENERAL HOSPITAL
SouthSW	KERRY GENERAL HOSPITAL
SouthSW	MERCY HOSPITAL, CORK
SouthSW	SOUTH TIPPERARY GENERAL HOSPITAL, CLONMEL

Table 2. The 17 Model 3 Hospitals providing both acute and elective general surgical care.

Currently 49.9% of all general surgical activity nationally occurs in Model 3 Hospitals. Figure 1 show surgical activity for both day case and inpatient care. Inpatient care can be broken down into surgery and no surgery reflecting those patients who undergo an operative procedure and those who do not. Figure 1 also shows inpatient bed days for these groups.

It should be noted that the Model 3 Hospitals generally have a greater proportion of acute no surgery patients (those admitted acutely but not operated on) than larger hospitals. This group comprised 62% of all surgical admissions in the Model 3 Hospitals in comparison to 54% nationally. The reasons for this are multifactorial and reflect demographic changes, social and community issues and the generalist nature of surgical practice in Model 3 Hospitals. Of further note is the observation that 48% of all acute surgery patients nationally (those admitted acutely and operated on) are treated in Model 3 Hospitals, taking up 35.8% of the national inpatient surgical bed complement.

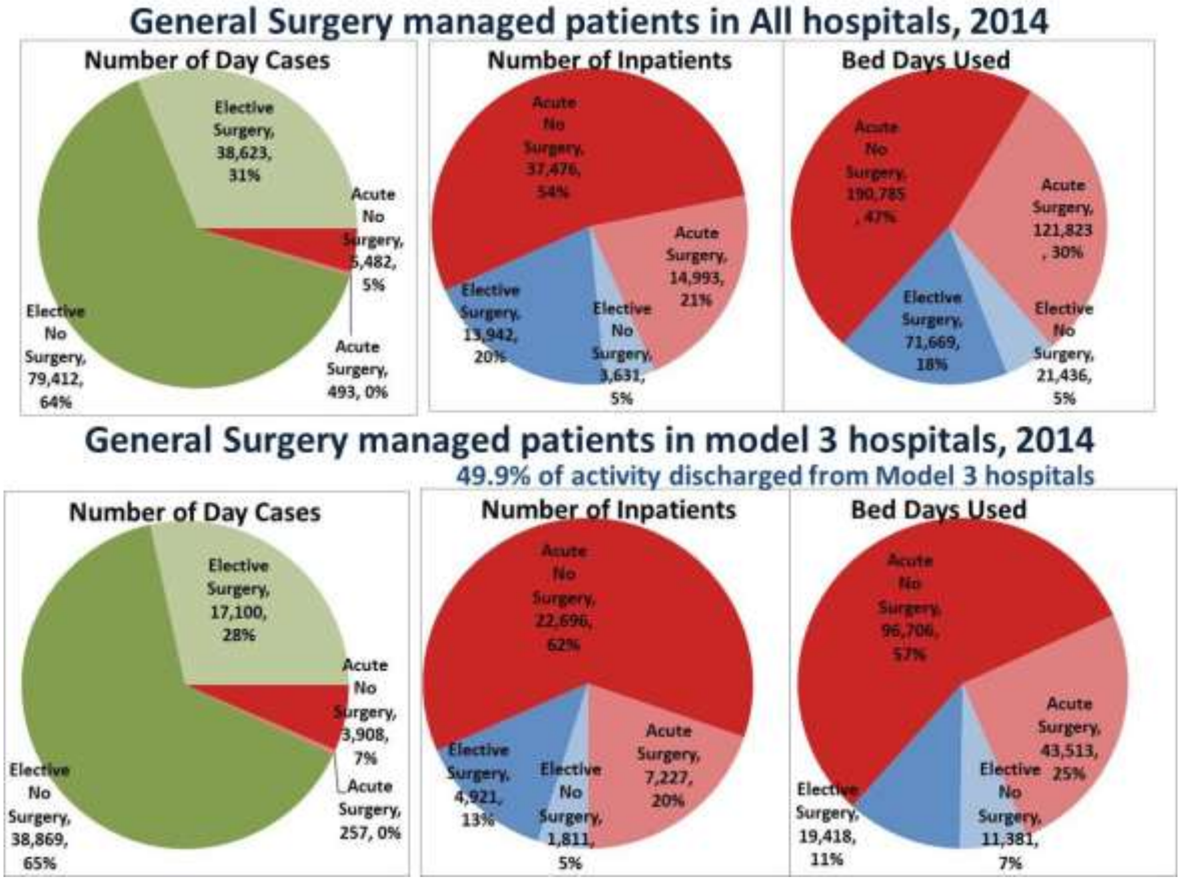


Figure 1. Pie charts demonstrating day and acute and elective admissions nationally and in Model 3 Hospitals.

Figure 2 shows total surgical discharges for all hospitals in Ireland. It is obvious that some of the larger Model 3 Hospitals have higher general surgical activity levels than some of the Model 4 Hospitals. This figure however does not take in account specialty surgery carried out by non-general surgeons.

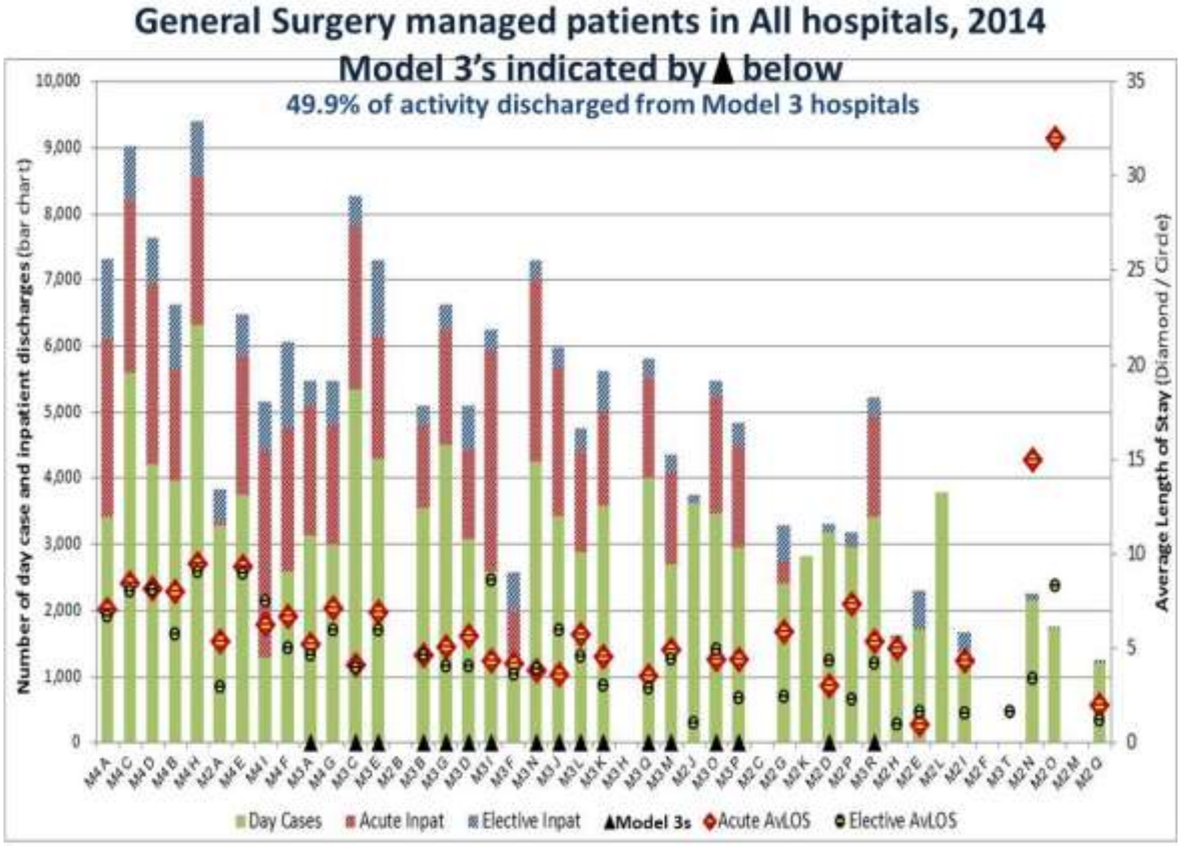
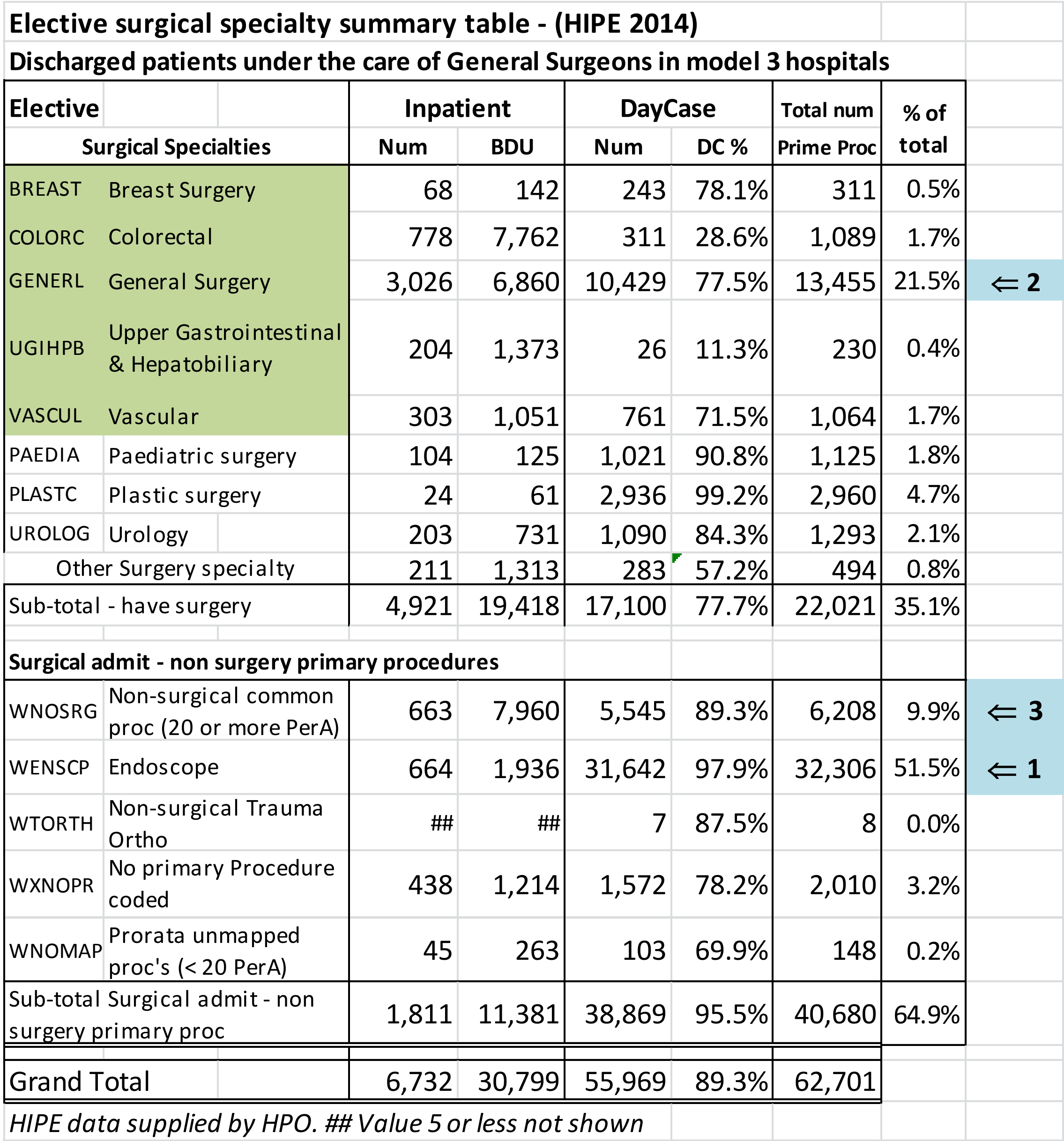


Figure 2 shows all hospitals discharging general surgery patients. Each hospital is shown on the horizontal axis with the larger Model 4 Hospitals on the left of the diagram. The vertical axes show discharge number on the left and average length of stay on the right. (Avlos refers to Average Length of Stay)

Figures 3 and 4 show in more detail acute and elective surgical activity performed by general surgeons mapped to Model 3 Hospitals. A small proportion of activity is coded to specialties other than general surgery reflecting the wider spectrum of surgical activity performed by general surgeons in Model 3 Hospitals. In the elective setting it is apparent that a major component of surgical activity relates to endoscopy. In the acute setting non-surgical procedures and patient discharge without any operative procedure or the performance of any diagnostic test or attached HIPE code is common. 54% of all national surgical day case and inpatient surgical endoscopies are performed in Model 3 Hospitals.



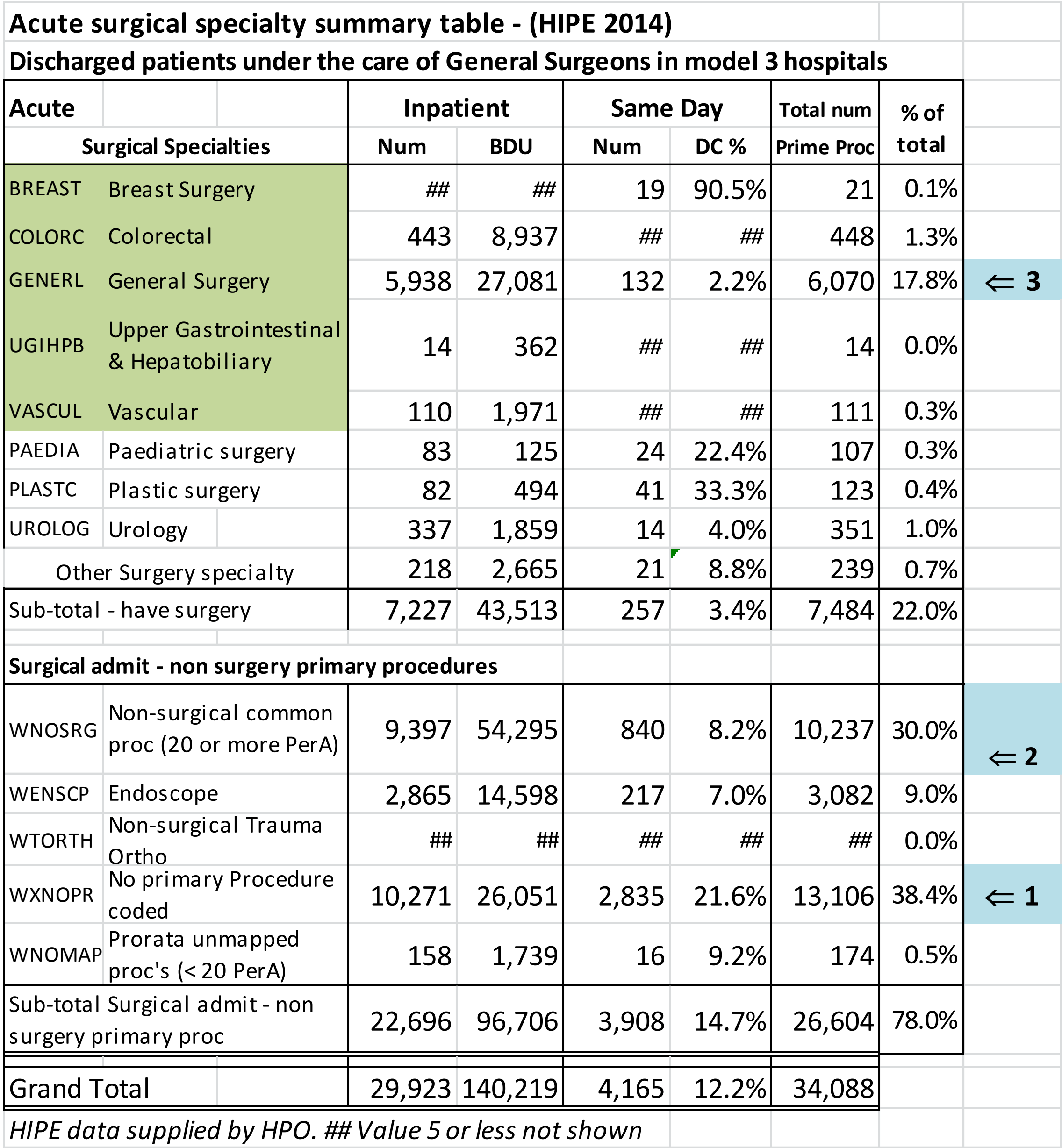
Elective surgical specialty summary table - (HIPE 2014)

Discharged patients under the care of General Surgeons in model 3 hospitals

Elective		**Inpatient**		**DayCase**		**Total num**	**% of**	
Surgical Specialties		**Num**	**BDU**	**Num**	**DC %**	**Prime Proc**	**total**	
BREAST	Breast Surgery	68	142	243	78.1%	311	0.5%	
COLORC	Colorectal	778	7,762	311	28.6%	1,089	1.7%	
GENERL	General Surgery	3,026	6,860	10,429	77.5%	13,455	21.5%	⇐ **2**
UGIHPB	Upper Gastrointestinal & Hepatobiliary	204	1,373	26	11.3%	230	0.4%	
VASCUL	Vascular	303	1,051	761	71.5%	1,064	1.7%	
PAEDIA	Paediatric surgery	104	125	1,021	90.8%	1,125	1.8%	
PLASTC	Plastic surgery	24	61	2,936	99.2%	2,960	4.7%	
UROLOG	Urology	203	731	1,090	84.3%	1,293	2.1%	
Other Surgery specialty		211	1,313	283	57.2%	494	0.8%	
Sub-total - have surgery		4,921	19,418	17,100	77.7%	22,021	35.1%	
Surgical admit - non surgery primary procedures								
WNOSRG	Non-surgical common proc (20 or more PerA)	663	7,960	5,545	89.3%	6,208	9.9%	⇐ **3**
WENSCP	Endoscope	664	1,936	31,642	97.9%	32,306	51.5%	⇐ **1**
WTORTH	Non-surgical Trauma Ortho	##	##	7	87.5%	8	0.0%	
WXNOPR	No primary Procedure coded	438	1,214	1,572	78.2%	2,010	3.2%	
WNOMAP	Prorata unmapped proc's (< 20 PerA)	45	263	103	69.9%	148	0.2%	
Sub-total Surgical admit - non surgery primary proc		1,811	11,381	38,869	95.5%	40,680	64.9%	
Grand Total		6,732	30,799	55,969	89.3%	62,701		

HIPE data supplied by HPO. ## Value 5 or less not shown

Figure 3 shows elective surgical discharges in Model 3 Hospitals broken down by specialty. Note the large number of endoscopies performed.



Acute surgical specialty summary table - (HIPE 2014)

Discharged patients under the care of General Surgeons in model 3 hospitals

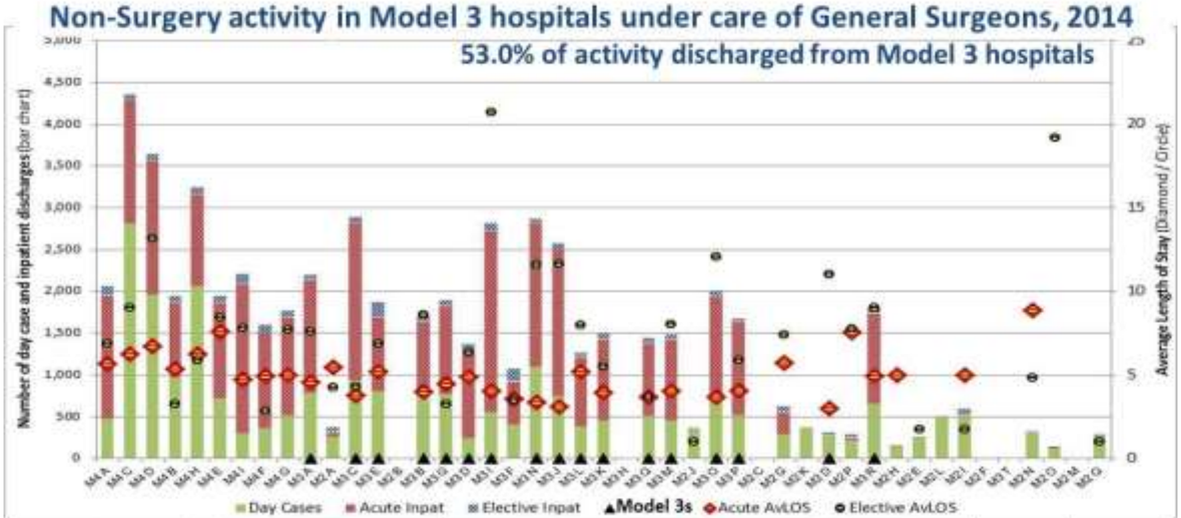
Acute		**Inpatient**		**Same Day**		**Total num**	**% of**	
Surgical Specialties		**Num**	**BDU**	**Num**	**DC %**	**Prime Proc**	**total**	
BREAST	Breast Surgery	##	##	19	90.5%	21	0.1%	
COLORC	Colorectal	443	8,937	##	##	448	1.3%	
GENERL	General Surgery	5,938	27,081	132	2.2%	6,070	17.8%	⇐ **3**
UGIHPB	Upper Gastrointestinal & Hepatobiliary	14	362	##	##	14	0.0%	
VASCUL	Vascular	110	1,971	##	##	111	0.3%	
PAEDIA	Paediatric surgery	83	125	24	22.4%	107	0.3%	
PLASTC	Plastic surgery	82	494	41	33.3%	123	0.4%	
UROLOG	Urology	337	1,859	14	4.0%	351	1.0%	
Other Surgery specialty		218	2,665	21	8.8%	239	0.7%	
Sub-total - have surgery		7,227	43,513	257	3.4%	7,484	22.0%	
Surgical admit - non surgery primary procedures								
WNOSRG	Non-surgical common proc (20 or more PerA)	9,397	54,295	840	8.2%	10,237	30.0%	⇐ **2**
WENSCP	Endoscope	2,865	14,598	217	7.0%	3,082	9.0%	
WTORTH	Non-surgical Trauma Ortho	##	##	##	##	##	0.0%	
WXNOPR	No primary Procedure coded	10,271	26,051	2,835	21.6%	13,106	38.4%	⇐ **1**
WNOMAP	Prorata unmapped proc's (< 20 PerA)	158	1,739	16	9.2%	174	0.5%	
Sub-total Surgical admit - non surgery primary proc		22,696	96,706	3,908	14.7%	26,604	78.0%	
Grand Total		29,923	140,219	4,165	12.2%	34,088		

HIPE data supplied by HPO. ## Value 5 or less not shown

Figure 4 shows acute surgical discharges in Model 3 Hospitals broken down by specialty. Note the large number of discharges without an operative procedure.

As shown in Figures 1,3 and 4, a major component of Model 3 Hospital surgical activity is non-operative. Figure 5 shows non-operative surgical activity across all hospitals nationally. Model 3 Hospitals account for 53% of this activity.

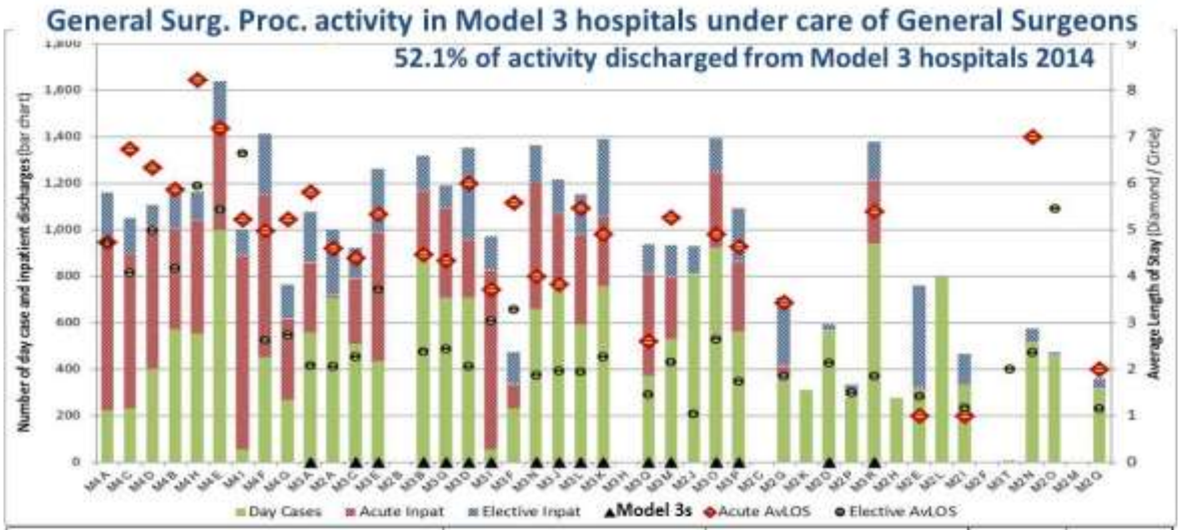
The table attached to Figure 5 shows the ten most common HIPE codes attached to this subgroup of patients. By far the greatest group are those without any HIPE code who are presumably admitted for observation.



Top 10 primary procedure by volume	Acute			Elective				Total
ProcDesc (Code)	Inpat	BDU	AvLOS	Inpat	BDU	AvLOS	Day Cases	Discharges
No Prime Proc	10,271	26,051	2.5	438	1,214	2.8	4,407	15,116
CT abdomen & pelvis w IV contrast medium (5650700)	2,155	10,014	4.6	19	158	8.3	95	2,269
Computerised tomography of brain (5600100)	970	4,277	4.4	21	510	24.3	265	1,256
Rubber band ligation of haemorrhoids (3213500)	19	83	4.4	18	39	2.2	1,027	1,064
CT of abdomen & pelvis (5650100)	932	3,653	3.9	13	112	8.6	112	1,057
Sclerotherapy for haemorrhoids (3213200)	24	69	2.9	##	##	1.2	819	848
Allied health intervtn, physiotherapy (9555003)	693	5,519	8.0	116	1,834	15.8	20	829
Computerised tomography of abdomen (5640100)	642	2,691	4.2	##	##	4.0	63	709
Anorectal examination (3217100)	31	193	6.2	13	18	1.4	515	559
Allied health intervention, pharmacy (9555009)	460	1,938	4.2	11	188	17.1	36	507

Figure 5 shows non-surgical activity across all hospitals nationally. Each hospital is shown on the horizontal axis with the larger Model 4 Hospitals on the left of the diagram. The vertical axes show discharge number on the left and average length of stay on the right. The accompanying table lists the ten most common non-operative HIPE codes discharged from the Model 3 Hospitals.

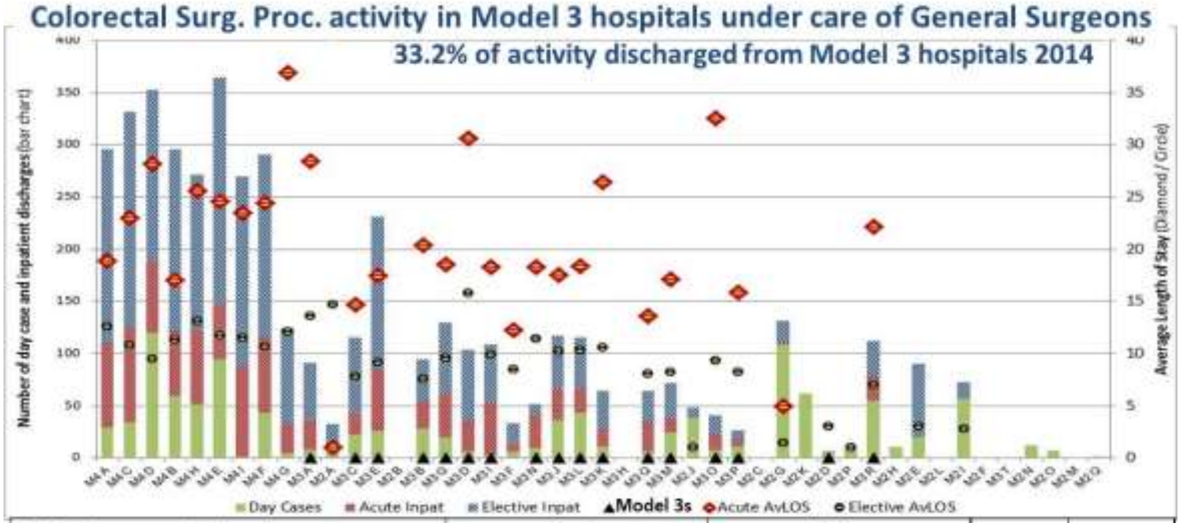
Figure 6 lists the general surgical activity across all hospitals with the ten most common operative codes listed. Model 3 Hospitals account for 52.1% of all operations performed by general surgeons nationally. As expected and shown in the accompanying table, many of these operations are of low acuity. 3,377 appendicectomies (laparoscopic and open), 2,534 cholecystectomies and 2761 hernia repairs are performed in Model 3 Hospitals and are 50.4%, 55.2% and 46.6% of these operations performed nationally.



Top 10 primary procedure by volume	Acute			Elective				
ProcDesc (Code)	Inpat	BDU	AvLOS	Inpat	BDU	AvLOS	Day Cases	Total Discharges
Exc lesion(s) of SSCT, other site (3120500)	12	25	2.1	40	73	1.8	4,223	4,275
Laparoscopic appendicectomy (3057200)	2,339	6,882	2.9	44	71	1.6	26	2,409
Laparoscopic cholecystectomy (3044500)	370	1,643	4.4	1,194	2,144	1.8	783	2,347
Repair of inguinal hernia, unilateral (3061402)	80	328	4.1	541	859	1.6	688	1,309
Wedge resection of ingrown toenail (4791500)	##	##	2.0	6	6	1.0	1,094	1,102
Appendicectomy (3057100)	960	3,142	3.3	6	15	2.5	2	968
Excision of lesion(s) SSCT, leg (3123503)	##	##	1.0	17	64	3.8	946	964
Excision lesion(s) of SSCT, neck (3123501)	##	##	1.3	##	##	1.0	825	834
Repair of umbilical hernia (3061700)	38	148	3.9	138	213	1.5	271	447
Incision & drainage of abscess of SSCT (3022301)	384	1,038	2.7	6	41	6.8	45	435

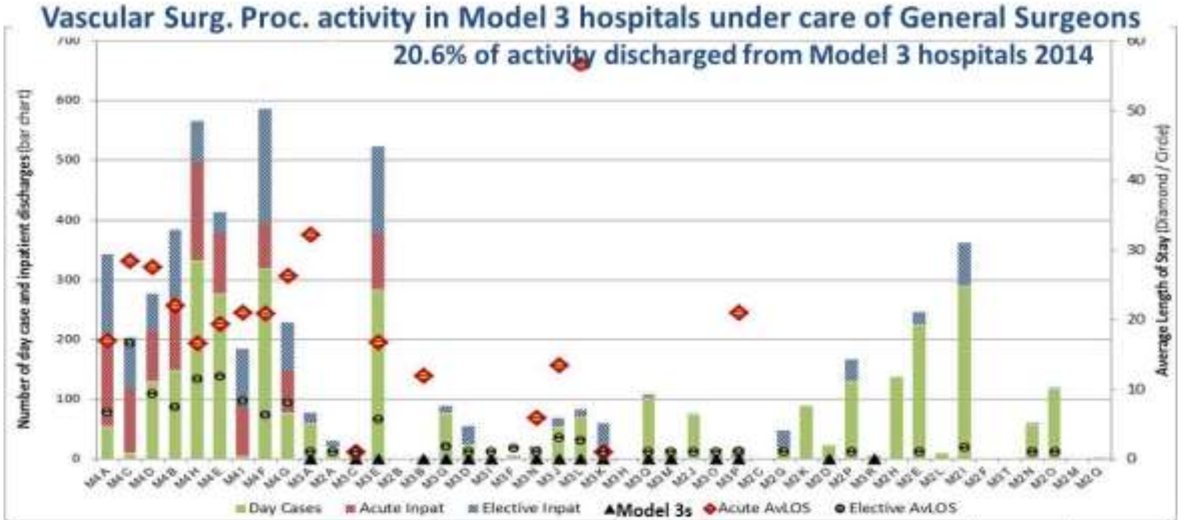
Figure 6 shows operative surgical activity across all hospitals nationally. Each hospital is shown on the horizontal axis with the larger Model 4 Hospitals on the left of the diagram. The vertical axes show discharge number on the left and average length of stay on the right. The accompanying table lists the ten most common operative HIPE codes discharged from the Model 3 Hospitals.

Higher complexity surgical activity in the areas of colorectal and vascular surgery does take place in Model 3 Hospitals (Figures 7 and 8). Model 3 Hospitals account for 33.2% and 20.6% of colorectal and vascular activity respectively. The majority of Model 3 Hospitals carry out colonic surgery and a small number carry out more complex colorectal surgery and one Model 3 Hospital performs complex vascular surgery.



Top 10 primary procedure by volume	Acute			Elective				Total
ProcDesc (Code)	Inpat	BDU	AvLOS	Inpat	BDU	AvLOS	Day Cases	Discharges
Right hemicolectomy with anastomosis (3200301)	104	1,920	18.5	182	2,008	11.0	##	287
Incision of rectum or anus (9033800)	6	13	2.2	16	19	1.2	112	134
Limited excision lrg intestine w anstms (3200300)	32	701	21.9	94	858	9.1	##	128
Rectosigmoidectomy w stoma formation (3203000)	91	2,055	22.6	10	122	12.2	##	101
Left hemicolectomy with anastomosis (3200600)	24	570	23.8	43	450	10.5	##	67
Restor continuity after Hartmann's proc (3203300)	##	##	29.0	58	525	9.1	##	59
Insertion of anal seton (3216600)	##	##	2.2	6	14	2.3	48	59
Excision other lesion or tissue anus (9031501)	##	##	1.3	10	26	2.6	33	46
Extended right hemicolectomy w anstms (3200501)	18	280	15.6	27	336	12.4	##	45
Incision of abdominal wall (9095200)	14	142	10.1	10	32	3.2	20	44

Figure 7 shows colorectal surgical activity across all hospitals nationally. Each hospital is shown on the horizontal axis with the larger Model 4 Hospitals on the left of the diagram. The vertical axes show discharge number on the left and average length of stay on the right. The accompanying table lists the ten most common operative colorectal HIPE codes discharged from the Model 3 Hospitals.



Top 10 primary procedure by volume	Acute			Elective				Total
ProcDesc (Code)	Inpat	BDU	AvLOS	Inpat	BDU	AvLOS	Day Cases	Discharges
Interruption sapheno-femoral jnct VV (3250800)	##	##	1.0	162	173	1.1	672	836
Carotid endarterectomy (3350000)	##	##	7.6	48	177	3.7	##	53
Amputation of toe (4433800)	19	290	15.3	10	61	6.1	##	30
Perc transluminal balloon angioplasty (3530306)	9	97	10.8	8	61	7.6	10	27
Arteriovenous anastomosis of upper limb (3450901)	##	##		##	##	1.0	19	23
Endarterectomy of extremities (3353900)	##	##	12.3	20	103	5.2	##	23
Reoperation for varicose veins (3251400)	##	##		##	##	1.0	17	20
Amputation toe including metatarsal bone (4435800)	10	151	15.1	##	##	12.4	##	17
Interptn saphofemor saphopoptl jnct VV (3251100)	##	##		##	##	1.0	15	17
Amputation above knee (4436700)	12	419	34.9	##	##	35.0	##	16

Figure 8 shows vascular surgical activity across all hospitals nationally. Each hospital is shown on the horizontal axis with the larger Model 4 Hospitals on the left of the diagram. The vertical axes show discharge number on the left and average length of stay on the right. The accompanying table lists the ten most common vascular operative HIPE codes discharged from the Model 3 Hospitals.

Consultant staffing in Model 3 Hospitals

In July 2014, The Royal College of Surgeons in Ireland (RCSI) produced an Interim Report of a Working Group on Surgical Service Delivery and Workforce Planning6.This looked at consultant numbers in all surgical specialties. This 2014 database was updated by contact with all Hospital manpower managers in Oct – Dec 2015 to determine current general surgery consultant staffing in all Model 3 Hospitals.

Table 3 lists general/vascular consultant numbers for the 17 Model 3 Hospitals providing both acute and elective general surgical services. Locum numbers, retirements within five years and number of surgeons who have not undergone formal training in Ireland are also shown.

Consultant manpower analysis indicates that currently 76 consultant general or general/vascular surgeons work in Model 3 Hospitals. Of these, 19 (or 25%) are in locum posts. Age profiles indicate a further 17 surgeons will retire within the next five years. Of the current cohort of 76 surgeons, 41 (54%) have not undergone formal training in Ireland. We do not have the data to indicate whether these surgeons have undergone formal training in another country. The data indicates that if consultant general surgeon recruitment and retention fail to improve within the next five years then locum numbers could increase to 47% and those without formal training in Ireland might increase to 76% respectively of all general surgeons in Model 3 Hospitals.

Group	Hospital Name	Number of Surgeons	Number of Locums	Retiring within 5 years	No Formal Training in Ireland
Dub MidL	MIDLAND REGIONAL HOSPITAL, PORTLAOISE	3	1	0	3
Dub MidL	MIDLAND REGIONAL HOSPITAL, TULLAMORE	4	1	1	1
Dub MidL	NAAS COUNTY HOSPITAL	4	1	2	0
Irl Est	MIDLAND REGIONAL HOSPITAL, MULLINGAR	5	2	0	3
IrlEst	OUR LADY'S HOSPITAL, NAVAN	4	2	1	3
Irl Est	ST. LUKE'S HOSPITAL, KILKENNY	5	3	1	4
Irl Est	WEXFORD GENERAL HOSPITAL	5	2	2	4
RCSI	CAVAN GENERAL HOSPITAL	4	0	0	2
RCSI	CONNOLLY HOSPITAL, BLANCHARDSTOWN	4	2	1	2
RCSI	OUR LADY OF LOURDES, DROGHEDA	9	1	2	5
Saolta	LETTERKENNY GENERAL	6	3	2	5
Saolta	MAYO GENERAL HOSPITAL	3	0	1	1
Saolta	PORTIUNCULA, BALLINASLOE	4	1	1	0
Saolta	SLIGO GENERAL HOSPITAL	4	0	1	2
SouthSW	KERRY GENERAL HOSPITAL	4	0	2	1
SouthSW	MERCY HOSPITAL, CORK	5	0	0	5
SouthSW	SOUTH TIPPERARY GENERAL HOSPITAL, CLONMEL	3	0	0	0
Total		76	19	17	42

Table 3 lists general/vascular consultant numbers for the 17 Model 3 Hospitals providing both acute and elective general surgical services

Survey of Surgical Trainee career intentions

In December 2015, all general surgical trainees on the National Surgical Training Programme were asked by the National Clinical Programme in Surgery to complete a questionnaire on their career intentions. 39 of 80 trainees responded giving a 46% response rate.

When asked about career intentions following training, a post in a Model 4 Hospital was considered most desirable by 83% of the trainees. In contrast a post in a Model 3 Hospital was considered most desirable by only 3% of trainees. A varying degree of support was demonstrated for a joint position between a Model 3 and 4 Hospitals, as shown in Table 4.

		1 Most Desirable	2 Desirable	3 Less Desirable	4 Least Desirable	
Seek a consultant post in a M3 Hospital		3%	21%	26%	50%	
Seek a consultant post in a M4 Hospital		73%	19%	3%	5%	
Joint appointment between a M3 & M4 Hospital		11%	36%	42%	11%	
Work abroad		15%	21%	24%	41%	

Table 4. Career intention voiced by general surgical trainees.

Table 5 indicates that the reasons supporting this decision was related to the post offering training and skills enhancement, research and academic involvement and most importantly the structure of the post and management of the care of complex surgical conditions. Interestingly work-life balance, lifestyle and cost of living and location and geographically issues appear to be of little importance to surgical trainees. When asked about the negatives of working in a Model 3 Hospital the reasons listed included rota issues, limited work schedules, isolation from colleagues and lack of peer support, limited academic opportunities and uncertainty regarding the future of this hospital type.

Trainees were questioned regarding inducements for taking up a post in a Model 3 Hospital. The use of retention bonuses for staying in post a certain number of years, entry on a higher point of the salary scale (level 3 or 4) and a defined on-call rota (1:5 or 1:6), contractually protected academic, teaching and research time within the hospital group and the attachment of a senior trainee to the post were all considered favourable. A shorted duration of training for a Model 3 Hospital post was not attractive to the majority of trainees. A variable response was seen with the offer of a funded foreign fellowship having complicated an undefined number of years in post.

		1 Most Relevant	2 More Relevant	3 Relevant	4 Somewhat relevant	5 Less Relevant	6 Least Relevant
Work-Life Balance		9%	9%	12%	21%	32%	18%
Lifestyle &Cost of Living		0%	15%	6%	15%	24%	41%
Training & Skills Enhancement		18%	26%	32%	18%	6%	0%
Research & Academic		18%	26%	15%	21%	9%	12%
Location and Geographical issues		12%	12%	18%	15%	24%	18%
Structure or the Post and access to complex cases		49%	16%	16%	11%	3%	5%

Table 5. Reasoning behind general surgical trainee career choice.

Table 6 shows the elements of a Model 3 Hospital post which would be appealing to trainees. These include guaranteed beds, theatre time and endoscopy sessions. Joint appointment with Model 4 Hospitals and guaranteed connectivity to the Hospital Group network are also considered desirable.

	Very Appealing	Appealing	No impact on decision
Guaranteed Endoscopy sessions linked to post	55%	18%	27%
Joint appointment with M4 hospital	39%	45%	15%
Protected theatre beds	70%	24%	6%
Guaranteed connectivity to MDTs and Grand Rounds in M4 Hospital	50%	29%	21%
Protected beds	58%	36%	6%

Table 6. Possible elements making a Model 3 Hospital consultant post more appealing.

Discussion

This study examines surgical activity, consultant manpower levels and general surgical trainee attitudes to a career in a Model 3 Hospital. Our data shows that in the acute setting a high volume of low acuity and non-operative surgical activity occurs in Model 3 Hospitals whereas in the elective setting a significant proportion of all national general surgery and endoscopy workload are performed in these hospitals.

The consultant manpower analysis shows a system under considerable strain with a high proportion of posts filled with locum consultants and posts being filled with surgeons who have not undergone formal training in Ireland. Highlighting the high locum rates and lack of national formal training should not be considered a criticism of the current Model 3 general surgical consultants in post as many currently provide comprehensive surgical care under difficult circumstances and have done so for a considerable time. The current situation however is far from ideal and will undoubtedly worsen in the coming years with retirements due to the demographic profile of the current Model 3 Hospital general surgical consultant population.

In addition to these issues, other pressures will continue to add further stress to the system. These include the slow development of functioning hospital groups, the unhelpful geographical configuration of some hospital groups, lack of capacity within the system limiting reconfiguration and the understandable political and societal concern in redesigning and reorganising medical services. It is the opinion of the National Clinical Programme in Surgery (NCPS) however that failure to put in place a sustainable solution to address these difficulties will lead to the inability to implement the NCPS Acute Model of Care and compromise the provision of safe acute general surgical services nationally. Despite these numerous challenges various solutions are worthy of consideration.

Two obvious approaches could be considered. The first approach is to redesign the training scheme to make it ‘fit for purpose’ in producing surgeons suitably trained for approximately half the consultant general surgical posts in the country. Currently all general surgical trainees are subspecialised which many would argue discourages appointment to generalist posts in smaller hospitals. Redesigning the current training scheme to produce generalists would require major discussion with the training body and the Joint Committee for Surgical Training7, the body which has oversight of surgical training and is overseen by representatives from all of the Surgical Colleges in Great Britain and Ireland. However, even if this were to occur there is still no guarantee that trainees would apply for such a training scheme or apply for posts in Model 3 Hospitals on completion of training.

The other approach is to redesign general surgical services to improve the attractiveness of posts which would have the added benefits of rationalising our current fragmented surgical service.

Regional solutions within hospital groups could allow appropriate reorganisation of acute general surgical services enabling complete separation of the acute and elective general surgical streams as envisioned in the NCPS Acute Model of Care8.This would lead to improved rotas, better connectivity and an improved working environment for surgeons within the system, all of which would provide higher quality sustainable acute and elective general surgical services for patients. Specific benefits from such a reorganisation would include the identification of acutely ill surgical patients who require complex critical care. However, clear referral pathways would be required for transfer of these vulnerable patients who frequently have poor and variable outcomes. Evidence from the UK indicates considerable variation in survival for patients undergoing emergency laparotomy and it is likely that outcome variation is similar in Ireland1.

Geographically, this will not be possible in some regions of the country in which case transfer of patients between hospital groups and possibly also to hospitals within Northern Ireland would be necessary to allow access to appropriate surgical care. With any remodelling of surgical services, capacity issues would clearly need to be addressed. Previous experience with reconfiguration of smaller hospitals indicates the need for proactive community engagement to address understandable societal concerns.

A further additional benefit from such structural changes would be to support the elective Model of Care with improved access to pre-admission processes and elective/scheduled care in an appropriate setting. While local solutions could vary depending on catchment population, geographical location and capacity issues within the supporting hospital group. Model 2 and 3 Hospitals in general have a better track record of protecting day bed facilities and supporting integrated pre-admission and day care surgery. Models for this form of surgical care already exist in some hospital groups and could be expanded nationally.

The data presented here however also allows and should encourage a more global consideration of general surgical service redesign. As highlighted, a considerable volume of surgical care in Model 3 Hospitals is non-operative in the acute setting and in the elective setting involves endoscopy. Many of these patients are currently poorly served with a lack of continuity of care as surgeons frequently do not have the skill base to provide integrated care to many of these patients who are frequently elderly, have significant comorbidities and have diverse health care needs. In many other health care systems, care for such patients would not be provided for by surgeons. This questions whether surgeons are best placed to provide these services in Ireland.

With appropriate service planning much of the current workload performed by general surgeons in Model 3 Hospitals could be performed by other specialty groups. We would argue that care of the elderly physicians would provide better quality comprehensive care for many within the cohort of acutely admitted surgical patients who do not undergo surgery. In the elective setting, medical gastroenterologists could care for many of the patients who undergo endoscopy. Clearly changes in the management of these patient groups would require long-term strategic planning and dialogue with the appropriate specialists groups.

The National Clinical Programme in Surgery however has the underlying capability to allow capacity and demand modelling to examine and fully understand the patient shifts that would result from such a fundamental change in acute service provision. It is our contention however that in the long-term changes of this nature would provide a more efficient use of valuable surgical skills and deliver improved long-term integrated patient care for our increasingly elderly population.

Conflict of Interest:

The authors declare that they have no conflict of interest.

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Safetynet

The main arguments presented in this submission as summarised as follows:

Marginalised Groups Access to Healthcare

- People from marginalised groups (homeless, migrants etc) suffer excess burdens of ill health. They die earlier and have very high rates of physical and mental health problems.
- Despite this excess burden they have poor to access health services. This is known as Tudor Harts Inverse Care Law i.e. those in most need of health services are least likely to obtain them.
- There has been a debate as to the best approach to improve access to healthcare for these groups. Some advocate the development of targeted or specialised services for such groups that are located close to their communities and are known to be accessible, open, welcoming and culturally and clinically appropriate for these groups. Opponents of this approach argue this is segregation and we should seek to maximise access to mainstream services for everyone. Internationally, health services have been adopting the targeted services approach which is also favoured by members of the marginalised groups themselves
- The further development of targeted services can further improve the health of marginalised people and reduce the burden on secondary care and result in cost savings to the health service. This can be done in tandem with improving access to mainstream services.

Deprived Communities Access to Healthcare

- It is well recognised that communities affected by deprivation have lower life expectancies and significantly worse health profiles than well off communities.
- It is further recognised that such communities have significantly poorer access to primary and secondary healthcare.
- Safetynet has developed a model for improving access to primary care for communities in areas of deprivation. Safetynet believes the Department of Health and the Health Service Executive should promote this model nationally to improve access to healthcare for those most in need i.e. communities in areas of deprivation.

Strategic Recommendations

The present targeted services are organised ad hoc with differing funding, service delivery and strategy approaches. Government Strategy should rationalise present targeted services for marginalised groups into a coherent single model that applies nationally.

The Government needs to improve access to General Practice in areas of deprivation. Safetynet has developed a good model of practice to help achieve this target. This model could also apply to isolated rural areas.

Primary Healthcare for Marginalised Populations

Marginalised groups have been defined as "populations outside of 'mainstream society'" and "highly vulnerable populations that are systemically excluded from national or international policy making forums" Marginalised populations would include homeless people, travellers, migrants, Roma, sex workers etc. These groups are recognised as having significantly worse inequitable health indices than the general population and have poor access to healthcare.

Marginalised populations universally have poor health indices

Homeless people mortality rates are have been estimated to be 3.5-40 times that of the housed population. Homelessness: An Unhealthy State ((2015 found that homeless people in Dublin and Limerick had high rates of morbidity from diseases that are common the general population as well as conditions not common in the housed population. Forty-six percent said that health affected their daily activities. Sixty-eight percent had a chronic physical condition. One in thirty had HIV, one in twenty, Hepatitis B and one in four, Hepatitis C. This high rate of Blood Borne Virus Infection was related to the high rate of drug usage amongst homeless people with 73% being addicted to alcohol or drugs. Mental health problems were very common with 58% having a mental health diagnosis, one in eight having schizophrenia and shockingly, one in three having attempted suicide at some time in their lives.

Travellers have a significantly reduced life expectancy which is similar to that of the general population in 1945-47 for males and 1962 for females. Only 3% of the traveller population are over 65 (compared to 13% nationally). They higher infant mortality rates. They are at much higher risk of death or disability due to accidents. They have very high rates of congenital malformations. They have poor diets and resulting poor nutritional status. They have poor mental health with suicide being nearly 7 times more common in the Traveller than then general population.

Migrants are recognised as having significantly higher levels of physical and mental ill health. They are affected by conditions endemic in their country of origin in particular infectious diseases. The process of becoming a migrant often places them at higher risk of mental illness.

Members of the Roma Community have a life expectancy 10 years below the national average and an infant mortality that is 1.4 times higher than the national average. They have a higher incidence of infectious disease, including HIV and Hepatitis B and C. They have very poor adult and child vaccination uptake. They have poor diet with resulting nutritional difficulties. They have a higher incidence of accidents and involuntary injury such as: burns, falls, pedestrian traffic accidents, bone fractures, cuts, intoxications, etc. Lastly, they are at higher risk of congenital malformations.

Access to Health Services

Homeless people known to have poor access to health services. They tend to present late on in the course of their illness; to make poor use of primary care services; to be high users of Emergency Departments and Inpatient services in secondary care; and to be poor compliers with medicines including psychiatric medications (which is of particular importance for those with schizophrenia). A recent study by Clíona Ní Cheallaigh in St James's Hospital, Dublin, found that,despite accounting for only 3 in 1,000 people in the catchment area, homeless people accounted for more than 60 in 1,000 ED visits and hospital medical admissions. This represents a twenty-fold use of unscheduled hospital healthcare. These individuals are often young and present with multiple chronic medical and psychiatric conditions. The vast majority of these ED visits and hospital admissions and associated costs could be prevented if housing, social supports, primary care and assertive outreach specialist care were provided to homeless people.

Travellers have well documented difficulties obtaining access to healthcare. Many find the application process for a medical difficult and onerous. They often find GP's will not sign their application forms. They also feel intimidated in using healthservices that are dominated by and designed for the needs of the general population.

The Roma population have well documented difficulties to obtaining access to appropriate primary care. Barriers include structural barriers such as the non Habitual Residence requirement that denies many of them access to a medical card. Even those with a medical card often find it difficult to obtain a GP to sign their application. And those who do have a medical card often cannot avail of the GP services due to the absence of appropriate translator services.

Primary Healthcare Provision for Marginalised Populations

There has been a tension within international literature as to whether marginalised populations should have targetted or specialised services or should attempts be made to integrate them into the mainstream services.

Specialised services are specifically designed to suit the Health Service Usage behaviour of homeless people. Pleace commented that "services have obviously been developed or modified to counteract the known attitudinal and organizational problems that were blocking access to the NHS for homeless people." They are delivered in locations accessible to homeless people; they do not require appointments; staff are trained to engage with homeless people and to deal with challenging behaviours; services are tailored to the specific health needs of homeless people e.g. the provision of substance misuse treatments, hepatitis B vaccination, TB screening etc. These services are undoubtedly favoured by homeless people. There is also significant evidence that such services improve access to health care for homeless people both internationally and in Ireland. They have also been found to reduce attendances at ED. When offered as a part of a multi-faceted response 'specialised' health services can help offer a route out of homelessness.It has been suggested that the adaptation of mainstream services would require such a radical overhaul of service delivery logistics (e.g. appointments make a practice inaccessible) as well as requiring the addressing of the huge, entrenched stigmatising attitudes faced by homeless people and drug/alcohol misusers as to become accessible that would be practically impossible to achieve. The vast majority of health services are adopting targeted/specialised services to provide accessible healthcare to homeless populations.

Central to the concept of parallel services stigmatizing homeless people by segregating them from 'mainstream' services is the notion that such services are separate to mainstream services. An alternative conceptualization of 'specialised' services is to recognise that the health sector offers services to many differing communities who have differing needs and differing HSU behaviours. If we want to ensure that the population as a whole has access to healthcare we need a health system that has the flexibility to take these differing needs and HSU behaviours into account. Lester et al argued that specialised and mainstream services should be combined e.g. a rough sleeper could register with a specialised service to address his/her immediate health needs and then transfer to a general surgery. Services designed to meet the needs and HSU of homeless people are required, as are services to meet the needs and HSU of elderly people; business people and workers who cannot make daytime surgery hours; substance mis-users, disabled people, members of the travelling and Roma communities; families with young children; migrants etc. Some of these groups will require tailored adaptations to ensure they will access the full arsenal of health interventions available to meet their needs. By integrating such services into the mainstream general services, patients attending these services will be able to access the full benefits available within the general services.

In Ireland targeted primary care services exist for the Traveller population (who use a peer led approach to the delivery of primary care) ; the homeless population (as provided by Safetynet associated services in Dublin, Cork, Limerick and Galway); for the Roma population (as provided by Safetynet in Dublin central and Tallaght) and for the migrant population (as provided by Safetynet in Dublin Central. Safetynet further provides specific targeted drug treatment services which are provided within hostel services for homeless people; a targeted consultant led secondary clinic from Merchants Quay Ireland; and a targeted diabetic service for diabetics from the homeless and Roma populations.

It is suggested that the Government should recognise that targeted services are an essential and integral component of the Health Service that are required to deliver health services to marginalised populations. This is not to say that efforts should not to continue to make mainstream services accessible simultaneously. At present such services have been developed piecemeal with differing funding, service delivery and strategic models nationally. The Committee should recommend a coherent policy framework that would rationalise targeted services for marginalised communities. Appendix A provides a suggestion for such an approach as multi disciplinary GP led targeted teams. Appendix A further provides suggestions for improving the performance of such teams resulting in better healthcare for marginalised populations as well as reduced pressure on the secondary care system.

Primary Healthcare for Areas of Deprivation

Health inequities result in premature death and disability. It has been demonstrated that the more unequal a country the worse their health outcomes in both terms of mortality and morbidity for all citizens. In the UK Marmot estimated people from areas of poverty died on average 7 years younger than people from well off area and that the average difference in a disability free life was 17 years.

It is known that Ireland has excessively high levels of income inequality with only Australia, the UK and US have worse indices. Such inequities result in higher mortality rates with an estimated 5,400 excess premature deaths per year caused by health inequities. People in areas of deprivation in Ireland have a life expectancy of 4 years for males and 3 years for females less than that of people from well off districts ; double the rate of cancer deaths ; 120% the rate of circulatory mortality and respiratory disease; and 150% higher mortality rates for injuries and poisonings. Child mortality is also higher for those from areas of deprivation. Mental ill health is also correlated to health inequites.

Primary Care Service Provision in Areas of Deprivation

Despite the higher burden of excess mortality and morbidity, people from areas of deprviation have poorer access to GP care (again proving Tudor Harts Inverse Care Law). Internationally, it is known, GP's tend to gracitate towards affuent areas resulting in low GP: patient ratios in areas of deprivation. This combination of higher need (with consultation rates in poorer areas being 42% higher than richer ones) and lower numbers of GP's results in overburdened GP service which furhter deters young GP's from being attracted to work in those areas. Ireland has a similar disproportionate distribution of GP's. It is known that the GP to patient ratio in North Dublin is 1/2500 which far exceeds the ratio nationally (1/1600). West Finglas which has a similar population to Mullingar has no GP within its boundaries.

The North Dublin City GP Training Programme was set up to help redress this inequity in GP distribution. It specifically trains GP's to work in areas of deprivation and with marginalized groups. It is an international first. Trainees are educated in hospitals and GP practices in areas of deprivation; have health inequalities, change management, leadership and self-care modules on their curriculum; and in their last year spend one day a week for 4 months in homeless GP services, one day a week for four months in drug treatment services, and one day a week for four months in prison and migrant services.

Proposed Service Development to Address inequitable GP distribution

Safetynet has a proposed solution for this mismatch. Our proposed solution involves funding the start up of new practices in areas of deprivation with social entrepreneurial funding and once the practices are profitable to use that profit to fund new practices. NDCGP is producing GP graduates who want to work in these areas but they are fearful of firstly, starting a practice without any income and secondly, starting a practice in an area of deprivation where associated social problems can create difficulties for newly establishing GPs. The basic model is that Safetynet would use seed funding to develop practices in areas of deprivation. Safetynet would employ GP's, practice nurses, receptionists and practice managers. Safetynet would pay all other associated costs. Safetynet would attract newly qualified GP registrars who want to work in practices in areas of deprivation but are fearful of setting up such practices. Safetynet would use it's expertise in working with populations affected by deprivation and marginalization to help address problems associated with setting up practice in areas with social problems. While the practice is establishing itself Safetynet would absorb the losses. As the practice becomes profitable Safetynet would recoup the initial investment plus interest. After this amount has been recouped Safetynet would offer to the GP's to either take over the running of the practice or else to remain as employees on a rising pay scale. The proposal is described in more detail in Appendix B.

In order to demonstrate to social entrepreneur funders that this project was viable we have piloted it with a Safetynet practice in Summerhill Dublin 1. it is known that in the Summerhill area (Dublin 1) there are 38 GP's /100,000 patients versus 68/100,000 nationally. This practice has been highly successful and already after 8 months we have over 550 patients. Our target is 1000 patients by December 2017 at which stage we will be profitable. We are well ahead of schedule and I expect us to reach 1000 by the year end.

One big advantage of Safetynet providing both services to marginalized groups and to areas of deprivaiton is that it can integrate it's targeted services into it's GP practices. For example, Safetynet intends to set up a practice in Tallaght and to integrate the targeted service for the Roma in Tallaght into this service. This will mutually enhance both services.

It is proposed that the Department of Health examine this Safetynet model as a possible solution to the inequitable distribution of primary care GP services in areas of deprivation. Of interest this model also provides a possible template for similar issues in isolated rural areas. This model could be facilitated via the GMS comtract which could allow organizations tender for organizational zero patient medical cards (time limited) lists in areas that it wants to improve access to primary care.

In summary, this document proposes that the Health Policy recognise that targeted services are an essential component of a health service that seeks to provide equitable access to marginalised groups. It further proposes that Health Policy adopt an innovative approach to address the inequitable distribution of GP's to areas of deprvation.

APPENDIX 1.

Specific Proposed Developments to Improve Targeted Services

Development of a Primary Health Team and Primary Care Centre for Homeless People

In Dublin at present Safetynet has helped develop a network of primary care centres for homeless people sites that homeless people use (hostels; food halls; drop in centres etc) with 9 sites in Dublin 2 in Cork, one in Galway and 1 in Limerick. We all use the same internet based practice records so that if a patient visits one site one week and another the next the doctor will be able to see what happened in the previous health sites the patient visited and what medication they were prescribed. In addition, Safetynet operates an Outreach Medical Clinic which provides GP services for free to rough sleepers. This is staffed voluntarily by GP registrars and outreach workers from Simon and Chrysalis.

These GP’s are supported by Safetynet but are paid by the HSE through a STC system and in effect are individual contractors. They are supported by a number of nurses who work in the sector and who are employed by differing voluntary agencies. In many ways they work as a single team but the fractured structure significantly interferes with their ability to deliver effective healthcare. There are significant problems with this particular structure that can easily be addressed by a rationalising of present structures:

LACK OF CLEAR CLINICAL GOVERNANCE: There is no clear governance structure for both doctors and nurses working in the homeless sector. While they all do work together they are all working under different employment structures and arrangements. It is known in the literature that fragmentation of services with differing policies and procedures is one of the main barriers to effective service delivery. Safetynet can define guidelines and protocols but is not in a position to enforce these as it is not the employer of the nurses. The ideal would be for the GP’s and nurses to be employed by the agency defining the protocols and guidelines. Whichever agency this is would need to have an expertise in delivering health care and a governance structure with a nursing and clinical director.

LACK OF PLANNING OF SERVICES: Agencies that have nurses and/or doctors have services and those who do not have a nurse or doctor have no nursing services. There is no focusing of services to where there is the most need. A primary care team for homeless people would be flexible enough to outreach to where there is mostr need and would change their outreach delivery if the need shifts.

LACK OF ACCESS TO PRIMARY CARE TEAM AND NETWORK RESOURCES. At present Safetynet is unable to access community physiotherapists, occupational therapists, chiropodists, counsellors etc. as they are not recognised as a primary care team. The creation of a homeless primary care team would allow homeless people to access these services.

POOR COORDINATION OF SERVICES: Safetynet attempts to coordinate services so that for example all clinics provide cervical smears, vaccination programmes, methadone treatment etc. However, the lack of a primary care team hampers this ability to create a cohesive clinical service that meets the needs of homeless people. For example, we could develop a diabetic service for homeless people based in our central hub receiving referrals from the outreach team.

LACK OF CAREER STRUCTURE FOR NURSES AND DOCTORS. There is no clear career structure for nurses and doctors to develop their skill base to work in homelessness and have their particular skill set recognized. There is a poor retention rate in particular for nurses in the sector which prevents the development of expertise. Having the nurses under the same primary care team would allow the development of educational structure and also the development with An Bord Altranais of an

Advanced Nurse Practitioner role for Nurses working in Homeless Services. This would enhance their skills for working in homelessness and as importantly, improve retention rates for nurses.

IMPROVING FINANCIAL EFFICIENCY: Safetynet doctors see people who have no medical card or who cannot or will not access their own GP for emergency care. However, as many homeless people who have medical cards cannot attend their own GP and visit Safetynet there is in effect a double payment. We have suggested that the monies spent on primary care at present for homelessness be protected and invested into a primary care team which by then signing up homeless people with medical cards would then prevent the double payment to non Safetynet GP's.

We are a proposing to the Committee that the development of an enhanced Primary Care team for homeless people as exists in many boroughs in the UK. (see below). By enhanced we mean it would have a higher doctor and nurse to patient ratio and also include extra services pertinent to homelessness.

OXFORD MODEL OF PRIMARY CARE PROVISION TO HOMELESS PEOPLE

Luther Street Medical Centre

Luther Street Medical Centre offers a comprehensive primary care service for homeless and vulnerably housed people. They have GP's, nurses, dentists, support care workers and a podiatrist. They offer alcohol detoxification, addiction services and outpatient psychiatric care among other services. They are housed in a purpose built modern unit

Luther Street Medical Centre is open to anyone in Oxford who is homeless or vulnerably housed, and is not currently registered with an Oxford City GP.

Services

- A full range of GP services
- Practical help, advice and support for registered patients
- On-site dentist, podiatrist and acupuncturist (registered patients only)
- Referral to on-site drug services
- Referral to on-site psychiatric and psychology services

Open access surgery times

9am - 12.30pm: Monday - Friday

Booked appointment times

2pm - 5pm: Mondays, Tuesdays, Wednesdays, Fridays

General enquiries

8am - 6.30pm: Monday - Friday (Outside office hours, the phones are covered by Oxfordshire Out Of Hours Service [OXEMS])

WESTMINSTER MODEL OF PRIMARY CARE PROVISION TO HOMELESS PEOPLE.

Great Chapel Street Medical Centre

Great Chapel Street offers a one stop primary care service where services are offered by GP's, nurses, psychiatrists, dentists, benefit advice workers and advocacy housing support workers. It operates a one stop shop where people can walk in off the street. They also operate an outreach service.

Great Chapel Street Medical Centre provides primary care to homeless people. It's services include GP, nursing and psychiatric clinics. Specialist substance use nursing services, dentistry, podiatry, counselling and general housing/benefit advice is also available. Preventative healthcare in the form of hepatitis B vaccinations and hepatitis screening is a key innovative development. Its practice has led to the award of Beacon Status.

Homeless people would attend this multi disciplinary team for:

(i) Nursing and GP care from doctors, nurses, dentists, physiotherapists, chiropodists and occupational therapists;

(ii) Addiction Treatment Workers.

(iii) Mental Health Treatment Workers.

(iv) Alcohol Treatment Workers

(v) Social Care services such as community welfare, housing and keyworking services. This is an optimum approach to delivering a holistic framework of health service provision in the context of the social determinants model of health.

This team would be employed by an appointed agency (Safetynet would feel it has the expertise to provide such a service). The team would have a primary care centre in the inner city area. This would be open seven days a week. The team would provide an outreach service to visit hostels and also continue running the mobile outreach clinic which would come under the governance of the primary care team. Food halls and drop ins where we know there is a need for such services. These outreach services could refer to the central service for more in-depth medical interventions. The service would have clear clinical governance structures with a Medical and Nursing Director. The team would have access to the array of services available to primary care teams and networks i.e. OT, physio, chiropody, counselling, etc. as well as having access to homelessness services.

The financial modelling would require that monies given to GP's (via the STC system) and to agencies for nurses would be ring-fenced and used as a funding stream to develop this enhanced primary care team. The agency operating the primary care team would have a Service Level Agreement with the HSE for delivery of primary care services. The team would take homeless people on to it's medical card list. As it would have a block grant already there would be no need for funding to be given for medical cards i.e. the service would not be paid per medical card. Some initial capital investment would be required for the outfitting of the Primary care centre.

This Multidisciplinary Care Team would also ideally have as part of their service an Intermediate Care Centre (see below).

The Development of an Intermediate Care Centre to be attached to the Primary Care Team

It is proposed that a 20 bed intermediate care centre be developed as an adjunct to the Primary Care Team and Centre. This is a centre where homeless people who are too sick to sleep rough or to stay in hostels would be referred to or homeless people who are to be discharged from hospital but who are too sick for the street of hostels would be referred for up to 6 weeks of medical care and respite. While in this centre they would be treated medically and also offered interventions for any addiction; alcohol or mental health problems as well as having discharge planning for longterm accommodation and training rehabilitation.

As already noted by Dr Cliona Ni Cheallaigh, homeless people place a huge usage and financial burden on inner city Emergency Departments and Hospital Inpatients. An Intermediate Care Centre has been demonstrated to significantly reduce this burden and associated costs. The argument for the development of an intermediate care centre has been clearly made in the attached document: Homelessness, Health and the case for an Intermediate Care Centre. In the UK they have developed three such intermediate care centres. It has been estimated that there is a huge differential in the amount spent on homeless people in secondary care services than non homeless people (Table 3).

Table 3: Comparison Costs in secondary care for homeless and general population.

Indicator	Homeless Population	General Population	Ratio
Acute Services	£2,115	£525	4:1

Inpatients	£1,877	£391	4.8:1
Acute Services 16-64yrs	£1,877	£235	8:1

In St James's Hospital provision of unscheduled care to homeless people costs an estimated minimum of 1,000,000 euros per annum. There is evidence that homeless patients who are discharged from hospital to an intermediate care centre will have reduced hospitalisation, accident and emergency and OPD attendance rates compared to those discharged to non-respite type care. Buchanan et al (2005) in unpublished research conducted in a respite centre for homeless people in Interfaith House in Chicago compared a group of 161 homeless people who were admitted to the respite centre with 64 homeless people who were deemed eligible for respite but for whom no bed was available. The groups were comparable in gender though the group admitted to the respite centre more commonly had trauma as reason for admission.

They assessed the accident and emergency attendance rates and hospital admission rates in the 6 months prior to admission / non admission to the respite centre and found that the respite centre had more A/E attendances (1.5 versus 0.9) and in-patient days in hospital (5.8 versus 5.3) and similar rates of OPD attendances. They then followed the two groups for the 12 months post admission to hospital and found that the respite group had less A/E admissions (1.4 versus 2.2 p value < 0.09) and significantly less in-patient days in hospital (3.4 versus 8.1 p value < 0.002).

The average length of stay in the respite centre was 44 days at a cost of $79 per day so the net cost per patient was $3,476. This compared to the average cost per patient for an admission to Cook hospital of $2,972 per day. It was estimated that the respite care group had on average 4.7 days less in hospital, which represented a 58% reduction in hospital days. Thus the cost savings were $2,972 x 4.7 = $13,968 which well exceeded the cost of respite care.

Kertesz et al (2005) also conducted a retrospective study (unpublished) on the effect of respite care on hospital re-admission, number of in-patient days and financial charges and on mortality. They compared 136 homeless people discharged to a respite centre for homeless people to 433 who were discharged to self care, 174 to other planned care and 41 who left against medical advice. They found that homeless people who had been admitted to a respite centre had

- a reduced readmission and death rate at 90 days,
- a reduced in-patient stay and
- reduced in-patient charges

compared to those discharged to their own care, against medical advice or to planned medical care. The figures did not achieve significance. However, it could be presumed that those discharged to a respite centre would have worse health problems than those discharged to self care so even the fact that there was no significant difference between both groups for readmission / death at 90 days and in-patient days and charges is an important finding.

Table 4 Readmission/Death and In-patient Days post Discharge.

Characteristic	Respite	Own Care	Against Medical Advice	Other Planned Care	P value
N	136	433	41	174	
Readmission/Death	15%	19%	20%	22%	0.57
In-patient Days	1.0	1.2	1.4	1.7	0.35
In-patient Charges	$2522	$2819	$3722	$3910	0.45

At 90 days deaths (7) were < 5% of readmissions /deaths.

The Expansion of the Safetynet Specialised Drug Treatment Programme.

Homeless people who are seeking treatment for illicit substance misuse can access methadone provision through two routes, the National Drug Treatment Centre (Trinity Court) or Safetynet Drug Treatment Programme. There are homeless people who were initiated prior to becoming homeless who remain with their original clinic or GP.

The National Drug Treatment Centre provides substance misuse treatment to both illicit substance misusers, thought to be unsuitable for treatment in the community (due to forensic history; alcohol misuse; chaotic behaviour; significant mental health problems etc.); to communities where there is no local service; and homeless people. Historically, the rationale for treating homeless people at the NDTC was that due to the chaos in their lives they were thought to be unsuitable for treatment in community pharmacies.

Since 2002 Safetynet members have been providing specialised primary health care services to homeless people and currently operate 19 clinics at 10 sites in Dublin; 3 clinics at 2 sites in Cork and 2 clinics at 2 sites in Limerick. Specialized-services are primary-care services offered at points of contact with homeless people (e.g. hostels, food-halls). Homeless people have expressed a clear preference for having specialized-services over mainstream-services. The use of specialized-services has been shown to improve access to health-care and decrease the burden on secondary-care services.

The Safetynet Methadone Treatment Programme was set up in 2007 as a response to a number of homeless people presenting with drug related illnesses to Safetynet Primary Care Services. While there is a high level of awareness among the residents regarding the drug treatment services available at NDTC (the nominated drug treatment center for homeless persons), there has been reluctance on their part to attend. This has been due to a number of factors including both real and perceived waiting list; fears of intimidation from other clients of the service; fears of facing drug dealers who congregate where large numbers of drug users are in treatment; and poor motivation caused by the experience of the chaos of homelessness. Safetynet provides methadone treatment from the specialised GP cinics it has in hostels and drop in centres. The GP works with a key worker and uses homeless services (e..g accommodation services, hostel staff, drug homeless community drug stabilization services, homeless inpatient detox services etc) as required. The patients attend community pharmacies. Clients who are unsuitable for community treatment are referred to the NDTC.

The programme was started with 10 clients in 2 hostels. The pilot programme was formally evaluated in 2008. It was found here was a significant improvement in participants' health; social functioning; and ability to maintain accommodation with evictions dropping in the hostel from 8 in the 4 months prior to the programme to 0 in the four months of the programme (full report accompanying this document).

The Programme was expanded to allow 45 clients attend Safetynet Methadone Treatment Services in 5 hostels. It's was again formally evaluated in 2010 with a review of all treated cases between Dec 2007 to June 2010. (report attached). The report found the main reasons for taking on patients were inability to access treatment and lack of motivation or desire to attend the NDTC.

It further found that over 90% of participants had an improvement in their accommodation status while on treatment. Of note the cost per patient per annum in Safetynet is less than the cost of treating a patient in General Practice.

Over the years Safetynet has expanded its substance misuse programme initiated 378 clients on methadone. On the 31st December 2015, Safetynet were providing methadone treatment to 78 patients. On exit of the Safetynet Programme 65% of patients were successfully retained on methadone by transferring to other programmes and 3 % had successfully detoxed. Many (69) of the patients who moved on from Safetynet services were transferred to GP practitioners.

78 currently being treated.

378 have been started on methadone treatment

25% have been transferred to a GP or satellite clinics.

26% have been transferred to a HSE Treatment Centre (dispensing)

12% went to prison

2% were admitted to hospital

2% patients had detoxed

19% defaulted from treatment.

7 deaths i.e. mortality rate 2% (compared to ROSIE 0.5%; NTORS (UK) .2%; Smyth et al 1.8%; Mortality seven fold increase amongst homeless).

This programme is still considered a pilot programme and so is restricted in the number of potential patients it can treat. Safetynet believes that the case for mainstream recognition of this programme and expansion so that it can offer treatment to all homeless people who are suitable in Dublin and in other cities that have Safetynet services.

The Development of Inclusion Medicine Speciality at Secondary Care Level.

Challenges

Hospitals in Ireland are currently facing significant challenges. Bed occupancy is close to 100% in most acute hospitals, greatly exceeding the optimal occupancy level of 85% (OECD, 2014), and much higher than most other EU countries. This results in prolonged waits on trolleys the Emergency Departments (ED) and reduces efficiency.

Homeless individuals account for a small proportion of the population, but account for a disproportionately high amount of ED attendances, inpatient admissions and delayed discharges. There are multiple routes to homelessness but many homeless people will have experienced troubled childhoods and been exposed to disadvantage from a young age.

- Homeless individuals represent 7/1000 people living in the St James's catchment area,
- Homeless patients account for 60/1000 ED attendances (10-fold higher rate than the housed population

- Homeless patients account for 70/1000 inpatient bed days (20-fold increase over that of the housed population).
- The estimated annual cost of acute unscheduled care to homeless people in SJH is a minimum of €5,000,000, representing at least a 20-fold increase in per capita hospital costs compared to the general population.
- Delivery of care to this group has been characterised as “crisis management” as opposed to a proactive and preventative approach.

Homeless and other multiply excluded patients (e.g. injecting drug users, patients with addiction and psychiatric disorders) often display challenging behaviours. Drug dealing, theft and threatening behaviour in the ED and inpatient wards in SJH have become increasingly common, and are a frequent cause of patient complaints and concern regarding patient safety in the new Children’s Hoospital.

Patients with complex social, medical and psychological needs are difficult to discharge from hospital and represent a significant obstacle to patient flow through the hospital. The length of stay and readmission rate are at least 2-fold higher than patients with less complex needs. There are approximately 50 seriously delayed discharges/year in St James’s in this cohort. Waiting times for appropriate placement can be as long as 2 years. In addition, the fact that 40% of homeless people attending ED took their own discharge and that 15% of homeless inpatients left against medical advice highlights the mismatch between current services and the needs of homeless patients in SJH.

Despite these high levels of use of healthcare, health outcomes in homeless people are extremely poor. The life-expectancy of homeless men is 30% shorter than that of their housed peers, and there is a three-fold increase in reported ill health. The Healthy Ireland Framework (HIF), adopted by the Irish Government in 2013, makes a strong commitment to reducing health and commits to structural reform of services to improve equitable access to health services. Current healthcare structures do not adequately address the needs of homeless and other multiply excluded individuals

Opportunities

International evidence suggests that active, multi-disciplinary management of homeless and other multiply-excluded individuals results in reduced bed-days, reduced costs and improved outcomes. St James’s Hospital (SJH) serves a socio-economically deprived catchment area, and staff at SJH have extensive expertise in the care of multiply excluded individuals.

We propose the creation of a dedicated Inclusion Health Service within SJH to provide planned, co-ordinated, cohesive and effective delivery of care to rough sleepers and other multiply excluded individuals who currently experience poor outcomes despite heavy use of unschedulted care. This will be delivered through: an integrated network with specialist primary care teams and relevant stakeholders in hsouing and social care. Elements of the service will include:

- A dedicated rapid access outpatient clinic
- A dedicated, multidisciplinary inpatient Inclusion Health service to provide acute medical care
- Active collaborative case management with community services using ECHO-based multi-disciplinary and multi-site case conferences
- Outreach to community-based facilities including addiction services and intermediate/respite care
- Integrated IT with Safetynet practices serving homeless and other multiply excluded groups (eg Roma)
- A liason service for homeless and other multiply excluded patients in SJH
- Establishment of a psychologically informed approach to patient care in SJH thereby reducing challenging behaviour on wards leading to reduced stress to other patients and staff
- Active collaborative management of frequent attenders to ED
- Training at a local and national level in the principles and methods of Inclusion Health
- The creation of a national Homeless Health Taskforce including representatives from relevant NGOs and government departments
- Collection of data to inform hospital, local and national policy

Costs Associated with Homeless Patients in SJH and Potential Savings

	Ward Bed Days	ITU Bed Days	ED Visits	Cost of bed days	Additional costs
Current Model	5443	137	3534	3,463,695	

Additional security: minimum estimate 500,000/annum

Blood products (increased use in this population): minimum estimate 250,000/annum

Antifungals, antibiotics: minimum estimate 250,000/annum

Liason Service – 20% reduction in bed days 4354 110 2827 2,770,956

(saving: 692,739) 800,000

(saving: 200,000)

Complex Case Management including community key workers – 60% reduction in bed days 2177 55 1413 1,385,478

(saving 2,078,217) 400,000

(saving 600,000)

APPENDIX 2

Safetynet GP Practices in Areas of Deprivation.

Vision: A world where all patients have access to high quality General Practice Services

Mission: Safetynet will develop high quality GP services in areas of deprivation that are underserved with General Practice Services.

Implementation Plan:

Identify four areas where there is low GP / Patient ratio.

Work with HSE National Social Inclusion Office and HSE Planning Unit (Dr Steevens) in identifying suitable areas.

Rapid Needs Assessment (to be conducted by Dr Fiona O Reilly):

Aims:

Identify areas where there is low GP patient ratio.

Collate local population’s views on new GP coming into area.

Conduct needs analysis to identify local community health needs.

Conduct service provision analysis to identify local health service provision. This is to identify both local resources that could be tapped into by new GP practice as well as gaps in service provision.

Identify Suitable Premises for GP Practice.

Preferred option is to locate in HSE Health Care centres as this would create de factor Primary Care Team with PHN’s and other health staff based in Health Centres. If Health Care Centres not an option need to identify suitable premises that have or can obtain planning permission.

Advertise and employ two FTE General Practitioners; two Nurse Practitioners; two receptionists and one practice manager.

Year 1 Practice 1 Practice 2 Practice 3 Practice 4

Monday AM Doctor

PM Nrse Prct. AM Nrse Prct

PM Doctor AM Doctor

PM Nrse Prct. AM Nrse Prct

PM Doctor

Tuesday AM Nrse Prct

PM Doctor AM Doctor

PM Nrse Prct. AM Nrse Prct

PM Doctor AM Doctor

PM Nrse Prct.

Wednesday AM Doctor

PM Nrse Prct. AM Nrse Prct

PM Doctor AM Doctor

PM Nrse Prct. AM Nrse Prct

PM Doctor

Thursday AM Nrse Prct

PM Doctor AM Doctor

PM Nrse Prct. AM Nrse Prct

PM Doctor AM Doctor

PM Nrse Prct.

Friday AM Doctor

PM Nrse Prct. AM Nrse Prct

PM Doctor AM Doctor

PM Nrse Prct. AM Nrse Prct

PM Doctor

Nurse Practitioner at all times has telephone support from a Doctor.

In Year 2 the GP would become ¾ time and in Year 3 full time. In Year 4 the Nurse Practitioner would become full time.

Equip four Practices.

Indicative budget for capital costs to equip four GP Practices: €60,000

Service Delivery

Services provided in clinics to include:

a. Routine GP Care.

b. Out of Hours GP care using local Out of Hours services.

c. Preventative Services

i. Routine GP Preventative services

ii. COPD screening.

iii. Cervical Screening

iv. Screening for diseases prevalent in local population and its subgroups e.g. HIV / Hepatitis in IVDU users / Diabetes screening in Roma community.

d. Childhood Immunisation Services

e. Substance misuse treatment

i. Methadone Treatment

ii. Community Detox for methadone; benzodiazepines, Z-types and alcohol.

iii. Drug and alcohol educational interventions.

Financial modelling:

Indicative budget:

Expenditure for 4 practices Income for 4 practices.

Year 1 • Staff: (2 GP's: 2 Nurse Practitioners; 4 receptionists; 1 Practice Manager)

- Other current costs.

€326,000

€100,000

List 400 per practice

& Methadone Pts 5

€150,000

Year 2 • Staff: (3 GP's: 2 Nurse Practitioners; 4 receptionists; 1 Practice Manager)

- Other current costs.

€326,000

€120,000

List 800 per practice

& Methadone Pts 15

€350,000

Year 3 • Staff: (4 GP's: 2 Nurse Practitioners; 4 receptionists; 1 Practice Manager)

- Other current costs.

€506,000

€140,000 List 1200 per practice

& Methadone Pts 30 €800,000

Year 4 • Staff: (6 GP's: 4 Nurse Practitioners; 6 receptionists; 2 Practice Manager)

Other current costs. €868,000

€180,000 List 1600 per practice

& Methadone Pts 30 €1,200,000

Year 5 • Staff: (6 GP's: 4 Nurse Practitioners; 6 receptionists; 2 Practice Manager)

Other current costs. €868,000

€180,000 List 2000 per practice

& Methadone Pts 30 €1,600,000

Total €3,614,000 €3,700,000

Year 6 • Staff: (8 GP's: 4 Nurse Practitioners; 6 receptionists; 2 Practice Manager)

Other current costs. €968,000

€180,000 List 2400 per practice

& Methadone Pts 30 €1,900,000

Total €4,762,000 €5,600,000

8. Audit and Evaluation.

Audit and Evaluation to take place in three spheres

a. Financial Auditing: Need to monitor financial costs in order to ensure sustainable Practice development.

b. Clinical Audit. Practice doctor and nurse to conduct clinical audit to ensure quality of clinical care. Audits to include equity audits to ensure Practice is providing care to all members of local community and not creating barriers to any particular minority groups.

c. Service Evaluation: Service to be evaluated to ensure it is achieving targets of providing quality care to local community and impacting on local health problems. Such evaluation to have indicators identified prior to service initiation and data collection systems in place prior to launch of service using computerised record system. Evaluation also to include consultation with patients, local community groups and HSE.

http://primarycaresafetynet.ie/

Sage with Third Age, Family Carers Ireland and Alone

“Let this be the last Report”

In January 2016 in the run up to the general election Sage, in partnership with Third Age, Family Carers Ireland and Alone placed notices in the Sunday Independent and The Irish Times inviting submissions from members of the public, voluntary and community organisations, statutory and government bodies, trade unions, employers, cultural and religious organisations on the issue of long-term care for older people

Some 52 submissions were received. In May Sage commissioned a public opinion survey on long-term care for older people and on June 15th the first Forum on Long-Term Care for Older People was held in Dublin. At the Forum, the draft report developed so ably by Dr Michael Browne around the issues raised in submissions to the public consultation, was presented and debated. The results of the public opinion survey by Amárach Research were also presented.

There was remarkable unanimity at this Forum which could be summed up in a question; “Why, despite decades of policy reports and recommendations to government, is there still a systemic bias towards care in congregated settings and no formal legislative basis for support and care in the community?” It is likely that this question is also close to the top of an already crowded Department of Health agend

Despite consistent criticisms of the lack of a continuum of care there was agreement from the diversity of perspectives provided by campaigners, providers and regulators, that the development of such a continuum was now the key challenge. There was also a consistent message coming through the proceedings, and reflected in many of the submissions, that the issue is as much to do with supports, often minimal but nevertheless necessary, as it is to do with care and the intervention of providers whose focus can often be as much on the priorities of their profession as on the needs, and the capabilities, of the provided for.

In thanking all those who made submissions, attended the Forum or sent good wishes, we want to especially thank those individual members of the public who shared their personal experiences. The insight they provided was invaluable and the frustration of their experiences with ‘the system’ and the lack of serious focus on support and care in the home clearly emerged from their determined handwriting. The gap between the decades of rhetoric supporting home and community and the reality that congregated settings have become synonymous with long-term care, is large. It can however be tackled by effective and determined action. As one Forum participant put it, having heard the presentations and the results of the public opinion survey, “Let this be the last report”.

In the face of such an overwhelming consensus of public policy around home and community supports and care, and of a nationwide public opinion survey which reinforced the popularity of such policies, it can be difficult for the public to understand the depth of administrative resistance to change and the lack of political will to challenge this resistance. Public opinion surveys are just that; surveys. The fact that a strong majority favours using the taxation system designed for all to contribute according to their means to fund necessary supports and care for older people – as opposed to certain types of care being charged for while others are not – does not necessarily encourage legislators to act in the public interest. Other voices, in quieter corridors where decisions usually get made, speak of the public interest in terms of 'affordability What then are the next steps? The experiences of dealing with the state at national level and with services, or the lack of them, at local level suggests the following

We will not make the changes we seek unless we develop a popular vision of how things could be. Home, hospital, hotel, hospice – all share the same common denominator – hospitality – care for others. We need to develop a vision for long-term support and care which is as compelling as that of the hospice movement at its best.

Commissioning based on outcomes, rather than block grants and outsourcing for particular aspects of care.. The percentage of older people being supported and cared for in the places of their choice according to their will and preference and their changing needs – this has to be seriously considered as one of the objectives of commissioning. Far from the money following the patient the patient currently follows the silo where the money is. Where is the 'Fair Deal' in going where you don't want to go? The Expert Group on Resource Allocation and Financing in the Health Sector stated clearly that "…. the key issue is not whether Ireland has a social health insurance model or continues to fund health care out of taxation, but rather how to structure the financing system so that it supports the stated health-care objectives". If there is to be a continuum of support and care then funding for it must reflect that continuum.

Housing and health and social care can no longer remain parallel lines. They must converge. For this to happen we need to focus as much of our energy on local government as on national government; on housing policy as much as health and social care policy.The public sphere must be enriched through innovation and this can best happen at local level. County development plans need to reflect the valuable economic and social roles of older people as well as their healthcare needs.

Resources are limited so we need to make the best use of them. We may also need more resources. This will require challenging the current consensus that taxation and public spending, are of themselves, a bad thing. If we can put a compelling vision before people and show that social innovation can also support economic development then we have at least a fighting chance of being heard.

What gets measured gets focused on. One of the regular indicators of the misery of many older

people
– ‘trolley watch’ – is an initiative of a representative organisation for the providers - the Irish Nurses and Midwives Organisation. We need our own measurements and we need to focus relentlessly on them.

We need to aim at the programme for the next government. To do this we need to develop local Forums in key locations where we can engage with local and nation al public representatives on the issues raised by the Forum on Long-Term Care. We also need to bring this report to Oireachtas committees charged with oversight of issues such as housing, health, economic development, public accounts and public expenditure and reform of public services. In addition to consideration by the Ministers for Health, Older People and Housing we see this report as a useful resource to be considered by the Citizens Assembly chaired by Ms Justice Mary Laffoy of the Supreme Court.

For all of this to happen we need to build a coalition of forces and to have access to legal, financial, research and marketing resources to help us develop compelling messages and arguments so that we can forge a new national consensus.

“An té nach bfhuil láidir ní foláir do bheith glic”. We are not strong therefore we must be clever.

Patricia T. Rickard-Clarke, and Prof Cillian Twomey.

Joint Chairpersons: Forum on Long-Term Care for Older People. 15th
June 2016

Forum Report

There is a broad consensus on the direction that our approach to supporting older people who need care should take. This includes enabling people to stay at home and in their own communities for as long as possible, the need to cater for people at the lowest appropriate level of complexity and the need to provide high quality residential care when and if this is needed.

We know what needs to be done but actually doing it requires new thinking, innovative approaches and the availability of a mix of accommodation choices to enable progression as support and care needs change.

Link to **Sage Report of Forum on Long-term Care for Older People**

Outline of Forum Report

The Report contains five main sections.

Section One describes the background and current policy context relating to long-term care.

Section Two sets out six relevant considerations – respecting the rights of older persons; quality of life; choice and preferences; integrated medical, nursing and social care provision; meeting the specific needs of people with dementia; and equality of access between community and residential care.

Section Three identifies the components of a framework for long-term care – integrated needs assessment; a continuum of provision; inter-agency collaboration; supports for family carers; maximising the role of assisted living/sheltered housing; case management and inter-disciplinary working; and independent support and advocacy.

Section Four discusses the question of financing long-term care and summarises the relevant factors.

Section Five includes a synthesis of the main issues and an outlines and Agenda for Action.

Long-term Support and Care: What the Issues and Concerns Are

General

There is a major discrepancy in the Irish health care system between the way care for people with acute illnesses and those with a slow debilitating illness (such as dementia) is funded – a core question to be addressed by society is whether or not this is right or equitable;

Nursing home care is available on a statutory basis but there is no statutory entitlement to home care – the need to address this legislative gap is widely acknowledged and action by Government is required on the matter;

There is an urgent need to proactively plan for the financing of long-term care of an older population who are living longer and to make decisions about whether this is to be out of general taxation or through the social insurance system;

We need a single policy framework, societal and political consensus and a properly costed and phased implementation programme;

While there is broad acknowledgement of the principle of enabling people to exercise their will and preferences in the way care is provided, people regularly end up in nursing homes against their will because of a lack of community-based alternatives;

Quality of Life

Significant quality of life domains such as social connectedness, companionship and meaningful involvement in the activities of daily living tend not to be factored into care and support needs assessment;

There is much to be done to ensure that the design and location of care facilities, including, in particular, nursing homes, caters for key quality of life considerations – community access, maximising individual capacity and self-expression and individual preferences;

People’s inability to access the therapies that they require in order to optimise capacity (e.g., occupational therapy, physiotherapy, speech and language therapy) at a level commensurate with need impacts greatly on their quality of life and general well-being;

A community-based social enterprise model of support and care delivery (a business model that puts people and community before personal gain, while being commercially viable), supported by the State, has significant potential to target interventions at the lowest appropriate level and to optimise quality of life accordingly;

Care in the Community

- The provision of adequate state funding for support and care in the community requires social consensus and related political will and new legislation to achieve equality of access to care in the community and nursing home care;
- Criteria for accessing home care packages and home help need to be transparent and uniform across the country and the system needs to be fully regulated – this is not the case at present;
- People's long-term care and support needs should be assessed in an integrated and holistic manner and provided for and managed accordingly – such practice remains largely underdeveloped despite the emergence of the Single Assessment Tool;
- Multi-purpose community-based units providing a continuum of support and care (day facilities, sheltered accommodation, nursing units) can contribute enormously to enabling people to live independently or semi-independently and should be made an integral part of the community care infrastructure – such models could be developed initially in locations where existing public long-term residential care facilities have been deemed to be no longer fit for purpose;
- The role of family carers needs to be optimised and supported in the way home help and home care packages are delivered – this requires meaningful collaboration between service providers, families and individuals requiring care;
- There is a need to pilot a new national community-led social enterprise model of day resource care which would provide a comprehensive range of services and supports to enable people to continue to live independently in their own homes.

Inter-agency collaboration and inter-disciplinary working

- Providing people with a seamless service often requires much higher levels of co-operation between agencies and between disciplines than is currently the case – a greater integration of resource allocation and policy-making at both national and local levels is required;
- Inter-agency collaboration and interdisciplinary working at local level needs a dynamic impetus and energy on the part of all those charged with delivering supports and services to older persons;

- Inter-disciplinary working needs to be more embedded in the community care delivery system with particular reference to GPs, PHNs, health care assistants, home helps, physiotherapists, occupational therapists, social workers and speech and language therapists;

Maximising the role and contribution of housing

- The potential of appropriately designed housing has not been developed to date in Ireland – there are appropriate models of 'housing with care' that have been developed in other jurisdictions and some in Ireland that can and should be replicated nationwide;
- There is a need for Local Authorities to take on much more responsibility for the provision of sheltered and supported housing;
- Implementing the Building for Sustainable Communities and the future-proofing of housing in respect of adaptations would be beneficial from both a social integration and an economic perspective – these two principles should be embedded in long-term housing policy;

People with complex care and support needs

- More attention is required to ensure that best gerontological practice is always applied in meeting the specific nursing, medical and personal care requirements of people with complex care needs in both residential care settings and in the community;
- There is a dearth of appropriately designed and staffed dementia-specific accommodation, including both assisted living housing and full residential care – this gap in provision needs to be addressed a s matter of some urgency;

The Nursing Home Support Scheme (NHSS)/'Fair Deal'

- While the NHSS is a large area of health expenditure, there is little focus on outcomes, quality of life domains or on the creation of greater choice to reflect the will and preference of people who require nursing home care;
- The current model of fee negotiation between the National Treatment Purchase Fund (NTPF) and nursing homes is unsatisfactory, particularly, because it provides for 'bed and board' only and takes no account of different individual support and care needs;

A preventative approach

- Much more can be done at local community level to prevent or delay the onset of conditions that require more extensive care and support, including, in particular the availability of accessible transport and initiatives to combat social isolation and loneliness;

- Housing policy should include provisions for future proofing in respect of adaptations required to cater for reduced mobility;
- Ageing with confidence programmes have significant potential to equip people with the skills to maintain independence and to anticipate support needs before a crisis arises;
- There needs to be a stronger public discourse about elder abuse and more attention to sharpening public awareness of the matter;

Building on best international practice

- Ireland can learn much from practice in other jurisdictions with particular reference to:
  - Eligibility and access criteria for health, housing and social care support
  - Models of financing
  - The individualised payments approach
  - The optimal balance between funding for community-based care and for residential care
  - The devolved responsibilities of local government (municipalities) in providing long-term care accommodation, support and services
  - Integrating mainstream housing provision and specialised accommodation provision

Legal frameworks relating to people's rights in respect of long-term care

Addressing the challenge of long-term care financing

- The matter of funding long-term care needs to be addressed urgently by society generally and by Government with particular reference to:
  - What is the optimal level and type of care and support?
  - How much are we as a society prepared to invest in this area?
  - What are the respective responsibilities of the State and individuals in financing and planning for long-term support and care?
  - How do we get from where we are now to where we want to be?
- There is a need for a national consensus (political and civil society) approach based on the existing broadly agreed parameters of how long-term support and care should be

delivered and funded and the development of an agreed action agenda accordingly;

- A comprehensive piece of research funded by Government is required to inform policy thinking and planning in this area which would include am analysis of:
  - The dimensions of support and care
  - The options that are desirable and possible
  - The likely cost of each of these options
  - How these might be funded in the short, medium and long-term
  - An implementation framework and timescale.

What the public said about long-term care and support

The following comments are taken directly from the submissions to the Forum and are indicative of the main points made. Minimal editing has been carried out in order to preserve the voice of the person or organisation who submitted the comment.

The comments have been categorised under a number of headings for ease of reading: cross-cutting matters, community care deficits, family carers, nursing homes, enhancing the role of housing, integrated long-term care and, finally, a need for a national conversation about the need for fundamental change.

Cross-cutting matters

- “Many older people experience a deep fear of institutionalization”;
- “Loneliness and social isolation is a significant and widespread problem”;
- “Care in residential settings should be the ‘option of last resort’ and only put in place when all community- based options have been exhausted – for this to happen, best international practice in integrated housing and care support needs to be implemented”;
- “In some countries, residential care is particularly difficult to access (in terms of financial support, and needs assessment)”;
- “Institutionalising old people, for whatever reason, convenience or whatever, is a tradition only in some countries – in Africa and India, for example, there is no nursing home available to most people and they are looked after by their family”;
- “Poor diet and malnutrition is a problem for many older people who are no longer motivated to or able to cook for themselves”;

  - Transport services are often not available to assist people in managing their daily lives";
  - "What is lacking is a coherent plan of action that would provide a full range of measures and supports to allow citizens to continue to contribute to their communities and provide choices as to how and where they will live in advancing years";
  - "Financial considerations frequently determine quality of life in old age – many people simply have insufficient resources";
  - "Policies to create communities in which older people can live autonomous and valued lives and initiatives to implement such policies are urgently required";
  - "There is a lack of financial incentive to remain at home, the only real support being the 'Fair Deal'";
  - "The 'money follows the person' principle needs to be extended to all services – funding needs to be provided on an individualised basis so that responses can be tailored to the current and changing needs of people";
- "Moving to residential accommodation is a major event for older people and their families and there is a need for support to help deal with the psychological and emotional challenges involved";
- "There is a need for much more attention to the 'Think Ahead' concept and to Advance Care Directives on the part of both society generally, people who are becoming older and service providers and professionals";
- "There is a need for a significant investment in IT information systems to ensure the safe and efficient management of health records, to eliminate duplication and to ensure continuity of care and support";
- "Older people need to keep abreast of new technologies – Internet access helps to lessen feelings of isolation and prolong independence";
- "Service delivery should be informed by the Department of Health Framework for the Management of Chronic Diseases which includes a model of care integrated across organisational boundaries and using a multi-disciplinary team approach";
- "The needs of older adults with an intellectual disability are complex and are best considered along a spectrum involving social, quality of life, physical and mental health";
- "The National Dementia Strategy states that 'people with dementia should be supported to retain skills as much as possible' – the same is true of other chronic conditions that may cause disabilities which are so severe as to require care";

- A medical model predominates current provision in residential care services – this needs to be expanded to a more holistic model of care that acknowledges the importance of people’s psycho-social, emotional and spatial well-being”;

Community care deficits

- “Pathways to services are not always clearly defined or understood”;
- “There is a major shortage of occupational therapists in Ireland employed to work with people with neurological conditions”;
- “There are very few community social workers – there is an over reliance on Public Health Nurses (who are already over stretched with a broad remit)”;
- “The greater availability of day centres could mitigate the destructive effects of loneliness and social isolation”;
- “There is huge variance in access to and quality of day care support and lack of transport to same is a significant barrier in some areas”;
- “Delays in getting adaptations and specialised equipment for people moving out of hospital mean that they may have to stay in hospital longer or move to a nursing home until their home has been adapted to suit their requirements”;
- “Many home care packages and home help services do not meet the needs of people who get them”;
- “There is a need to better recognise the value of home help in enriching the lives of older persons and in reducing the risks associated with completing physical tasks”;
- “Access to home help is increasingly scarce with long waiting lists in operation”;
- “A home care package will generally only be approved to provide task focused care (i.e. personal care, meal preparation, medication prompting) – holistic needs are not considered (i.e. social support to address social isolation or complete practical tasks)”;
- “Carer visits of 30 minute duration are common – these visits can be appropriate but also can lead to a rushed, stressful visit which does not engender respect and dignity for the person being cared for”;
- “There is a lack of uniformity in the various HSE areas regarding Home Care Packages – the application process, the hours approved, the tasks covered by the HCP and the amount of funding (hours) available”;
- “Applications for HCPs from acute hospitals particularly for inpatients are prioritised leading to a lack of access to HCPs for those living in the community which can result in inappropriate

admission to hospital – a crisis response rather than a preventative approach is in operation";

- "Better GP services at local level would reduce dependency on hospital services and related hardship in accessing these services";

Family carers under pressure

- "Carer fatigue is a serious problem with carers becoming over-burdened and unable to continue providing care due to lack of adequate home care packages";
- "The PHN and community healthcare services are under-resourced and families find it difficult to navigate the system of application for supports and services";
- "A needs based approach to assessment should include both the needs of the older person and the carer";

Nursing Homes

- "Home is, of course, best, but a nursing home should be a positive experience for those who require that level of care";
- " A high percentage of people in nursing homes have multiple chronic conditions, frailty and disability which require gerontological expertise in care, including dementia care and palliative care";
- "In many cases, increased [nursing home] charges are being passed on to residents, causing worry and hardship";
- "People on low incomes such as Disability Allowance and basic State Pension can now find themselves with less than the 'Fair Deal' stipulated minimum after they have paid the extra charges";
- "The location of nursing homes should be reconsidered – many are built in isolated areas, cutting residents off from community life";
- "The practice of building nursing homes on green field sites outside villages and towns should be stopped. It serves no practical purpose and only isolates those residing in them, incapacitating them further";
- "We need to concentrate on the fact that this [nursing home] is a person's home – it is not a hospital, it is not a prison, it has medical input but it is not a medical facility";
- "A big issue for nursing home staff is conflict between risk management and quality of life and a related concern with avoiding litigation";
- "The 'Fair Deal' scheme is not working – it is too legalistic and does not meet the medical and care needs of the person, it does not include pressure relief mattresses or specialised wheelchairs in the cover";

Enhancing the role of housing

- “A range of housing options is a vital component in allowing people to live independently for longer”;
- “The lack of a funding model to support sheltered housing with care services is a significant obstacle to meeting the needs of people who wish to continue to live independently”;
- “Aids to support mobility and adaptation to homes to facilitate independent living are in short supply relative to need”;
- “Sheltered housing in a town or village is a good option for extending independence”;
- “The ideal provision would be a community setting of small houses, not too far from a town or village with a local bus route – the houses should be available to buy and furnish as one would wish or to rent, with an annual fee to be paid towards the upkeep of the facilities, landscaping and garden”;
- “If the needs of a sheltered housing tenant are such that they cannot be met by the sheltered housing they are living in, then the only option for the vast majority is a nursing home, even if they don’t need 24- hour nursing care”;
- “Sheltered housing needs to be properly staffed and supervised and more comprehensive cover and extended medical and care services are required in these situations – at present many such schemes have no staffing from 5.30 p.m. to 9.30 a.m., leaving vulnerable residents without assistance”;
- “There is little point in expecting an older infirm or immobilized person to be able to cope in their own house if their bedroom is upstairs, their kitchen and living room downstairs and their toilet and bathroom a flight of stairs out of reach”;
- “Given their role in maintaining older people in their own homes and communities, housing related support services provided by housing associations need to adequately resourced by Government”;

Integrated Long-term Support and Care: Components Identified

- “Existing community-based services should be integrated under a local formal team structure involving all service delivery stakeholders”;
- “There should be a built-in bias towards community care solutions (while retaining capacity for some funding for residential care facilities)”;
- “The State should take the lead role in pioneering and developing new and innovative

models of care and support in the community – collaboration with NGOs has significant potential";

- "A Case Management approach should be used to assess and determine needs";
- "All relevant public services should be designed and delivered in an integrated manner around the needs of the care recipient, based on a national standardised needs assessment";
- "Access to care and support should be on the basis of need and should not be based on ability to pay";
- "There is a need as a matter of urgency to provide more high-dependency residential care beds, particularly in dedicated units for people with advanced stage dementia";
- "The funding for long-term care should be comprehensive and commensurate with current and projected need";
    - "A mechanism needs to be put in place to explore in detail the public financing of long-term care – this should build on the previous work carried out by Mercer [a 2002 report commissioned by the Department of Social and Family Affairs] ";
    - "Maximising people's independence, autonomy and choice is essential to ensure that their constitutional rights and international human rights are protected";
    - "There is a need for a funding model that is financially sustainable over the long-term taking into account demographic, labour market and social changes –there should be appropriate levels of co-payment by care recipients";

Need for a national conversation about the need for fundamental change

- "There is a need for a national conversation around developing a new approach in Ireland which embraces attitudinal and value changes as well as systemic change;"
- "We need to fundamentally question current practices and create a shift in the way we look at this issue"
- "There is a need for a stronger focus on all older people as unique persons with histories, hopes and aspirations, and preferences as distinct from people who just engage with the health and social care delivery system";
- "Active community engagement and community connectivity is at the core of citizenship and social solidarity – this requires society to maximise older people's involvement and independence";

- “We need to move from the treatment of people with long-term care and support needs as ’objects’ of health and social care policies towards viewing them as ’subjects’ with rights who are capable of claiming those rights based on social justice”;

http://www.thirdageireland.ie/sage

Information and policies that we already have and need to build on

Since the late 1960s, there has been a plethora of policy documents, reviews, strategies and research reports published which refer directly or indirectly to long-term support and care. There is a significant body of research in Ireland relating to long-term support and care mainly carried out by the NCAOP during the 1990s and early 2000s, by the Law Reform Commission, by NESC, NESF, third-level colleges and medical/ nursing organisations and by government departments. Since we already have a lot of research evidence and related policy statements and strategies, we do not need to ‘re-invent the wheel’ but rather apply greater urgency to policy implementation **(see below for a selected list of documents).**

Age Friendly Strategy (Various Local Authorities)

Healthy Ireland Strategy, A Framework for Improved Health and Wellbeing 2013

– 2025 National Council on Ageing and Older People (NCAOP) (Various

Reports)

National Standards for Residential Care Settings for Older People in Ireland

(HIQA 2016) The Irish National Dementia Strategy (2014)

HSE Safeguarding Vulnerable Persons at Risk of Abuse: National Policy and Procedures (2014)

Creating Excellence in Dementia Care: A Research Review for Ireland’s
National Dementia Strategy (2014)

Fourth Age Trust (2014), Individual Needs – Collective Responses: The Potential of
Social Enterprise to Provide Supports and Services for Older People

National Positive Ageing Strategy

(2012) (2013) National Carers

Strategy

NESC (2012) Quality and Standards in Human Services in Ireland: Home Care for

Older People NESC (2012) Quality and Standards in Human Services in Ireland:

Residential Care for Older People Law Reform Commission (2011) Legal Aspects of

Professional Home Care

OECD (2011) Help wanted? Providing and paying for long-

term care NESF (2009) Implementation of the Home Care Package Scheme

Report of the Commission of Investigation (Leas Cross Nursing Home) (2006) Law Reform Commission (2006) Vulnerable Adults and the Law

OECD (2005), Long term care for Older People

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Seamus Healy, Co. Sligo

Observations on Developing a Strategic Consensus on Future Healthcare

1) The long-term consensus needed on a strategy for successful publicly organized Healthcare is more than a consensus by the Members of An Oireachtas.

2) In the past delivery on politically desirable earlier strategies was frustrated by other interests and inflexibly held ideological viewpoints. The pattern will continue unless all involved in organizing Healthcare can be embraced to work together towards an overarching goal. The immediate task is to produce a strategic consensus on such an energizing goal.

3) The Irish State is a maturing republic and there is a broad understanding that a republic should if needed support each of its citizens in matters of their personal health. However, republics differ in their nature and also in how they organize to discharge a role in supporting Healthcare.

4) The Irish Republic through its democratic representative arrangements can express a consensus on the understanding of its citizens of the shared citizen-state role in healthcare matters. Such a high-level consensus aims to provide an overarching framework within which citizens will expect ideological interests and other parties to adapt and work to facilitate future healthcare arrangements by their Rebublic.

5) The members of An Oireachtas may be able to make possible a consensus on the place of publicly organized healthcare in our Republic and so provide a satisfactory and secure foundation for Future Healthcare.

6) The statement of the consensus strategy might be something like … to arrange for Healthcare that reflects the chosen nature of our Republic.

Reference: "How to Practise population Medicine", by J.A. Muir Gray. It covers the Terms of Reference of the Committee on Future healthcare comprehensively and points the a way forward. I suggest obtaining a copy 14.99 pounds sterling for each member of the committee. It will greatly facilitate their work.

www.offoxpress.com/how-to-practise-population-medicine.html

Seamus Healy
Carinya
Ballincar
Sligo.

See http://www.bettervaluehealthcare.net/about-us/

Senator Colette Kelleher

The Irish healthcare system has drifted from crisis to crisis for decades. Both piecemeal and radical reforms have failed to transform it. It now needs a new vision, new purpose and new focus.

This submission provides nine recommendations on how the Irish healthcare system can be recast to become a citizen centred healthcare system. At the core of each of these recommendations is a vision for a high quality, universal, single-tier healthcare system that adequately meets the needs of the Irish people. These recommendations draw primarily from my working life in social care over three decades.

Purpose, Principles & Promises

I urge the Committee to begin their deliberations at first principles – stripping back the layers and examining the values and rights that should underpin our healthcare system.

I recommend that:

1. The future of healthcare strategy be citizen focused and rights based.
2. A set of values form the foundation of the Irish healthcare system – with a clear path outlined on how these values will be promoted and embedded.
3. The right to good quality universal healthcare is established and clearly defined.

Priorities, People Focused & Population Planning

I call on the Committee to ensure that the voice and needs of the citizens are heard and met. To achieve that I recommend:

4. Tackling health inequalities and meeting the needs of the aging population be prioritised for attention and resources.
5. A pilot version of NHS Citizen and Healthwatch be established as a means of ensuring that the voice of the citizen is heard.
6. Area based, inclusive, stakeholder model of Healthcare Planning Forums be established on a statutory basis for on-going population planning.

Payments, Partnership & Politics

As legislators we are empowered by citizens to allocate resources, establish strategies and make decisions for the common good. In this regard I recommend that:

7. Adequate funding be found to bring all services up to standard.
8. Interdisciplinary working is put at the heart of health and social care delivery.
9. Political consensus, on a realistic plan, for the future of Irish healthcare be achieved and maintained.

I propose that the Committee consult with some of the experts who advocate for the proposals outlined, such as Henry Mintzberg of McGill University, Robert Yates of Chatham House, and Michael West, of the King’s Fund. More importantly however, I urge the Committee to consult with as many citizens as possible - as the future of Irish healthcare is of grave importance to us all.

Background

This submission draws on my three decades of experience working to advance the rights and supports of children and young people, people experiencing homelessness, people with disabilities and people with dementia in Ireland as well as in the United Kingdom. It also draws on my formal education and learning, my life experiences and values. Above all I reflect on what I have learned from the people on whose behalf I have worked.

My professional experience spans Chief Executive roles with the Alzheimer Society of Ireland, Cope Foundation, Cork Simon Community and the Daycare Trust. In addition, I served as Special Advisor to Right Honourable Margaret Hodge MP as Minister with responsibility for early years and childcare. I'm a qualified Social Worker. I hold a Master's in Business Administration (MBA) and have recently become a Certified Practitioner in Change and Consulting at the Tavistock Institute.

Whilst I take full responsibility for this submission, I wish to acknowledge and thank those who helped me develop it.

Senator Colette Kelleher

Nine Steps to Achieving Citizen Centred Healthcare

Purpose & Strategy

The core purpose of the Irish healthcare system should be to enable all of our citizens to live long and full healthy lives. The strategy developed to achieve this should be rights based and citizen focused.

The overall purpose of the health system is often lost in heated debates about waiting times, new wonder drugs, consultants' salaries, poor management and under resourcing. Instead of focusing on units like hospitals and healthcare centres, I believe the committee should focus on achieving a citizen centred healthcare system whose purpose is a healthy population as a whole. Instead of thinking in terms of the patient, the client or even the voter, I believe the Committee should be orientated to the citizen and their rights to a healthy life.

Recommendation: That the future of healthcare strategy be citizen focused and rights based.

Principles and Values

The culture, values and guiding principles that underpin the ten year strategy for healthcare should be as important, if not more important, than the strategy itself. Management thinker, Peter Drucker, noted 'culture eats strategy for breakfast'. This maxim contains a useful challenge to the thinking that just getting the ‘strategy right’ will solve all the problems in the healthcare system. I believe the Committee needs to look deep at the culture, values and guiding principles of our healthcare system.

The 1984 Canada Health Act set out the values[1] that the Canadian health system would be built on. These acted as the guiding principles for the decisions taken by politicians, health administrators and clinicians in the years that followed. I believe Ireland should follow a similar approach setting out a list of shared values capable of creating a culture of compassionate healthcare.

The principles developed by the Irish Health Reform Alliance (2016) are a good starting point on which the Committee can build its recommendations for the future of Irish healthcare. These are:

- The health and social care system treats everyone equally.
- The health and social care system is focused on the need of all groups in society.
- People are entitled to health and social care free at the point of access.
- The different elements of the health and social care systems work together and are connected.
- The health and social care system is a universal and publicly funded system.

I would add *kindness* and *respect* to the list of key principles and values. These are of particular importance in light of recent scandals of abuse revealed in Áras Attracta, within the NHS, in Mid Staffordshire, England (Francis, 2013) and in other parts of the health and social care system. The consequence of a disconnection from the values of kindness and respect in health systems for vulnerable people has rightly shocked us all.

These values should be more than words. They should be discernible, actively lived and tangible in the governance, leadership, management, training, education, professional development, everyday actions and decision making of those working in any healthcare system, at every level, starting at the top. The nurturing of a values based culture is something that doesn’t happen by itself but has to be led and encouraged across the healthcare system and organisations. This approach is currently in practice in some parts of our care services. Cork Simon Community, for example, used its values as a starting point to review its work on a quarterly basis, identifying how the organisation lived its values, as well as reflecting on how it fell short, and how it could and would do better.

Embedding and achieving a values based culture in health and social care systems has been well researched and set out by the UK’s King’s Fund, a charity working to improve healthcare in England (West, 2013).

Recommendation: That a set of defined values form the foundation of the Irish healthcare system – with a clear path outlined on how these values will be promoted and embedded.

1. **The Promise – Universal Healthcare for All**

Access to high quality universal healthcare for all should be a right, not just an aspiration. I believe there needs to be a definition of what that ‘universal’ system will consist of and clarity about what healthcare the citizen will have a right to.

The World Health Organisation (2016) define universal health coverage ‘as ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship’. This quality should be measured using several criteria such as effectiveness, patient focus, timeliness and safety.

Recommendation: That the right to good quality universal healthcare is established and clearly defined.

Priorities

Tackling the gross health inequalities in Ireland and preparing for the consequences of an ever aging population should be key priorities for the ten year healthcare strategy.

Health Inequalities

A key feature of the Irish healthcare system as it stands is that it is failing particular groups and populations – this needs to be urgently addressed.

The poor health of our country’s Traveller community (29,500 people) is a national scandal:

- Traveller infants are 3.6 times more likely to die than infants in the general population (HSE, 2016).
- The mortality rate among Travellers is 3.5 times higher than the general population.
- The suicide rate in male Travellers is 6.6 times higher than in the general population (The Ireland Traveller Health Study Research Team, 2010).
- The life expectancy for Traveller males was 61.7 years in 2008 compared to 76.8 years for males in the general population – a difference of more than 15 years.
- The life expectancy for Traveller females was 70.1 years in 2008 compared to 81.8 years for females in the general population – a difference of 11.7 years.

Stark health inequalities also exist for other marginalised groups such as people who are homeless:

- The average life expectancy of homeless people is 47 years for men and 43 years for women – decades short of the average (Walsh, 2013).
- In 2013, 517 people with a ‘temporary place of residence’ were admitted to A&E with the most frequent diagnosis ‘injury, poisoning and certain other consequence of external causes’. While homeless people are high users of emergency services they have low use of planned outpatient facilities (HSE, 2016).
- 60% of lesbian, gay, bi, transgender, intersex (LGBTI) people have seriously thought of ending their own life. 40% of LGBTI people who have self-harmed and 30% who have attempted suicide did not access mental health services, with cost, stigma and lack of understanding of LGBTI issues cited as the main barriers (GLEN, BeLonGTo & TENI, 2016).

An aging population

One of the products of improving health is that the aging population is growing.

- By 2021, there will be 107,600 additional people aged 65 and over (HSE, 2016). Increasing from 11% of the population to 15.4% (ESRI, 2008).
- By 2026, the number of people experiencing dementia will grow to almost 80,000 from the current 55,000 (Pierce et al, 2014).
- By 2031, the population aged 65 or older in Ireland is projected to be 991,000 - up from 532,000 in 2011 (CSO, 2013).

This throws up a number of challenges for the healthcare system. Firstly, older people are major consumers of health services – being almost 20% more likely to be health service users in a given year than those under 65 (HSE, 2013). They are also particularly vulnerable to abusive and inadequate care.

Second, as a result of population aging there are new unmet complex needs – for example, as people with Down Syndrome now live longer they are more susceptible to early onset dementia. Currently there is little understanding or appropriate supports for people with both Down Syndrome and dementia.

Finally, there is a clear wish of older people to remain independent (Houses of the Oireachtas, 2012), and to remain in their own homes for as long as possible (UCD, Age Action, The Alzheimer Society of Ireland & IASW, 2016). These preferences should be supported and catered for. The health and social care system needs the capacity and ability to make new services and supports available that will meet the changing and complex needs of the aging population.

There is a need for immediate and sustained long term healthcare planning and investment to tackle the health inequalities faced by marginalised groups and to adequately care for Ireland's aging population.

Recommendation: That tackling health inequalities and meeting the needs of the aging population be prioritised for attention and resources.

People Focused

The citizen in Ireland is poorly represented and protected in the healthcare system. With the exception of the regulator HIQA, who have successfully exposed poor standards and some other useful initiatives around safeguarding vulnerable adults, little is being done to ensure that citizens are involved, heard and protected.

As part of redressing the disconnect in healthcare in the UK, a project called NHS Citizen has been developed by the Tavistock Institute to connect the healthcare decision makers with the citizens they serve, actively engaging them in the planning and delivery of health and social care (NHS Citizen, 2016). In addition, a national consumer champion Healthwatch has been established. This body has statutory powers to ensure the citizen is heard by those who deliver and regulate healthcare services.

The citizen should be put in a position of influence on all deliberation on the future of healthcare – including the work of this committee. Their voice should be actively promoted and their needs and preferences listened to and met.

Recommendation: that a pilot version of NHS Citizen and Healthwatch be established as a means of ensuring that the voice of the citizen is heard.

Population Planning

Population planning mechanisms need to be put in place to allow for ongoing planning of future healthcare needs.

This could take the form of 'Healthcare Planning Forums' established on a statutory basis, and coinciding with the nine Community Health Care Areas. Such forums would include all the different stakeholders, for example, citizens, providers, commissioners, professionals and politicians. They could include outreach to marginalised groups not currently benefitting from healthcare for example Travellers, people living in remote communities and people with a disability.

The needs and priorities that emerge from these Healthcare Planning Forums could form the basis of what is then commissioned on behalf of the citizen. These healthcare population planning mechanisms would need to be well resourced to operate effectively.

A version of this kind of area planning mechanism is being commenced this autumn to assess dementia needs, the dementia gap in services and supports and to make a local multi annual dementia plan. Such a mechanism was also used to good effect in planning and developing homeless services in 2000's[2] and for the expansion of early years and childcare services in the UK[3]. Another initiative of this kind was the recent roadshow by the National Association of GP's as part of its call for a Tallaght Strategy-style consensus to deliver health reform, with meetings in Dublin, Cork and Limerick (Irish Medical Times, 2016).

Recommendation: that an area based, inclusive, stakeholder model of Healthcare Planning Forums be established on a statutory basis for on-going population planning.

Paying the Full Cost

The historic chronic underfunding of some areas of social care, as part of the overall healthcare system, must be redressed and factored into the Committee's calculations.

A key example of that underfunding is the poor standards in our community hospitals and disability centres and the funding gap required to meet the HIQA's national standards.

There has also been a fall in the level of funding for homecare over the last number of years in spite of its need, demand and unequivocal citizen preference, as well as its cost effectiveness (UCD, Age Action, The Alzheimer Society of Ireland & IASW, 2016).

Other key areas of social care have been left by the state to charities. As a result, citizens have to rely on services and supports which require fundraised income to supplement the inadequate state funding. There are well publicised examples of core services for vulnerable people being delivered by charitable organisations under question. This mode of delivery of social care has been a contributory factor in the proliferation of poorly funded and poorly governed charities. Social care services for vulnerable people should not be left to unaccountable 'do gooders' and must be transparently commissioned, adequately funded and properly governed.

Recommendation: that adequate funding be found to bring all services up to standard.

The Professions and Vested Interest

There are many vested interests in healthcare including the providers – public, private and voluntary; the pharmaceutical industry; insurance companies, the professionals, professional bodies and unions (Goldarce, 2013).

As with most health care systems, the Irish one is dominated by the professions or producers, with the medical profession first among equals setting the paradigm of 'the silo' mentality. The result is a dysfunctional healthcare system where the health needs of the citizen are not necessarily to the fore. This effect occurs across different jurisdictions even if the health system takes very different forms. This is cogently described by renowned academics Henry Mintzberg and Sholom Glouberman (1997) in two short papers. Their solution is to achieve 'one system', with collaborative management of the entire system. Among other things, they cite collaborative networks and guiding principles or values as necessary to create the right culture for the successful delivery of healthcare for all citizens.

Ways of promoting shared values in the Irish healthcare system should be explored across the various healthcare professions. Interdisciplinary work, training and organisational learning across the different healthcare professions in the workplace and universities should become the norm - with the focus on the healthcare team, planning and providing care around the citizen. Cope Foundation reorganised its interdisciplinary staff (nurses, physiotherapists, occupational therapists, speech & language therapists, social workers, care staff etc.) based on a model developed in the UK to achieve the right mix of accountability in decision making (Dive, 2008).

The early intervention team in Cope Foundation developed a co-ordinated approach to multi-disciplinary interventions called 'the team around the family'. This approach involved co-ordinating a range of disciplines and made a positive difference in developing child centred care that was relevant and collaborative. It also helped the parents of children diagnosed with intellectual disabilities handle the plethora of sometimes conflicting advice at a vulnerable and difficult time.

A real move to interdisciplinary working may be resisted as it will pose a challenge to current received wisdom and the role of professional bodies and unions.

Recommendation: That interdisciplinary working is put at the heart of health and social care delivery.

Politics

Finally, as politicians we must lead an honest conversation about what form of universal healthcare can realistically be achieved and in what time frame. Yates (2015) notes that ‘for too long politicians have been less than upfront with citizens, making perhaps unrealistic promises that are popular electorally though unrealistic without radical change’. This outcome can and must be avoided here – healthcare is too important to the lives of all citizens to remain on as a political football.

Recommendation: That political consensus, on a realistic plan, for the future of Irish healthcare be achieved and maintained.

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Notes

1. The values set out in the Canada Health Act were: Public Administration; Comprehensiveness; Universality; Portability; & Accessibility.
2. Cork Homeless Forum ran for over a decade and by 2011 had all but eliminated rough sleeping in Cork City, a situation now sadly reversed for all those without shelter in the City today.
3. Early Year Development & Childcare Partnerships were developed in every local authority to expand services and supports for children from birth to 14 years in England and Wales 1998 – 2002.

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Shire Pharmaceuticals

> *"It is estimated that there are over 6,000 identified rare diseases. We know that many of these conditions are complex, severe and debilitating. There are many challenges for patients living with a rare disease in Ireland. Our public consultation highlighted the challenges involved in arriving at a timely and correct diagnosis as well as accessing appropriate medications and technology."*
>
> *Minister for Health James Reilly TD,*
>
> ***National Rare Disease Plan for Ireland 2014 – 2018***

A 'rare disease' is defined in Europe as a life-threatening or chronically debilitating disease affecting no more than 5 people per 10,000. There are an estimated 6,000-8,000 known rare diseases affecting up to 6% of the total EU population, and up to 300,000 Irish people during their lives. This means that 6-8% of the Irish population or 1 person in 12 may have a rare disease at some stage in their lifetime.

With an ageing population and the increased demands on healthcare resources, requirement-based budgeting for rare diseases must become the hallmark of efficient services. This principle would see the distinct allocation of funds to ensure that where there is patient need, appropriate resources have been accordingly set aside to allow for effective and timely treatment.

In this submission, we have focused on three key areas that we believe will have a major impact on the future of rare diseases and patient care in Ireland –

- Putting forward the case for a '**Centralised National Budget'**, ensuring that an adequate budget is secured and made available specifically for the funding of drugs required to treat rare diseases. A centralised budget, where allocation is based on a clearly defined medical criteria and within agreed timelines, would aid patient needs and reduce delays in funding being allocated for these much needed medications. This would ensure that a fair, transparent and consistent approach is followed in the event of every diagnosis in Ireland, further allowing the HSE to better forecast need and manage budgets more effectively. This links directly to point two:
- Highlighting the current **lack of transparency** surrounding funding decisions for orphan medications* and the unsatisfactory process currently in place for the reimbursement of such drugs for patients (primarily children) diagnosed with rare diseases. In the National Rare Disease Plan 2014 – 2018, one of the key findings from their research was that *"there was considerable concerns raised in terms of transparency and fairness of decisions made on the assessment of orphan drugs."* A centralised budget with a national funding framework would bring clarity to funding decisions and speed up the rate at which newly diagnosed patients get access to the necessary medications.
- The final key point Shire would like to see occur as a result of this consultation process is the implementation of the recommendations made by the Steering Group on the **National Rare Disease Plan 2014 – 2018 (NRDP)**. Shire welcomes the establishment of the National Rare Diseases Office as the beginning of this implementation process but calls for further steps in resourcing that Office and in supporting its work and objectives. Shire wants to ensure that the future of healthcare in Ireland takes into consideration the specific challenges of those affected

by rare diseases, and their families, and looks forward to working with the Committee on this important work.

****An orphan drug is a pharmaceutical agent that has been developed specifically to treat a rare medical condition. They are "orphans" because under normal market conditions they would not necessarily be developed or marketed given the small number of patients suffering from such very rare conditions.***

STRATEGY

What are the key priorities for inclusion in a ten-year plan for the health service?

In order for a health service to be truly effective, it requires that the needs of all its citizens are catered for, and that budgeting and forecasting is prepared in anticipation of need and with a full understanding of the most efficient and effective ways of achieving success.

In order to do this successfully, it is paramount that the mechanics, processes and tools are in place to do this effectively, and will best prepare the system, and those working within it. Understanding demographics, need and prevalence is crucial. As is a recognition of the need for a balanced emphasis on community care provision, where possible, must be paramount – particularly when considering patients with chronic, long-term and rare conditions.

It is generally agreed that Health Technology Assessment (HTA) assist payers in making informed decisions before allocating resources in the health system, including medicines. However, an increasing number of stakeholders acknowledge that a conventional HTA process runs the risk of denying patients with rare diseases appropriate access to treatment. This has been evidenced in an article titled '*Orphan drug considerations in health technology assessment in eight European countries',* **An International Journal of Public Health***, where the authors outlined that *"a number of European HTA agencies have started to implement specific policies to address the challenges related to evidence requirements for the case of orphan drugs."*

We at Shire believe there is an opportunity in this health system for relieving the current budgetary burdens through a refined approach, and equally relieving the burden on acute hospitals treatments, especially with regard to rare disease patients, with a well-managed community and homecare setting approach. Quite often, medication for rare diseases lend themselves to homecare treatment as they greatly reduce the need for hospital services and as a result have immense cost savings. They are better suited to be treated locally within the community, removing pressure on hospitals and reducing unnecessary costs.

What actions are needed to plan for, and take account of, future demographic pressures (population growth, ageing population), and their impact on the health system?

In order to future plan for rare diseases in Ireland, the first step that needs to be taken is the establishment of a Centralised National Budget. This is key if our aim is to correctly pinpoint where demands the system sit, and how they can be met in the most efficient manner possible.

A system of information sharing between the National Rare Disease Office, hospitals, rare disease advocacy groups and companies like Shire who are already providing services and research in the area of rare diseases is essential. This will allow for greater transparency and ensure the needs of patients are met. The prevention and early intervention in rare diseases is key to keeping treatment costs to a minimum and optimising outcomes for patients.

One important finding in the NRDP is the ability to share clinical case studies regarding pro-allocation or reimbursement of costs and examples of best practice, both within Ireland and abroad, in order to improve and upgrade our services and offerings. Better basic health intelligence on the number of people with rare diseases was seen as critical to awareness and advocating for appropriate service and policy developments.

Additionally, a clear policy, data protection and ethical frameworks were seen as critical for rare disease research; the development of basic epidemiology of rare diseases in Ireland through rare disease registries was seen as a priority; and rare disease registries were considered a critical tool to support many types of rare disease research.

Understanding geographical demands in specific regions will allow us to work with patients in a much more effective manner. Having a centralised budget will allow those managing the budget to better identify where the pressure areas are coming from and to manage them more efficiently. Ensuring that community treatment and home-care arrangements can be financed should be a priority for the HSE, with additional resourcing and support.

***Rare Diseases and Orphan Drugs - An International Journal of Public Health, July 2014, Volume 1, Number 3, by David Tordrup, LSE Health, London School of Economics and Political Science, London UK, Victoria Tzouma, LSE Health, London School of Economics and Political Science, London UK, and Panos Kanavos, Department of Social Policy, London School of Economics and Political Science, London, UK**

INTEGRATED PRIMARY AND COMMUNITY CARE

What steps are needed to move from the current model towards a model based on integrated primary, secondary and community health care?

The publishing of The National Rare Disease Plan 2014 – 2018 was a positive step towards achieving a more effective model for community care. We welcomed the establishment of the National Rare Disease Office. However, in order for the Office to become effective, it will require additional resources and financial support from the HSE. Once this is in place, the office will begin to play a key role in integrating care across the area of rare diseases.

In keeping with the model of integrated care outlined in Future Health – A Strategic Framework for Reform of the Health Service, 2012-2015 (Department of Health, 2012), services for patients with rare diseases ‘*must be planned and delivered with patients’ needs and wishes as the organising principle*’. In the case of rare diseases, better outcomes for patients and more efficient use of resources will necessitate integrated and coordinated service planning and delivery across a range of health and social services, such as hospitals, primary care, specialised community services, social care and beyond into the education and labour sectors.

Currently, home-care services are provided by Shire to certain patients across Ireland. This eases the patient from difficult trips to hospital and releases the burden on already pressurised acute hospitals and their staff, particularly in more rural areas where distance and cost of travel are bigger factors for consideration. Support and information sharing with the NRDO will lead to a more integrated system which will benefit the patient. The benefits for homecare were outlined in an NHS Report in 2011*, where it outlined how *"homecare medicines delivery and services can release hospital beds and return patients to their homes earlier. Patients do not need to make visits to hospital to receive periodic medicine treatment or prescriptions, and is consistent with the theme of 'increased patient choice'.* It also identified a number of additional benefits for the patient, including less travel, hospital parking, time off work, reduction in clinic times, greater control over treatment, and discretion and privacy.

What are the key barriers to achieving this, and how might they be addressed?

Nationally, hospital funding decisions are made on an annual basis as part of the HSE Service Plan process. Individual hospitals/regions are responsible for submitting business cases for funding as part of the national service planning process. The majority of orphan drugs are funded on an individual basis through the HSE, on a patient-by-patient case, and without a centralised budget or a transparency around timelines, this quite often leads to substantial delays in treatment for patients. For an individual hospital, the financial impact of reimbursing a very high cost orphan treatment can be substantial and without forward planning may lead to funding challenges with budgets being spent elsewhere if not ring-fenced in advance.

In addition, the NRDP found that a "*lack of funded programme for trainees in this area and HSE limitations on recruitment eliminate trainee opportunities to facilitate shared care at community level and make cost-efficiencies*."

At present, there is a challenge in providing relevant and up-to-date patient information due to a number of reasons. At present there are no National registries for rare disease patients and as a result much information cannot be accurately costed. In the UK for example, there is considerable public information available so that best practice can be outlined and replicated. In Ireland, with no general electronic database of patients, and a lack of financial information available, this information is much more difficult to obtain. There is a challenge when offering or launching new treatments when the supporting infrastructure is not up to date.

In order to provide a best in class service at a primary and community level, a broader range of services have to be available. If a budget is not allocated for rare disease patients, it is unlikely that money will become available later in the year and this will prevent any substantial change from happening.

In your experience, what are the key roadblocks you encounter in your particular area of the health service?

By the very nature of rare diseases, they occur in isolation and many medical professionals only sporadically come across them. They are also often difficult to diagnose. Once they have been diagnosed, it is extremely important that treatment commence as soon as possible in order to be effective.

Clinicians must be able to access reimbursed medications for their newly diagnosed patients, and patient care must be optimised to suit the specific needs of rare disease patients.

Further, as there has been insufficient community care to date, there are significant difficulties in accessing services due to long waiting lists, gaps in those services, delays in specialists securing funding on behalf of their patients, and quite often the amount of funding available does not cover all patients.

Are there any examples of best practice that the Committee should consider? Please refer to any evidence you have to support this.

Ireland: The Oncology Drug Management System (ODMS) for specific high-cost drugs administered in hospitals.

The National Cancer Care Programme (NCCP) introduced the Oncology Drug Management System in July of 2012 to oversee and manage the funding of specified hospital-administered systemic anti-cancer drug treatments to public hospitals. The Primary Care Reimbursement Service (PCRS) facilitates the operation of this system. The system also addresses the growth in costs associated with new drugs and new indications of hospital administered systemic anti-cancer drug treatment and allows for the introduction of a “money follows the patient” funding model.

Germany: Since the introduction of the AMNOG law (i.e. Value assessment process that leads to setting the public price for new medicines) in 2011 in Germany, early benefit assessment is conducted for all new medicines. This enhanced approach to orphan drugs ensures that they can be administered as timely as possible, recognising the urgency in treating patients with rare diseases. According to German legislation, orphan drugs are automatically granted added value based on their 'significant benefit assessment' by the European Medicines Agency (EMA). This allows those medicines to get preferential treatment in price negotiations. This would be considered by many in the industry as best practice. Additionally, because the German system grants all EMA approved drugs automatic reimbursement, it is considered as one of the most effective systems in Europe.

France: In France, orphan drugs are treated as any other innovative medicines, however patient access is managed in a particularly efficient manner, ensuring patients get access to required medications very quickly after diagnosis. Following the publishing of the French National Plan for Rare Diseases 2005 – 2008, one of the key objectives outlined was “*to ensure the availability and reimbursement of orphan drugs and prevent the halt in commercialisation of certain health products.”* Additionally, the French Temporary Authorisations for Use (ATU) system ensures early access to new medicines before they are actually approved by European Commission. This program is best in class, and it is funded by the government. The ATU procedure is an exceptional measure, making available medicinal products that have not yet been granted a Marketing Authorisation. The aim of ATUs is to provide early access to new promising treatments where a genuine public health need exists, i.e. in the treatment of patients suffering from serious disease and having reached a situation of therapeutic impasse. This regulatory provision, stipulated in the French Public Health Code, has actually been applied in France since 1994.

***Homecare Medecines – Towards a Vision for the Future' sponsored by the Department of Health (UK),for Mark Hackett, CEO Southampton University Hospitals NHS Foundation Trust, to lead a rapid review of Homecare Medecine Supply to cosider the current operational arrangements and its future for the best value for patients, the NHS and the provider market.**

> *"Respondents to the GRDO Patients' Experience Survey (2012) report many difficulties in obtaining appropriate treatments and medicines: 41% of respondents do not consider that they have access to the best medical care for their condition, while 64% state that 'Access in Ireland to medicines/treatments available in other countries' would make a great difference to them."*
>
> *NRDP, Section 5*

Shire Pharmaceuticals calls on the Oireachtas Committee on the Future of Healthcare to recommend the following crucial initiatives for the improvement of Health Delivery services, efficiencies, patient experiences and outcomes for the sufferers of rare diseases in Ireland:

- Establish a '**Centralised National Budget'** to fund the medicines and supports required by the small number of rare disease patients in Ireland.
- Ensure that this budget is managed by a centralised Office for Rare Diseases, which is resources and equipped to meet demand and deliver a transparent, consistent and effective system for HSE staff, hospital employees, patients and their families
- Implement the recommendations made by the Steering Group on the **National Rare Disease Plan 2014 – 2018 (NRDP)**.

Shire wants to ensure that the future of healthcare in Ireland takes into consideration the specific challenges of those affected by rare diseases, and their families, and looks forward to working with the Committee on this important work.

https://www.shire.com/

Simon Communities of Ireland

This submission looks at healthcare specifically as it relates to people who are homeless or at risk of homelessness. The submission opens with a series of recommendations across Health; Mental Health; Alcohol and Drug Use; Support for the Implementation of Housing First; Dual Diagnosis and Complex Needs; Older People; and Women. This is followed by a brief overview of homelessness, the reasons people become homeless and the current housing and homelessness crisis. Building on this, the submission then outlines the health issues experienced by people who are homeless with regard to their physical health, mental health, problematic drug and alcohol use; and dual diagnosis and complex needs. This progresses to a discussion of the importance of housing first as a proven concept for the delivery of targeted clinical supports for people who are homeless. The barriers to accessing healthcare are then examined with specific reference to those experienced by people who are homeless. The submission concludes with a brief examination of the beneficial cost implications associated with the delivery of targeted health care and housing services for people who are homeless as experienced in Ireland, the UK and Australia.

The content of this submission is built on a number of data sources that measure the incidences of health issues experienced by people who are homeless in Ireland. A number of additional resources are relied on to give context and greater detail in relation to concepts mentioned, current health strategies across the spectrum of healthcare in Ireland, and international practice with regard to the delivery of targeted healthcare and housing services for people who are homeless. The content is further influenced by the front line experiences of the Simon Communities around the country.

The data relied on in this submission shows that people who are homeless experience a complex range of health issues and complications both as a cause and consequence of homelessness. This is exacerbated by a number of barriers in accessing healthcare specific to people who are homeless. Resources referenced in this submission point to a number of cost saving implications attached to the wider provision of primary healthcare services for people who are homeless in addition to achievable healthcare cost savings linked to the delivery of Housing First for people who are homeless.

Recommendations discussed include but are not limited to the following:

- Increase access to general practitioner (primary healthcare) services to meet the healthcare needs of people who are homeless and to provide early intervention to prevent further chronic illness.
- Increase funding for mental health services to 8.24% of the national health budget as recommended in ‘A Vision for Change’. This should include the dedicated ring fencing of funding streams for the full implementation of the commitments contained in ‘A Vision for Change’.
- Alcohol and drug services must be resourced to target the needs of people who are homeless with alcohol and/or drug related problems in line with the four tier model. This should include rapid access to substitution treatment, detoxification, rehabilitation/recovery and aftercare countrywide to include all substances.
- Extend Housing First nationwide and put in place and maintain funding for Assertive Community Treatment (ACT) Teams.
- Improve health outcomes for people with dual diagnosis by ensuring greater collaboration between drug and alcohol services and general mental health services.

- Appoint a Palliative Care Coordinator to enhance access to end of life care for people who are homeless as recommended in the Simon Communities of Ireland exploratory research '*Homelessness, Ageing and Dying'.*
- Establish targeted services for women and trauma informed responses to deal with the complexity of need.

The submission does not review in detail existing Government health strategies but does where possible reference the interconnectedness of these strategies with health issues specific to people who are homeless.

Introduction

Housing is a key social determinant of health which impacts on the ability to live a healthy life (FEANTSA). The World Health Organisation defines health as "a state of complete physical, mental, and social well-being and not merely the absence of infirmity."[218] Poor quality housing can impact greatly on health and wellbeing with the absence of a home being detrimental. In addition, chronic conditions occur more frequently among people in lower socioeconomic groups and those who are more vulnerable in society. (Institute of Public Health, 2010).[219] It is widely evident that there is a strong link between homelessness, poor housing and health. The relationship is complex in that health problems can cause a person to become homeless while being homeless can exacerbate particular health conditions. Access to mainstream health services can be difficult for people experiencing homelessness[220]. Research has found that people who are homeless often have higher healthcare needs, are more at risk of illness and have earlier mortality rates than the general population.[221] Although the health conditions experienced by people who are homeless are very often the same as those experienced by the general population, they occur more frequently, are often more severe and develop at a younger age. In addition, blood borne diseases such as HIV, Hepatitis and TB are more common among people who are homeless than the general population[222]. People who are homeless are less inclined to access general healthcare services and it is often when a crisis occurs that they present to Accident & Emergency departments (A&E). This is one of the best examples of 'Inverse Care Law' where those who most need a health service are the least likely to receive it.[223]

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[218] http://www.who.int/about/definition/en/print.html

[219] Balanda KP, Barron S, Fahy L (2010) *'Making Chronic Conditions Count: Making A systematic approach to estimating and forecasting population prevalence on the island of Ireland"* Institute of Public Health in Ireland http://www.publichealth.ie/sites/default/files/documents/files/Making%20Chronic%20Conditions%20Count%20Exec%20Summary.pdf

[220] Simon Health Snapshot Report (2011) http://www.simon.ie/Portals/1/Publications/Simon's%20National%20Health%20Snapshot%20Study%202011.pdf

[221] Simon Communities in Ireland '*Homelessness, Ageing and Dying'* (2014) http://www.simon.ie/HomelessnessAgeingandDying/index.html#/14/

[222] O'Reilly, F., Barror, S., Hannigan, A., Scriver, S., Ruane, L., MacFarlane, A. and O'Carroll, A. (2015) Homelessness: An Unhealthy State. Health status, risk behaviours and service utilisation among homeless people in two Irish cities. Dublin: The Partnership for Health Equity. http://www.healthequity.ie/#!report-launch/iuv63

[223] Cited in Feantsa Health Working Group Paper (2013) *'Health and Well-being for All – Holistic Health Services for People who are Homeless'*

Recommendations

Health

- Increase access to general practitioner (primary healthcare) services to meet the healthcare needs of people who are homeless and to provide early intervention to prevent further chronic illness.
- Ongoing resourcing for primary care services and interventions in homeless services where required nationwide. . There are some excellent examples of such initiatives in operation in the Simon Communities.
- Undertake a review of the efficacy of catchment areas in relation to access to drug detoxification, treatment and aftercare and mental health service to ensure those that need the services most have ease of access especially vulnerable target groups such as people who are homeless.
- Establish multidisciplinary and patient-centred approaches to health treatment across the board.
- Agree a mechanism to capture the views of service users which are central to the design and delivery of services across the health system.
- Resource the delivery of step up/step down beds for people who are homeless being treated for chronic illness.
- Ensure sufficient resourcing of case management teams in all regions.
- Develop, resource and implement discharge protocols for general hospitals, mental health services and drug treatment services for people who are homeless in conjunction with primary care networks and local primary care teams. Nobody should be discharged back into homelessness.
- Resource the delivery of specialist intermediate care health facilities to provide step down facility from hospital following medical and surgical treatment and to reduce hospital stays.
- Implement the prioritised recommendations of the National Hepatitis C Strategy 2011–2014.[224]
- Reverse cuts to the HSE homelessness budget and health services in general.
- Have representation from homeless healthcare providers on Primary Care Network teams to progress and highlight the unique healthcare needs of homeless people.

Mental Health

- Fill essential posts in mental health services to ensure nationwide coverage of Community Mental Health Teams.
- Clear identification of CMHT team with responsibility and accountability for people who are homeless in each catchment area. CMHT to be equipped to offer assertive outreach.
- Develop 'Specialist Adult Teams' to manage the combination of complex and problematic drug and alcohol use and mental health issues as recommended in 'A Vision for Change' 225and the 'National Clinical Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self Harm' and ensure interagency responses. 226
- Increase funding for mental health services to 8.24% of the national health budget as recommended in *'A Vision for Change'.* This should include the dedicated ring fencing of funding streams for the full implementation of the commitments contained in '*A Vision for Change'.*

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[224] https://www.hse.ie/eng/services/Publications/HealthProtection/HepCstrategy.pdf

[225] Specialist adult teams should be developed, comprising one consultant psychiatrist, one doctor in training, four substance misuse and dependency key workers/ counsellors, two clinical nurse specialists, one clinical psychologist, two social workers and one occupational therapist, in each catchment area of 300,000 to manage complex, severe substance abuse and mental disorder. Each member should have specialist expertise in the field of addiction in addition to mental health expertise.

[226] https://www.hse.ie/eng/about/Who/clinical/natclinprog/mentalhealthprogramme/selfharm/nationalclinicalprogselfharm.pdf

- Put in place an out of hour's self-harm nursing service in all hospital accident and emergency departments.
- Provide for a dedicated counselling service to provide out of hours outreach support to clients in homeless accommodation services who are expressing suicidal ideation.
- Consideration should be given to resourcing homeless services to introduce suicidal ideation and self-harm services on site because going to a hospital is not always the answer.
- It is essential to ring-fence a dedicated funding stream for the full implementation of *A Vision for Change.*
- The proposal in the *Implementation Plan on the State's Response to Homelessness* to provide a dedicated Community Mental Health Nurse in each ISA[227] area to support the needs of people who are or at risk of homelessness needs to be actioned. This is supported n the *Report of the Committee on Housing and Homelessness* (2016).
- Monitor, record and respond to breaches of discharge protocols for people who are homeless being discharged back into homelessness.
- Develop onsite counselling/psychological services in homeless accommodation services to provide trauma informed care.

Alcohol and Drug Use

- Alcohol and drug services must be resourced to target the needs of people who are homeless with alcohol and/or drug related problems in line with the four tier model[228]. This should include rapid access to substitution treatment, detoxification, rehabilitation/recovery and aftercare countrywide and include all substances.

- It is essential to provide funding for step down options and support for people once they have completed treatment so they have accommodation to go to and have a support plan in place. We welcome the commitment contained in the *Action Plan for Housing and Homelessness* that through the new National Drugs Strategy, drug rehabilitation pathways will be linked to sustainable supported tenancy arrangements. It is essential that such approaches are underpinned by a Housing First approach to addressing homelessness.
- In-reach support for people while in treatment to prevent homelessness on discharge.
- We welcome the commitments contained in the *Action Plan for Housing and Homelessness* for enhanced supports for people who are homeless with mental health and drug and/or alcohol issues in addition to commitments for increased funding for people with chronic and enduring health needs.
- The Drugs Initiative budget has seen cuts of 37% in the past six years[229]. At the very minimum these cuts need to be reversed to ensure adequate support services are available. These cuts have had an impact on people who are homeless and are impacting on waiting times and waiting lists.
- Rapid Access to treatment. People who are homeless often have to wait in homeless services until a treatment place becomes available.

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[227] ISA – Integrated Service Areas are Community based health services outside acute hospitals for people with low-medium level of need in primary care, social care, mental health and health & wellbeing.

[228] http://www.drugs.ie/resourcesfiles/reports/3966-42381118.pdf

[229] http://www.citywide.ie/news/2015/03/04/citywide-calls-for-confirmation-of-appointment-of-minister-for-drugs/ ibid.

- Harm reduction must be at the heart of homeless and drug service provision and is key to the success of Housing First approaches including the rollout of Naloxone and widespread availability and training on same and introduction of Medically Supervised Injecting Centres (MSIC).
- Implement the recommendations contained in HSE Introduction of the Opioid Treatment Protocol report.[230]
- Increase incentives and access for GP's to encourage them to become level 2 GP's under the Methadone Protocol[231] for methadone prescribing and methadone management. In addition there is a need to increase the number of methadone clinics in rural areas so people don't have to travel to city areas daily to collect daily doses of methadone.

Support for the implementation of Housing First (housing plus support)

- Extend Housing First nationwide and put in place and maintain funding for Assertive Community Treatment (ACT232) Teams.
- The roll out of Housing First nationwide should be inclusive of Regional Homeless Fora to ensure the complex health needs of homeless people are met. This should include the development of formal protocols to fund, second or broker in specialist health professionals onto Housing First teams.
- Prioritisation and targeting of people who are homeless and those with complex support needs particularly rough sleepers and people who are chronically homeless with complex and compound health needs.

Dual Diagnosis and Complex needs

- Improve health outcomes for people with dual diagnosis by ensuring greater collaboration between drug and alcohol services and general mental health services.[233]
- Establish a post of National Policy Coordinator to deliver national objectives and standards pertaining to primary care and community interventions for drug and alcohol use and their linkage to mental health services.
- Ensure coordinated responses for people with co-morbid mental health, people with dual diagnosis (mental health and drug and/or alcohol issues) and people experiencing homelessness. We welcome the commitment contained in the *Action Plan for Housing and Homelessness* for a more coherent government wide response. We continue to support the call in the *Report of the Committee on Housing and Homelessness* (2016) for increased resourcing for and improved coordination between HSE mental health services and homeless service providers.
- Identify the clients 'falling through the gaps' such as those with mild- moderate intellectual disabilities or late or undiagnosed autism in the 80's which resulted in them ending up in homelessness and resource responses to address their needs.

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[230] http://www.drugs.ie/resourcesfiles/reports/Opioid_Treatment_Protocol.pdf

[231] http://www.drugsandalcohol.ie/6721/2/Butler_1983_The_Making_of_the_Methadone_Protocol.pdf

[232] https://www.centerforebp.case.edu/practices/act

[233] The National Advisory Committee on Drugs (NACD) (2005) commissioned a report on dual diagnosis. They suggested that closer collaboration between addiction programmes and general mental health services was needed in order to improve outcomes for individuals with dual diagnosis. Overall, service users with dual diagnosis and complex needs respond well to case management, and use of multi-profession teams. http://www.drugs.ie/resourcesfiles/research/2004/Dual_Diagnosis.pdf.

Older people

- With an aging population of people who are or have experienced homelessness there is a need to plan for and address their deteriorating health and make provisions for end-of-life care for people who are homeless.
- Appoint a Palliative Care Coordinator to enhance access to end of life care for people who are homeless as recommended in the Simon Communities of Ireland exploratory research '*Homelessness, Ageing and Dying'.*[234]
- Ensure that palliative care beds are accessible to people who are homeless.[235]

Women

- Research suggests that women who are homeless are more likely to have higher health and mental health needs than men and to have particular past experiences that require a gender sensitive approach to policies and services.[236]
- Need to establish targeted services for women and trauma informed responses to deal with the complexity of need.

Homelessness

People become homeless for a whole range of complex and overlapping reasons. Primary causes relate to poverty, inequality and lack of affordable housing, often coupled with systems failures and individual circumstance. The Simon Communities come across many reasons why people become homeless and we deal with them all. Many of the people we work with have been disadvantaged and isolated from a young age; they have been failed by the state time and time again. Homelessness is extremely traumatic and damaging having a serious impact on people's mental and physical health, as well as their overall wellbeing.

When people think of homelessness, they often think of rough sleeping. However rough sleeping is the most extreme form of homelessness; it also includes people who are living in shelters and emergency accommodation, and other people who have no place of their own and therefore end up staying with family and friends, people who are living in inadequate housing or those at risk of homelessness who are living under threat of insecure tenancies or eviction. Homelessness and housing insecurity are more acute and visible in our cities but the Simon Communities are working at capacity countrywide – in urban and rural areas.

Homelessness can happen as the result of a crisis or an accumulation of crises in a person's life. It can build up over time, sometimes years. With access to affordable housing and the right supports people can move out of homelessness quickly. Limited access to housing and support services is increasing the risk of homelessness and is preventing people moving out of homelessness. It is vital to ensure people can remain in their communities where they have family and support networks when

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[234] http://www.simon.ie/HomelessnessAgeingandDying/pubData/source/Homelessness_Ageing_and_Dying.pdf.

[235] Ibid.

[236] Mayock et al. (2015), Women and Homelessness in Ireland: Service use patterns and service needs; St. Mungos (2014), Rebuilding Shattered Lives: Getting the right help at the right time to women who are homeless or at risk.

they run into housing and financial difficulties, often times when these supports are most important. Therefore responses must be nationally driven but locally resourced and delivered.

The housing and homeless crisis can only be addressed effectively with integrated plans across all forms of housing and the provision of support in housing. We must learn from past mistakes and change expectations - we need to expect that people will move on from homelessness quickly to a decent, affordable home of their own. Some may need support – visiting or on-site. This needs to be the expectation of people who are homeless, the expectation of staff and volunteers in homeless services and the expectation of our Government. We need to agree that every man, woman and child in this State is entitled to an affordable, safe and secure home.

Homelessness and health

There is a complex relationship between homelessness and health incorporating physical health issues, mental health issues, problematic drug and alcohol use and complex needs. Heath issues can be the cause of homelessness occurring in the first place but they can also be a consequence of the experience of being homeless. What is clear is the longer a person is homeless the greater the impact on their overall health and wellbeing. These are all explored individually below.

Physical Health

The physical health of a person who is homeless can be exacerbated due to not having a stable home. Health conditions can also develop as a result of homelessness, and people who are homeless are more at risk of developing an illness than the general population.

Homelessness

An Unhealthy State report 67.8% of participants in the study had a chronic physical health diagnosis, such as diabetes, high blood pressure, arthritis, heart disease, epilepsy, tuberculosis, and chronic respiratory & stomach problems[237]. Blood borne viruses such as, hepatitis, HIV etc. are also high among people who are homeless and they are more at risk of contracting one of these diseases. 10% of respondents in the 2011 Simon Communities Snapshot Report had a Hepatitis C diagnosis.

The 2011 Simon Communities Snapshot Report also found that 65% of the 603 participants had at least one diagnosed physical health condition. Dental related issues were among the most frequently occurring health issue among respondents, while chronic diseases such as asthma and other respiratory problems, diabetes, migraines, and arthritis were also very dominant among respondents. Further support for these findings can be found in a recent study by the Royal College of Surgeons in Ireland and Doctor Austin O'Carroll of Safetynet Dublin which examined '*Health and use of health services of people who are homeless and at risk of homelessness who receive primary healthcare in Dublin*'. [238]

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[237] O'Reilly, F., Barror, S., Hannigan, A., Scriver, S., Ruane, L., MacFarlane, A. and O'Carroll, A. (2015) Homelessness: An Unhealthy State. Health status, risk behaviours and service utilisation among homeless people in two Irish cities. Dublin: The Partnership for Health Equity. http://www.healthequity.ie/#!report-launch/iuv63

[238] http://epubs.rcsi.ie/cgi/viewcontent.cgi?article=1079&context=gpart

Mental Health

Mental health issues can be a reason for people becoming homeless in the first place while the experience of being homeless can impact on a person's mental health, deteriorating the longer a person remains homeless. In *Homelessness: An Unhealthy State* it was reported that 58% of participants in their study had at least one mental health condition. Of a sample size of 596 participants, 52% were diagnosed with depression with 44% being treated for their depression. Thirty-nine percent of respondents were diagnosed with anxiety with 32% receiving treatment. This study also reported self-harm and attempted suicide rates among participants. 13.4% of participants had self-harmed in the past 6 months while 24.7% had self-harmed prior to the past six months. Twenty-nine percent of participants had attempted suicide in the past six months while 28% had attempted suicide prior to the past six months. In acknowledgement of this, the National Office for Suicide Prevention 2020 strategy highlights people who are homeless as a priority group.

The 2011 Simon Communities Snapshot Report found 47% of respondents reported having been diagnosed with at least one mental health condition. Depression was the most commonly reported mental health condition, reported by 30% of respondents. Other mental health conditions reported included schizophrenia, panic attacks, bipolar disorder and social anxiety. Staff also identified undiagnosed mental health conditions among respondents. There were 154 participants that showed signs of at least one undiagnosed mental health condition. The most frequently occurring conditions included mood disorders and anxiety disorders. Mental decline[239] was also present in 23 of the participants who had an undiagnosed mental health condition. Nineteen percent of participants had self-harmed and 17% had attempted suicide within the previous six months.

Problematic Drug and Alcohol Use

Problematic drug and/or alcohol use can put people at an increased risk of homelessness, and can also be caused and/or exacerbated by traumatic experiences, including homelessness. The *Homelessness: An Unhealthy State* report found there was a rise among participants in problematic drug and alcohol use in particular, as well as a dramatic rise in dangerous drinking among women who were homeless, a rise in illicit use of benzodiazepines, while poly-drug use among participants became the norm with a high use of prescribed sedatives. Cannabis was the drug most commonly used among current drug users followed by illicit use of benzodiazepines and heroin.

Some of the Simon Communities have seen an increase in the use of opiate drugs, prescription drugs (in particular, benzodiazepines) and also synthetic benzodiazepines drugs. Drugs from Head Shops and the use of 'legal highs[240]' are very difficult to control. Although many head shops have now closed 'legal highs' are still accessible online. It is very difficult to know what substances a person has taken if they were purchased/secured online. A report by European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Europol (April 2016) found that the use of 'Legal Highs' shows no signs of

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[239] Mental decline is a decline in mental ability which can affect memory, thinking, problem-solving, concentration and perception. http://www.mentalhealthireland.ie/

[240] Legal highs are substances that mimic the effects of illegal drugs, but are not currently controlled by the Misuse of Drugs Act. Legal highs can be purchased in Head Shops and on the internet http://www.aldp.ie/resources/legal_highs

decreasing across Europe and there are challenges for Ireland in legislating for these drugs as they are quickly developed and disposed of; as soon as a ban is introduced for one substance another is developed quickly to replace it[241].

The Simon Communities Snapshot Study Report found that over 50% of respondents reported that they were current alcohol users, while 31% reported that they were current drug users.

Alcohol use

That health snapshot study found that alcohol use was highest among respondents living in high-support housing and emergency accommodation. 70% of high-support housing residents and 64% of emergency accommodation residents that participated in the study reported alcohol use. The study found that 28% of all participants had health issues directly related to their alcohol use, and that 9% of the respondents had attended a detox facility in previous 12 months. Forty four percent of respondents who indicated that they were current alcohol users at the time of the study also had alcohol related health issues. The most common alcohol related health issues included; falls/head injuries, memory loss, gastric problems, liver damage and seizures.

Drug Use

The snapshot study found the highest level of drug use was found among people sleeping rough and those using emergency accommodation. Heroin was the most frequently used drug among participants, with more than 58% saying they used this drug. Cannabis was the second most frequently used drug with 47% of participants reporting that they use it. Forty one percent of people reported taking methadone; with 29.1% using prescribed methadone and 12.2% using un-prescribed methadone.

Polydrug use

The health snapshot study found that levels of polydrug use[242] was high among drug users with 76% of drug users saying they used more than one drug. 28% said they used a combination of two drugs and 45% of drug users said they used three drugs. Fifty two percent of those currently using drugs at the time of the study said they had used drugs intravenously (IV) in the previous 12 months, half of which said they experienced health complications as a result of IV drug use.

Problematic drug and/or alcohol use can lead to a range of physical and mental health conditions. Falls/head injuries and memory loss were the highest reported health problems caused by alcohol use. Fifty percent of those who were currently using drugs intravenously at the time of the snapshot study reported experiencing health complications as a result. The most frequently reported conditions included abscesses, Hepatitis B and/or Hepatitis C, overdose and vein damage.

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[241] **Article in Journal.ie 5th April 2016** ***Ireland is the biggest user of legal highs in Europe as their growth shows 'no signs of a slowdown'*** **http://www.thejournal.ie/legal-highs-new-drug-report-2699032-Apr2016/**
http://www.emcdda.europa.eu/system/files/publications/2373/TD0216072ENN.PDF

[242] Polydrug use is concurrent drug use, which involves a person using at least two substances during the same time period http://www.nacda.ie/images/stories/docs/publicationa/nacdpolydrugusebulletin5.pdf

Dual Diagnosis and Complex Needs

A person who is homeless very often has multiple needs or complex needs[243], such as problematic drug and/or alcohol use, mental health difficulties, physical health difficulties, personality or behavioural disorder, challenging behaviour and vulnerability. This makes it very difficult for people to be in contact with all the various services they may need at one time. If one issue was to be resolved, other issues would still be cause for concern (Homeless Link, 2002)[244].

The Homelessness: An Unhealthy State report found that 47% of participants had a mental health diagnosis and a self-diagnosed drug and/or alcohol problem. 35% of participants had a mental health diagnosis and current illicit drug use.

According to the Simon Communities Health Snapshot study, people who are homeless are more likely than the general population to experience complex needs, including a dual diagnosis of mental health and problematic drug and/or alcohol use due to environmental factors, in particular a lack of supported housing. It was very difficult to ascertain how many respondents had dual diagnosis and complex needs but 20% respondents were identified as having a diagnosed mental health condition as well as alcohol and drug related conditions.

People with dual diagnosis can find it very difficult to access services. They often fall between two stools with mental health services suggesting they deal with their drug issue first and vice versa. International best practice would argue that the two issues should be treated at the same time and in a co-ordinated way.

Housing First: Addressing Homelessness Effectively

There is a strong and well documented association between the experience of long term homelessness and a range of complex health and related needs. Housing First programmes are internationally considered to represent best practice in housing people who are long term homeless with complex needs. People with physical health, mental health, dual diagnosis and complex needs often remain trapped in homelessness. Without the necessary supports in place they are unable to access or sustain a tenancy or access support services. There can be issues accessing mental health hospital, attending primary health care facilities or utilising mental health housing programmes for active drug and/or alcohol users. People can be deemed ineligible for housing payments such as Rental Accommodation Scheme (RAS) or Housing Assistant Payment (HAP) scheme if they had rent arrears in the past three years or a criminal record in the last two years. This runs contrary to the ethos of Housing First approaches and presents a real risk of institutionalisation for those people in emergency accommodation.

Housing First offers housing without preconditions and offers a range of supports focussed on harm minimisation and supporting recovery and empowerment through Assertive Community Treatment (ACT) teams. The success of such initiatives depends not just on housing but also, crucially, on drug

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[243] A person with ‘complex needs’ is someone with two or more needs affecting their physical, mental, social or financial wellbeing (Turning Point, 2014) http://www.turning-point.co.uk/media/636823/appg_factsheet_1_-_june_2014.pdf

[244] As cited in Feansta Health Working Group paper (2013) *'Health and Well-Being for All Holistic Health Services for People who are Homeless'*.

and/or alcohol, mental health, and community integration services being available to tenants who were formerly homeless. *Vision for Change – report of the expert group on mental health policy* highlights the lack of adequate housing and accommodation options for enabling people with mental health issues to move through the different stages of recovery and progress towards independent living[245]. However, since 2010 the HSE budget for homelessness has been cut by 20% and the Drugs Initiative budget has seen cuts of up to 37% over the past six years. These cuts have had an adverse impact on people who are homeless and on access to treatment and one-to-one supports.

Emergency accommodation has formed the basis of Ireland's response to the homeless crisis. In some cases this has included hotel rooms and B&B's and in others additional shelter beds, often dormitory style, have been provided. As a strategy this fails to address homelessness effectively and in the long run can lead to additional problems of institutionalisation and dependency. A broad Housing First strategy, focused on people who are long term or repeatedly homeless, will substantially reduce the number of shelter beds needed and address rough sleeping and long term homelessness effectively. Analysis of shelter usage statistics in both Cork and Dublin show that a relatively small proportion of people who become homeless account for the majority of the emergency beds put in place to address the crisis. In Dublin, O'Donohue-Hynes (2015)[246] found that from 2012 to 2014, of the 7,254 people that used emergency accommodation just 13% (924) could be considered long stay[247] shelter residents. However this group accounted for 52% of emergency bed nights[248]. Remarkably, Cork Simon's most recent data mirrors that finding - 12% of residents in its emergency shelter in 2015 met the government's definition of long term homelessness, and this group accounted for 51% of shelter bed nights. These statistics clearly suggest that a strong focus on housing people who are long term homeless will have the greatest impact on freeing up emergency bed-nights and thus eliminating rough sleeping. We welcome the commitment to triple Housing First tenancies in the Dublin area by 2017. We encourage the DHPCLG to set and publish attainable tenancy targets with regard to the roll out of Housing First nationally.

There are two key aspects to the Housing First[249] approach - immediate provision of housing without pre-conditions or the requirement of housing 'readiness' and the provision of support in housing at the level required, for as long as necessary. With Housing First the goal is to move people out of homelessness as quickly as possible into permanent housing where tailored support services are more effective. These approaches, once properly resourced, improve the outcomes and quality of life for people who are homeless, or at risk in Ireland. Housing First approaches involve three dimensions of support:

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[245] Vision for change – the Report of the Expert Group on Mental Health Policy (2006) http://health.gov.ie/wp-content/uploads/2014/03/vision_for_change.pdf

[246] O'Donoughe Hynes (2015) *Patterns of homeless emergency accommodation use in Dublin: how do we compare?* Paper presented at European Research Conference **Families, Housing and Homelessness** Dublin, 25th September 2015

[247] Long Stay* or chronically* homeless according to typologies developed by *Aubrey et al (2013) Kahn and & Culhane (2004)

[248] Total number of emergency bed-nights available" is the total number of emergency beds available in a given period.

[249] In 2014 research undertaken by Mental Health Commission of Canada as part of the *At Home/Chez Soi study*, the largest ever study examining the effectiveness of the Housing First approach compared with the traditional staircase approach. The study followed more than 2,000 people who were homeless over a two year period across 5 Canadian cities. The findings were very clear: The Housing First intervention was twice as effective as the staircase approach in ending homelessness for people who had been long-term homeless with complex support needs. Furthermore, the intervention led to significant cost savings when compared with traditional interventions[249]. The key to the success of Housing First is its comprehensive model of support for the most 'hard core' people who are homeless with the highest level of needs.

Housing supports: The initial intervention of Housing First is to help people obtain and maintain their housing, in a way that takes into account client preferences and needs. Key housing supports include; finding appropriate housing; supporting relations with landlords; applying for and managing rent subsidies; assistance in setting up apartments.

Clinical supports: This recovery-oriented approach to clinical supports is designed to enhance well-being, mitigate the effects of mental health and addiction challenges, and improve quality of life and foster self-sufficiency.

Supports towards Community Integration: These supports are intended to help individuals and families improve their quality of life, integrate into the community and potentially achieve self-sufficiency. They may include: life skills; engagement in meaningful activities, income supports, assistance with employment, training and education, and community (social) engagement.

Accessing Healthcare Services for People who are Homeless

There is the aspiration that every person in Ireland is entitled to access a wide range of community and hospital health services, and where income is an issue, that this is accessed through a medical card or at a reduced cost, with some services free of charge if referred by GP[250]. (www.HSE.ie). The Health Service Executive (HSE) Transformation Programme 2007-2010 stated that by 2010 "*Everybody will have easy access to high quality care and services that they have confidence in and that staff are proud to provide".*

The HSE's aim was to place clients at the centre of the care continuum and this is particularly relevant in the context of people who are homeless[251].

People who are homeless and those that provide services for people who are homeless have reported many challenges that they face when trying to access services. Cutbacks in health and HSE budgets since the onset of the financial crisis have had a detrimental impact on access to services. Despite there being access to health care in Ireland for all, many people who are homeless only access health services when they are in crisis or when illness is well developed and severe, a point at which they access health care through emergency departments. (Partnership for Health Equity, 2015)[252]. This is a prime illustration of the inverse care law in operation, whereby those that are most likely to need services are the least likely to get them. Some of the Simon Communities in Ireland reported that having treatment services and multi-disciplinary teams in place is very advantageous however barriers to accessing off-site health care for people who are homeless still exist.

Stigma

People who are homeless often avoid accessing health care services as there can be stigma that is still attached to being homeless[253]. Other reasons identified in the *Homelessness: An Unhealthy State* report for not presenting to primary care services included difficulties with complex administrative forms, difficulties making and keeping appointments due to the nature of homelessness; being too

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[250] http://www.hse.ie/eng/services/Find_a_Service/eligibility.html

[251] HSE Transformation Programme 2007-2010 http://www.hse.ie/eng/services/Publications/corporate/transformation.pdf

[252] O'Reilly, F., Barror, S., Hannigan, A., Scriver, S., Ruane, L., MacFarlane, A. and O'Carroll, A. (2015) Homelessness: An Unhealthy State. Health status, risk behaviours and service utilisation among homeless people in two Irish cities. Dublin: The Partnership for Health Equity. http://www.healthequity.ie/#!report-launch/iuv63

[253] Simon Communities in Ireland (2013) *'Homelessness, Ageing & Dying'* http://www.simon.ie/HomelessnessAgeingandDying/index.html#/26/

busy to attend due to other priorities such as looking for food, shelter, money, and problematic alcohol and/or drug use[254].

Cuts to Health and HSE Budgets

The impact of the crisis and cuts to HSE budgets are still being felt in health and homeless services. These cut-backs to funding and lack of resources have impacted most on high risk groups, especially on people who are homeless. Some health services that were available have been amalgamated with others or have almost disappeared, making it more difficult for people to access.

Catchment Areas

Catchment areas can pose a problem for people when trying to access services. For example, Dublin Simon Community residential detoxification services operate within the Dublin Southside catchment area, and although the North-side services operate in the same surrounding area, people using the residential detox service are unable to access North side catchment areas services. The amalgamation of Mental Health services between Galway City and County and Roscommon is making it more difficult for people to access these services. Waiting times for appointments are longer and it can be more difficult for people to travel to city centre services.

Flexibility of Services

Many challenges continue to be experienced by both service-user and service provider when linking with mental health services. Barriers to accessing services continue to be experienced. The absence and inflexibility of some services can hinder the progress of people moving out of homelessness. If a person misses an appointment with psychiatric services, they can be discharged from the waiting list for this service resulting in another referral being required.

Discharge from Institutional Settings

Discharging people from institutional settings e.g. hospital/prison/care system into homelessness remains an issue. Discharge protocols must be published, implemented and resourced for those leaving state care or residential institutions. This is supported in the *Report of the Committee on Housing and Homelessness* (2016). The *Rebuilding Ireland: Action Plan on Housing and Homelessness* does not contain detailed targets in this regard.

Case-Management Teams

There are no case-management teams in some regions. Meetings take place but often do not involve the patient, family members or a person’s key worker. This goes against the person-centred approach.

Out-of-Hours Services

There are now self-harm nurses in most Accident & Emergency (A&E) departments of Irish hospitals. While this is a positive development, the nurses are only available between the hours of 9-5 Monday to Friday; times at which people are less likely to present to A&E with such issues[255]. An out of hour’s

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[254] Ibid

[255] Interview with Galway Simon Community Staff

service is not available, although protocols exist for nurses to follow-up in cases where presentations are made outside of service hours.

Mental Health Services

One of the major challenges is that posts in mental health services have been extremely slow to be filled, leaving some areas without a full Community Mental Health Team for long periods of time[256]. Staffing in Mental Health services is still 22% below the recommended level outlined in *A Vision for Change.*[257] Although funding for mental health services was restored to the recommended €35 million in Budget 2016, there are still significant shortfalls in funding for mental health services which, at just 6.5% of the health budget, is still well below *A Vision for Change* recommended level of 8.24%.[258]

Drug and Alcohol Services

A full range of harm reduction services and responses is not available to all that need them. There are also a limited number and spread of residential treatment and rehabilitation places across the country. This results in long waiting lists and people having to travel to access services only to have to return to their county of origin following treatment/rehabilitation.

Lack of Specialist Services

Simon Communities have reported extreme difficulty in supporting people with complex needs or dual diagnosis as there is no designated service in some regions. Often it appears that no one will take responsibility resulting in people being passed back and forth from drug and alcohol service to mental health services.

Services for Older People who are Homeless

There is a clear recognition within the health services that people who are homeless have a reduced life expectancy and that those aged 50 and over who are homelessness often have health needs more generally associated with people who are older. The provision of appropriate housing, along with adequate healthcare support is needed. There is also a clear need to plan for and address end-of-life care for people who are homeless. In the study *Homelessness, Aging and Dying* (2014)[259] many older people who are homeless reported worrying about what would happen to them as their health deteriorated.

Services for Women who are homeless

Women's health experiences, drug and alcohol use and homelessness can differ to men's experiences in terms of causes, experiences and pathways out of drug use/homelessness. In research carried out by the Simon Communities *Women, Homelessness and Service Provision* (2015)[260], women who participated in the study identified a number of health issues they had or were currently experiencing. These included problematic drug and alcohol use, mental health issues, sexual abuse and harassment, physical illnesses and pregnancy related health needs.

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[256] Simon Communities in Ireland Pre-Budget Submission 2016 'Changing the Forecast' 2015 www.simon.ie

[257] Mental Health Reform online petition (2015) https://www.mentalhealthreform.ie/news/thousands-call-for-government-to-invest-in-irelands-mental-health/

[258] Department of Health *A Vision for Change* 2006

[259] http://www.simon.ie/HomelessnessAgeingandDying/index.html

[260] http://www.simon.ie/Women_Homelessness_and_Service_Provision/pubData/source/Women%20Homelessness%20and%20Service%20Provision.pdf

Accessing healthcare in a rural setting

Responding to the healthcare needs of people who are homeless in a rural setting is accentuated by not having access to services. Homeless service users have to travel significant distances sometimes outside their own county to access health services. The additional costs incurred by Homeless Services because of rural isolation and poor transport infrastructure has not been recognised by State funders of homeless services.

Healthcare Cost Implications

Recent research has shown that improving access to primary healthcare services for people who are homeless has significant cost saving implications for health service providers. In a recent study by the Royal College of Surgeons in Ireland and Dr. Austin O'Carroll of Safetynet Dublin, general practice was identified as an important setting to meet the healthcare needs of homeless people and to provide an opportunity for early intervention. This has been shown to improve the health of people who are homeless and reduce hospital admissions, resulting in reduced overall cost to the healthcare system.

Additional research by the Australian Housing and Urban Research Institute has shown that the provision of housing for people who are homeless has led to a significant decrease in health service use when compared to the period before they were in such tenancies. In terms of the cost to Government including the provision of the tenancies in question, the potential health costs avoided represent an offset to the cost of providing social housing support.[261]

A 2012 report by the UK government revealed the beneficial cost implications of providing comprehensive health supports to people within stable accommodation as opposed to more piecemeal supports provided when the same people were experiencing homelessness. The research which examined two case studies showed that drug treatment, detoxification and mental health support costs were reduced from £16,000 to £2,700 and £32,000 to £3,000 when supports were provided in a stable accommodation setting.[262]

Conclusion

We welcome the opportunity to make this submission to the Oireachtas Committee on the Future of Healthcare. People who are homeless suffer from a range of health issues which include but are not limited too physical health issues, mental health issues, problematic drug and alcohol use and complex needs. People presenting to homeless services often display multiple or complex needs within these broad health categories. The prevalence of illness amongst people who are homeless is exacerbated by a lack of good quality housing and the absence of clinical and health supports in the home. People who are homeless often encounter other significant barriers to healthcare in the form of stigma, cuts to health/HSE budgets, administration of service catchment areas and the lack of homeless specialist health services. Best practice indicates that improving access to primary care services has large scale health benefits for people who are homeless in addition to cost saving

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[261] https://www.ahuri.edu.au/__data/assets/pdf_file/0021/8526/AHURI_Final_Report_No265_What-are-the-health,-social-and-economic-benefits-of-providing-public-housing-and-support-to-formerly-homeless-people.pdf?utm_source=website&utm_medium=report.PDF&utm_campaign=https://www.ahuri.edu.au/research/final-reports/265

[262] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf

implications for the health service as a whole. The solutions to homelessness involve preventing people from becoming homeless and providing access to affordable, permanent housing with support, as necessary (Housing First). Critical to this is the provision of clinical support. We know this approach works and we know that it can transform the lives of people who are living in hostels, hotels and B&B. We believe the work of the Committee can have a beneficial impact on the improvement of existing health services for people who are homeless and the delivery of future services that specifically target the myriad of homeless specific health issues identified in this submission

About Simon Communities

The Simon Communities in Ireland are a network of eight regionally based independent Simon Communities based in Cork, Dublin, Dundalk, Galway, the Midlands, the Mid West, the North West and the South East that share common values and ethos in tackling all forms of homelessness throughout Ireland, supported by a National Office. The Simon Communities have been providing services in Ireland for over 40 years. The Simon Communities deliver support and service to over 7,500 individuals and families throughout Ireland who experience – or are at risk of – homelessness every year.

Whatever the issue, for as long as we are needed, Simon's door is always open. For more information please visit www.simon.ie

Services include:

- Housing provision, tenancy sustainment & settlement services, housing advice & information services helping people to make the move out of homelessness & working with households at risk;
- Specialist health & treatment services addressing some of the issues which may have contributed to homeless occurring or may be a consequence;
- Emergency accommodation & support providing people with a place of welcome, warmth & safety;
- Soup runs & rough sleeper teams who are often the first point of contact for people sleeping rough.

For further information please contact:
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Appendix 1: Housing and Homelessness Crisis in numbers

- During one week in June 2016 (latest available figures), there were 6,358 men, women and children in emergency accommodation across the country; a 32 % increase from the same week in June 2015. This included 2,695 adults with no dependents in their care and 1,078 families made up of 1,457 adults and 2,206 children. (DECLG, 2016).
- On Census Night, 24th April 2016, there were 171 people without a place to sleep in Dublin City. This included 102 people sleeping rough and 69 people sheltering at the Nite Café. Unfortunately, Dublin is the only area where an official rough sleeper count takes place, making it difficult to get a countrywide rough sleeping picture. (DRHE 2015).
- Figures from Cork Simon Community indicate that rough sleeping in Cork City increased nine-fold in four years (2011-2015) from 38 people sleeping rough in 2011 to 345 people sleeping rough in 2015.
- Homelessness and housing insecurity are more acute and visible in our cities but the Simon Communities are working at capacity countrywide – in urban and rural areas.
- There are at least 90,000 people on the social housing waiting list. (Housing Agency, 2014).
- Social housing commitments will take time to begin to deliver housing. This is far too long for the people we work with and those at risk of homelessness. Social housing output for 2015, reached 1,030 new builds and acquisitions, with new builds accounting for 75 units. (DECLG, 2016). This is below the Social Housing Strategy target of 18,000 new units for the period 2015-2017.
- The average rent nationwide has risen by over one third since bottoming out in 2011 and has surpassed its 2008 peak. The average national rent is now €1,037 (Daft.ie Rental Report Q2 2016).
- *Locked Out of the Market III* (Jan 2016 Simon Communities) found that 95% of rental properties are beyond the reach for those in receipt of state housing support. Of all the properties available to rent in the eleven regions studied, only one was available for a single person see http://www.simon.ie/Publications/Research.aspx
- 41.2% of all accounts in mortgage arrears are in arrears of over two years. (Central Bank of Ireland, 2016).
- At the end of December 2015, 23,344 or 17% of buy-to-let mortgages, were in arrears of more than 90 days. (Central Bank of Ireland, 2016).
- 750,000 people are living in poverty in Ireland (*Poverty, Deprivation and Inequality* (July 2016) Social Justice Ireland Policy Briefing).
- Since 2007 the deprivation rate, which looks at the number of people forced to go without at least 2 of 11 basic necessities examined, in Ireland has doubled - 29% of the population or 1.3 million people are experiencing deprivation (Social Justice Ireland ibid).

SIPTU

1.1 The establishment of the Oireachtas Committee on the Future of Healthcare and the attendant focus on formulating a long term vision for a reformed public health service is a positive development.

1.2 The establishment of the Committee presents an opportunity to make a declaration of intent that, over time, we will move to a universal, fully integrated, single tier public health service that guarantees access and quality care, regardless of income.

1.3 The public health service should be funded through a progressive taxation system. At a minimum, the service should be allocated dedicated funding of 10% of GDP per annum, with a further recognition that significant additional capital spending will be required in some years. Over time, the state will cease to subsidise all forms of private health care provision.

1.4 For the vast majority of citizens the first point of contact with the public health service should be a network of public, locally based community health care centres. These Primary Care Centres will provide an expanded range of clinical and diagnostic services and will lead health promotion campaigns in the communities in which they are based.

1.5 The network of public hospitals will continue as a vital cornerstone of the public health service, but the role of the public hospital will be re-focused with some services devolved to the Primary Care Centres. Vital to reform the health service will be a move to a team-based approach to patient care which is consultant delivered and where all hospital staff are respected and enabled to perform tasks appropriate to their qualification levels and competence.

1.6 The increase in the number of older people living longer lives is the biggest challenge facing our public health service. This challenge is such that it will require the state to reverse its current policy of privatising elder care and re-engage as the principal provider of health care services for older people.

1.7 The incidence of mental health disorders continues to rise and demands a renewed commitment to deliver in full the proposals contained in the *Vision for Change* strategy published in 2006.

1.8 Not for profit organisations currently provide the bulk of health services to people with disabilities. A small number of highly publicised failures have highlighted the need for better oversight and a focus on quality assurance and patient care. A strategy of providing services in community-based settings must be part of an overall approach to the care of people with disabilities.

1.9 The Committee must accept that moving to a universal, fully integrated, single tier public health service presents a number of workforce planning challenges, not the least of which is understaffing. In designing the new system, full regard must be had for appropriate remuneration, reward and recognition systems and other conditions of employment, such that the Irish public health system is ultimately viewed as the employer of choice and is capable of attracting and retaining the most talented staff.

2. Introduction

2.1 An essential function of Government is to create the conditions under which all citizens can access high quality public health services.

2.2 The public health service in the Republic of Ireland is staffed by a wide range of highly qualified and dedicated healthcare professionals who strive to achieve excellent outcomes for patients. However a number of funding, structural and organisational difficulties embedded in the system can result in a less than satisfactory experience for some.

2.3 The establishment of this Committee represents a major opportunity to make a declaration of intent on the introduction of a universal, single-tier, public health service, where both access and quality are guaranteed regardless of income. It is imperative that over time the existing two-tier health system - with contradictory incentives and ability to pay guaranteeing faster access to diagnostics and interventions - is replaced by a single-tier, equitable, quality service.

2.4 Over the last three decades successive governments have proposed, and implemented, various organisational reforms. However real, transformational, change has not occurred, to the detriment of many who rely upon a public health service. The Committee must acknowledge that a meaningful transformation of Ireland's public health services will require far more than a decade of planning and implementation and as such, its deliberations should not be limited to addressing developments that may be completed within the next ten years.

2.5 In this submission Congress has sought to identify:

- The guiding principles that should inform any programme of reform;

- The measures required across the key pillars of the public health service: primary and community care, public hospitals, care of older people, the mental health service, care of people with disabilities; and

- The human resource issues arising from the implementation of a new vision for the public health service.

2.6 Congress is uniquely placed to provide the Oireachtas Committee with a view on a reformed public health service given that our affiliated unions represent well over 90% of all employees in the service. The views expressed in this submission have been developed in consultation with both the unions in the sector and the wider trade union in Ireland. However the Irish Medical Organisation (IMO) has independently developed a strategy for the organisation of the health services in Ireland over the next ten years and beyond, which is the subject of that union's separate submission to the Committee on the Future of Healthcare.

2.7 In our view an essential component of a single tier public health service is that all staff will be directly employed. Critically, any such service must function on a 24/7 basis, where required, and, at a minimum, on a 7/7 basis, in both the primary and secondary care services.

3. Guiding Principles for a Reformed Public Health Service

3.1 In the following paragraphs we set out the principles that Congress believes should guide the transformation of the public health service.

3.2 In the first instance, there should be an immediate declaration of intent to create a fully integrated, universal, single-tier public health service. Clearly, a considerable transition period will be required - probably in excess of a decade - and this should be acknowledged at the outset. It will be vital to secure citizen and stakeholder support for the process and the difficult decisions it may entail. This will require active consultation with those immediately affected *and* a commitment that no service will be discontinued until an alternative service is in place. Likewise, any proposed changes to employment contracts or other contractual arrangements must be the subject of consultation with recognised trade unions, acknowledging that significant red-circling of some current arrangements will be required. Although change will be gradual the transformation envisaged must be clearly set out, along with a timetable for implementation.

3.3 There should be a long-term, multi-annual commitment to provide ring fenced core-funding for the public health service at a minimum level of 10% of GDP per annum. This funding should be provided through a system of progressive general taxation.

3.4 Building a single tier health service will involve significant capital expenditure to provide the necessary infrastructure. The funding must be allocated, in any given year, in addition to, and separate from, the minimum expenditure of 10% of GDP on current service provision. All health spending must come as a result of realistic budgeting, which can adequately provide for the delivery of planned services and the development of infrastructure.

3.5 As we transition to the desired single tier system, parallel funding will be required as we reconfigure and develop new services, while maintaining existing service provision.

3.6 A further cornerstone of this transformational programme should be a declaration that the State will, over time, cease to fund or subvent any form of private healthcare provision. This will entail the phased elimination of all tax reliefs for private healthcare insurance and direct subventions, i.e. to existing private nursing homes. This funding should be redirected to specific programmes, required for, or linked to, the implementation of the reform programme for the creation of a single-tiered service.

3.7 Essential to a reformed public health service must be an appropriate remuneration system aimed at attracting the most talented. If we are to attract and retain the required number of additional staff, recognising the expansion of services that will be required, the change process must include a significant personnel component. This must recognise that Ireland will be competing with other countries for well qualified health professionals and significant ongoing training and professional development opportunities should be available. Ultimately a transformed public health service must be viewed as an employer of choice.

3.8 Organisational restructuring, planned or under way, will need to be reviewed in order to reflect the structures necessary to deliver the single tiered accessible healthcare service. The final organisational structure that emerges must be simple, integrated and readily understood by the general public. This is necessary to ensure efficiency and effectiveness, minimise duplication and, most fundamentally, to secure the confidence and support of the general public for the transformational programme.

3.9 Congress further calls for improved planning and expenditure on public health initiatives. The current population health strategy - *Healthy Ireland* – can be of considerable importance in lowering future disease burden. However it must be supported with a detailed implementation plan, ring-fenced funding and improved staffing of public health provision.

4. Primary Care: Local Health Services to Meet Local Need

4.1 The delivery of public health care should be designed to ensure that the first, and, for the most part, the continuing point of contact for most citizens, will be a community-based, publicly owned and managed primary health care facility.

4.2 A cornerstone of this enhanced system must be universal eligibility for all primary care services, to be provided by directly employed health professionals.

4.3 The range of services offered in these primary care centres is a matter for detailed consideration and may differ based upon urban/rural locations and population density. Staffing should be on the basis of 7/7 opening and centred on a team approach, providing direct access for the public to health professionals together with the provision of cross referral from one health professional to another.

4.4 These Primary Care Centres must offer sufficient diagnostic and support services to ensure that patients can access services at the most appropriate location, thus reducing the burden on acute and secondary services.

4.5 In that context any current or future discussions with regard to expanding or altering existing contracts or arrangements, must recognise the potential for significant change and not, in any way, inhibit or restrict the changes necessary to transform the provision of primary care services.

4.6 As suggested services should operate to direct patients to receive care at the most appropriate location. However, as patients will still need to attend public hospitals for particular treatments it is important that appropriate technology is utilised to ensure seamless transmission of patient information between the local facilities and public hospitals. This will require separate, ongoing, capital funding.

4.7 In paragraph 2.3 above we referred to once off capital costs that will be incurred as part of the required reforms. It will be necessary to expand the current programme to develop primary care facilities to ensure access to such centres countrywide. The development of community based health facilities is critical to the creation of a universal, single tier public health service.

5. Our Public Hospitals: Acute Care & More

5.1 Devolving some services from public hospitals to community based facilities, provides an opportunity to assess which services will remain with public hospitals and how they will be delivered.

5.2 However in any reform of the role of public hospitals we must ensure that there are sufficient beds in appropriate locations to meet expected demand.

5.3 It is widely accepted that there are insufficient available beds in our public hospitals. This is evidenced by the waiting times experienced in emergency departments and the severe and growing waiting lists for inpatient and/or diagnostic services.

5.4 Research carried out by the OECD[263] shows that in 2006 the number of hospital beds per 1000 of the population stood at 5.3. However by 2012 this had fallen to 2.8. If pubic hospitals are to be capable of responding to the needs of a growing and ageing population the number of available public beds will have to increase significantly to bring it into line with the OECD average of approximately 5 beds per 1000 of the population.

5.5 It is also accepted that significant change is required in how public hospital services are delivered. Fundamental to this is recognition of the leadership role played by consultants in hospital settings. In order to ensure the effective functioning of a single tier public health service it will require that patient care is delivered by consultants employed and working exclusively for the public health service. It will also require that consultants are rostered over an extended day and on a seven day a week basis. This will require a significant number of additional consultant posts in the core specialisms of medicine, surgery, paediatrics, obstetrics and emergency medicine.

5.6 Moving to a consultant-delivered service in public hospitals - to include a review of the existing ratios between qualified staff and professionals in training - presents an opportunity to create a system of team working where the role played by all working in the hospital is valued and recognised. It also presents an opportunity to assess how vital work is carried out. Most people working in the health service would agree that the quality of patient care could be improved by ensuring that tasks are carried out by the appropriate person in the most efficient way. It is further recognised that many staff in our hospitals are now trained to a level that would allow them to perform an enhanced role in patient care. In the move to a consultant-delivered service the duties currently performed by all those working in this vital

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[263] http://www.oecdilibrary.org/docserver/download/190800051e1t008.pdf?expires=1470239242&id=id&accname=freeContent&checksum=5EF2A2E6A34320414A2E6101A298CAF2

part of our health service should be scrutinised and tasks allocated on the basis of achieving the highest possible standard of patient care.

5.7 Congress requests that the Committee note that our affiliates have, particularly in recent years, engaged in very constructive discussions with regard to the reallocation of work, task transfers and the provision of frontline services to patients/client. This must be constantly reviewed during the transformation programme, as a properly staffed health service, with appropriate ratios of professionals to support staff, greatly enhances the patient/client experience and accelerates the return to full health.

5.8 Congress broadly welcomes the recent establishment of the seven Hospital Groups, including the Children's Hospital, as it has the potential to improve co-ordination of service delivery. However past experience with regard to reconfiguring acute hospital services is one of failure, with increased overcrowding, loss of public confidence and huge frustration amongst health service staff. However, Congress, as referred to in paragraph 4.1, continues to believe that the move to an integrated single tier public health service presents an opportunity, on a planned and agreed basis, to transfer some of the procedures, performed in hospitals, to more locally based public health facilities.

5.9 A fundamental requirement of any further reconfiguration of acute hospital services, as part of this transition must be to ensure the maintenance of all existing services in their current locations, until the alternative service is established, properly staffed, funded, and, most importantly, enjoys the confidence of the community it serves.

5.10 Where appropriate and proven effective, public hospitals should provide other services critical to the care of patients, necessary for the continuing improvement and development of the public health service. An example would be for major public hospitals to continue to provide advanced diagnostic tests for patients following referral from partner hospitals and/or locally based primary care centres. Public hospitals should also continue to play a key role in the education and ongoing professional development of those working, or seeking to work, in the public health service. It is also vital that our public hospitals are involved in advanced research and development thus ensuring ongoing improvements in patient care. When our public hospitals have the capacity to provide world class care and are recognised as leaders in education and research, the public health service is more likely to attract and retain the most talented staff.

6. Care of Older People: The Biggest Challenge Facing our Public Health Service.

6.1 While there has been an increase in both the birth rate and in the population, the long term trend shows a significant increase in number of older people who will live longer. While obviously welcome, this poses a considerable challenge to our public health service.

6.2 As our population ages, there will be an exponential rise in the incidence of chronic disease, and it is imperative that we radically reform the manner in which we deliver healthcare services to those affected. An expanding and ageing population places significant demands on the healthcare system with the incidence of chronic conditions expected to increase by 4% to 5% per annum during the next decade. Many services addressing chronic disease could be better delivered in a community setting and such services must be expanded accordingly.

6.3 Older people who live in their own homes will doubtless benefit from an expanded, locally based network of primary health care facilities. The development of these facilities will reduce their requirement to be admitted to public hospitals and the requirement to travel to avail of services currently provided in public hospitals.

6.4 Older people who do live at home will require support. The home help service currently provides such assistance and the provision of these crucial services are very often the reason why older people can continue to live independently. Close to 50,000 people availed of this service in 2015. It is therefore imperative that adequate funding and professional staffing are provided for the continued and improved running of this service.

6.5 For a growing number of older people the reality is they are unable to live independently. Most will require full time residential care. To date official policy has been to privatise this care through state subsidisation of private nursing home beds run by for profit businesses.

6.6 Congress believes it is vital for the State to declare that, over time, it will become the main direct provider of long term residential care for older people. This will require significant state investment in the development of facilities that will provide single room accommodation in residential settings. It will involve the construction of such facilities and the redevelopment of the existing public, long term bed stock to bring it up to the standards required by HIQA. An extended home help service can address the needs of those who can and wish to remain in their homes despite being unable to live independently.

6.7 As we have mentioned the move to a fully integrated single tier public health service will take a number of years to implement. In the transition the private sector will continue to be a provider of care to older people. However, there will be greater certainty and security for older people with the State moving to become the main care provider.

7. Mental Health: Removing the Stigma & Providing Effective Treatment.

7.1 In 2006 the then Government published a comprehensive policy on mental health entitled *A Vision for Change*. The key feature was to be the transfer of services to community settings. However in the ensuing decade there has been slow progress in implementing what constituted a transformational shift in the treatment of mental health disorders.

7.2 The proposal to move to a community setting is still relevant and this service should be fully integrated into the locally based primary health care services, referred to earlier.

7.3 However funding for the treatment of mental health disorders is drawn from the main budget, with no certainty about the availability of resources in the longer term.

7.4 Congress believes that mental health requires a dedicated, multi- annual budget. This would facilitate the integration of this important element of the public health service within the locally based primary care service, with the capacity to plan for the treatment of children and adolescents, along with planning for the treatment of adults presenting with mental health disorders.

7.5 Arising from the provision of this dedicated, multi-annual budget, specific goals and objectives must be set for the rapid development of mental health services. These must include significant investment in capital infrastructure (again through a separate capital budget) the provision of specialist services, universally available, and the employment of additional allied health professionals and nursing staff. Access to acute/supportive mental health services must be available, on a 24/7 basis, either through the primary health care centres, or dedicated staff within emergency departments in major urban areas.

7.6 An effective means of reducing the incidence of mental health disorders is through preventative programmes that seek to lessen the prevalence of risk factors, including: substance abuse, social isolation, economic disadvantage or family conflict. The dedicated budget for mental health referred to in paragraph 7.4 above should provide resources for the implementation of such programmes.

8. Disability Services

8.1 The funding of health services for people with disabilities dramatically reduced during the economic crisis and this must be reversed.

8.2 The delivery of these services is primarily carried out by not for profit voluntary organisations working nationally or locally. In the vast majority of cases the services provided are to the highest standard, given the resources made available to them.

8.3 However a small number of highly publicised failures in service provision highlights the necessity to ensure that quality assurance and patient care are at the heart of service delivery to people with disabilities. It must also be acknowledged that the provision of disability services, through numerous small, not for profit agencies has led to a lack of consistency, in terms of service location and access. Congress therefore proposes that the services be delivered, through direct provision and directly employed staff, and in a manner which ensures that access to necessary supports is available regardless of income and location.

8.4 Equally we must continue to relocate services, where appropriate, from existing residential type accommodation to more appropriate community based homes. While this is existing policy it has not been properly funded and, quite frequently, the infrastructure within the community home location is inappropriate for the needs of the client. It must also be recognised that there will be many occasions when the individual continues to enjoy a better quality of life by remaining in their current location, receiving the required level of supports.

8.5 The reform process must ensure that we fully utilise the skills and competencies of all staff working in the area of disability services. As part of the transition to this single tier system we must, without exception, maintain standards and practices and ensure respect for the human rights of the individual with a disability. The provision of such a service will require legislative changes to guarantee the rights of the disabled person, including the provision of all services necessary to optimise their lives, potential and overall well-being.

9. The Ambulance Service

9.1 The National Ambulance Service plays a critical role in connecting the community with hospital and other key health care services.

9.2 Due to changing demographics citizens dependent on community medical services will require support in the home. Citizens will require social support which is already provided by Home Help Services and as such it is imperative that adequate funding and qualified personnel be provided. It is therefore crucial that Government commits to adopting a strategic plan for care of citizens in the community which ensures the highest standards are maintained and that those who provide and manage the service are regulated. It is also vital that the workers in this sector are protected and remunerated in line with their counterparts who provide similar services in institutional settings.

10. Regulation & Standards

10.1 As an integral part of this transformation programme Congress supports strong regulations to govern how all health professionals practice. If the public is to have confidence in those providing care it is essential that very clear regulations remains in place to ensure high standards.

10.2 As we move to a single tier publicly provided, health system it will be necessary to ensure that a full independent inspectorate is established and properly funded, charged with the task of constantly challenging the health service to be world class in all facets of its operation.

11. Future Workforce Planning

11.1 There are significant workforce planning issues to be considered as part of the transition to a fully integrated single tier public health service.

11.2 It is our view that in the transition period all future recruits to the public health service will be direct employees working exclusively for the public health service.

11.3 Remuneration, reward and recognition systems and quality continuing professional development systems must be put in place, with the aim of attracting and retaining the most talented staff.

11.4 If the ambition of a fully integrated, single tier public health service is to be realised and if it is to operate across all settings in a timely and responsive manner, it will require significant investment in staff at all levels.

12. Conclusion

12.1 The establishment of the Committee on the Future of Healthcare presents a significant opportunity to develop a new, all-embracing and transformative vision for the future of our health care system.

12.2 It is the view of Congress that the Committee should clearly state that an overarching goal of this process is to move to a universal, fully integrated, single tier public health service, that guarantees access and quality care, regardless of income.

12.3 The public health service must be properly resourced through the taxation system to a minimum of 10% of GDP per annum, with acknowledgement that additional capital funding will also be required over time. This will also see the State cease funding for all forms of private health care.

12.4 A network of Primary Care Centres will act as the first point of contact for many accessing the health service, with the centres providing a range of key services and leading local health promotion campaigns. Service provision in the public hospital network will be refocused to reflect this change, but the network will continue as the cornerstone of the health care system.

12.5 At the heart of a transformed health service will be a consultant delivered, team-based approach to patient care, with all staff carrying out tasks appropriate to their qualifications.

12.6 The biggest challenge facing our public health service is the increase in the number of older people living longer. This will require the state to become the principal provider of health care for older people.

12.7 The growing incidence of mental health disorders demands the full implementation of the proposals contained in the 2006 *Vision for Change* strategy.

12.8 Moving to a universal single tier public health service presents major workforce planning challenges. Any new system must put in place conditions of employment that will make our health system the employer of choice for the most talented staff.

http://www.siptu.ie/

Sorcha O’Reilly

The following is my submission which looks at a varied number of areas which need addressing within the next 10 years. These are: Funding the Health System, Other Finance Issues, Staffing, Long term Illnesses and Conditions, Rare & Undiagnosed Conditions, Social, Community and Primary Care, Elder People and People with Disabilities requiring Care, Mental Health, Maternity and Children's Health, Geography & Access, Environmental and Planning, Transparency.

They each list a set of important recommendations but to summarise, they are based on the following themes:

- Sustainable, multi funding source model with cheap co-payments, free for some and based on need.
- Focus on health promotion and effective early intervention.
- A smart, joined up service without 'gaps' to fall through.
- Looking for best options longer term rather than short term cheapness which costs later.
- Sensibly planning where, what and how services are evenly spread across the country.
- Researching issues which impact health in order to advise planning.
- Increasing resources intelligently and reducing strain on system and staff.
- Investing in and maximising quality of life and preventing discomfort to minimise risk of creating extra healthcare costs.
- Acknowledging the importance of environment and protecting it.
- A transparent system which meets people's needs with accountability at every level.
- Caring for all stages of life including illness and death at all ages.
- Relieving health disadvantage

And the GOLDEN RULE:

- *Nobody left without their needs being met.*

Please note: References and evidence have been omitted to minimise word count while maximising the number of points covered and to increase ease of reading. However, evidence supporting the points made are mostly easy to find.

Sorcha O'Reilly *DipABRSM, HND (App.SocSc.)*

Funding the Health System:

Funding Models:
The need for the current models to change is undeniable. It's not truly a system but a patchy mixture of a private healthcare with some national health system features and a fraction PRSI funded.

UHI Model and Fine Gael's Faircare - Criticisms:

- This model is questionable so significant revision or making a new plan is needed.
- Moving people from hospital care to primary could reduce hospitals waiting times but FairCare acknowledges a shortage of GPs. FairCare is largely based on the Dutch system but statistics in the FairCare proposals show a greater shortage of GPs in the Netherlands. This could cause longer waiting times in primary care instead. Free GP care could exacerbate that problem if the shortage isn't properly addressed.
- Everybody being entitled to a basic package of health care sounds initially promising but it is unclear what will and will not be covered. Everything needed must be covered including expensive treatments and rare conditions if it is to be equitable. Even if packages seem comprehensive initially, cutbacks and price increases may happen as has in the Netherlands. If not everything is covered, it ensures the problem of the current "2 tier system" continuing.

Money-follows-the-patient is good but be careful. Insurance companies could put financial gain ahead of quality of care. Hospitals might too. Patients could be discharged early, develop complications and require readmission like in the Netherlands. Hospitals might treat them as a 'new patient' to get re-paid for the same person.

Beveridge/NHS type System
Some advantages:

- Nobody excluded from public health system due to lack of finances.
- Nobody locked "uninsured" out of the system.
- Nobody excluded from public system for having private insurance.
- UK NHS overall better than Ireland's current situation.

Some disadvantages:

- Like in the UK, **sustainability** could become problematic especially if future governments push for "lower taxes" and the public fail to realise that less tax = less available for public services.
- It seems inevitable that a totally public system means a private system appears, making up for gaps in the public system creating 2 tiers which is exactly what Ireland wants eliminated. It'd cause both public and private patients inequity of healthcare access eg the current exclusion of private patients from essential E112 treatment.
- Once done, it would be politically impossible to change the model if it fails because people will expect everything free and protest introduction of a Bismarkian model.

Bizmarkian Model:
Some Advantages:

- It is possible to do it in such a way that everyone is equally covered.
- If done in a manner like France, it could eliminate public/private divide and ensure

only one system exists which is a partnership of public and private funding ie public funding and staffing, small co-payments from patients/service users, levy paid by employers and contribution from private health insurers (note: these insurance companies must not provide access to services unavailable to others, they pay people's co-payments for them for a price).

Some Disadvantages

- Risk of cost at point of access being pushed up and up by successive governments like college contributions have.
- Funding can be complex.

It seems the best would be a careful combination of Bizmarck and Beveridge.

- Use a Bismarckian model where health tax is deducted at source and from general taxation, employer contributions, large enterprises, insurance companies and very small co-payments from the patient. These co-payments must not keep increasing but stay very small and be capped for individuals and households per month a bit like the current Drug Payments Scheme but also per year and at a lower price. Unlike the previously proposed “FairCare” plan, there should be <u>no limit on what is covered</u> but coverage based on need. Certain groups such as those unable to afford costs, those with serious or long term conditions, those in direct provision etc. (see note on LTI scheme) should have their co-payments covered by the state and free at the point of access so it works like an NHS type scheme for these people. These measures would ensure that no matter what their financial situation, people receive equal coverage and equal access to care.
- Like France, disallow “going private” from giving you a shorter waiting time to those “going public”. Make there be only 1 list. Use the NTPS to balance out waiting lists while transitioning to the new single tier system.
- Tax increases are necessary. Earnings over 100,000 should be taxed at 60% as a matter of principle. Let's stop being afraid and procrastinating. A number might adjust down their earnings but overall, tax raised will increase.

<u>Finance (Other):</u>

- <u>Create a Special Equipment Purchase Fund</u> outside hospitals' budgets. This will be dedicated to purchasing special, expensive equipment which is likely to be very worthwhile long term such as Exoskeleton Machines, Upright MRI etc. Hospitals/clinics/health centres etc could apply but also the Dept. Of Health should be able to apply/allocate where they see need so they can ensure resources are fairly spread countrywide. Reserve hospital budgets for running hospitals, free from other financial burdens.
- Continue full reinstatement of the National Treatment Purchase Fund as long as any private system exists. Expand for easier access, creating more equitable access to care. It must cover private treatment abroad because many people with rarer conditions are having to travel and pay.
- Financial penalisation of hospitals would be counter-productive. Hold managers accountable, not funds.
- Don't oblige providers to select cheapest option as these may be inappropriate to the patient or inefficient long term. Instead weigh up cost effectiveness long term with best patient outcomes.

- Don't introduce GP care for 6-12's. Instead introduce cheap state subsidised GP fees for all pregnant women and children up to age 12. This should be even lower than the inexpensive co-payment which should exist for all (excluding those exempt).

Staffing:

- Where shortages exist, create jobs. Initially it may cost but better conditions, outcomes, earlier intervention etc pay off.
- When there aren't enough graduates, incentivise school leavers and mature students to study in the needed fields. Work in partnership with the Dept. Of Education to “fund bomb” and vastly increase availability of these courses particularly Speech & Language Therapy. Audiology, Medicine, Occupational Therapy, Nutrition/Dietetics and Psychologist programmes.
- Oblige foreign students doing medical degrees here to intern in Ireland. This can also be part of initiatives addressing the problem of NCHDs working hours. It would also need increased nurse and healthcare assistant recruitment. Once there is an initial swell in staff, enforce shorter working hours for NCHDs and interns but don't wait for momentum to be lost. This may help incentivise people to work in Ireland and further help push doctors' working weeks downwards. Then it can extend to consultants.
- Reduce maximum doctors' shifts to 13 hours with strict rules for management in how they manage rosters. Once 13h shifts achieved, gradually reduce no. of days per week doctors work until consistent with nurses' working hours. Then graduates should serve time working here but not before conditions improve.
- More consultants for all chronic conditions. Where there is no specialist in a condition (eg Hereditary Connective Tissue Disorders), create posts for them which accept overseas applicants.
- Where impossible, have visiting clinics for doctors from abroad to see patients whose condition affects less than 100 in Ireland.
- Meet and surpass statutory requirements for hiring people with disabilities, allowing flexible and/or reduced working hours as well as other accommodations where needed.

Long Term Illnesses and Conditions:

- Revise the long-term illness scheme. In France, the equivalent scheme covers 32 illnesses and “other” so the person qualifies if their GP signs that they regard the person's condition as affecting them “seriously enough”. Base it on need.
- Do not place the responsibility of chronic illness care on GP's. GP's cannot be expected to know everything about everything. Consultants in these illnesses exist for a reason. They undertake specific training beyond what can be expected of GP's. People with chronic conditions need specialists overseeing and co-ordinating their care. Employers, colleges etc often require evidence from a consultant not GP so to take them away from consultant care compromises quality.
- Prioritise early intervention and continuous prevention of regression even if good progress is made. Avoid discharging which “washes hands of” people, leaving them without services.

Rare & Undiagnosed Conditions:

- Establish diagnostic centre for undiagnosed and rare disorders. Nobody should be left with no answers. Availability of GP and/or self referral is necessary since too often, people with these disorders are dismissed, misdiagnosed and/or denied access to investigation and care.

- Where expertise is lacking in Ireland, form relationships with experts abroad and invite them to educate workers, health system and Dept. of Health.
- Invite experts from abroad to run occasional clinics and to advise a person's whole care team on individual cases.
- Include coverage for outpatient care, consultations, reports, diagnostics and treatment where there hasn't been time for approval under the TAS/E112 and Cross Border Directive as these are all essential parts of care.
- "Undiagnosed/Unknown/SWAN (Syndromes Without a Name)" must qualify as a diagnosis for the purposes of accessing appropriate treatment.
- Ensure people who need treatment abroad are given access to it regardless of finances or whether it's public or private.

Social, Primary and Community Care:

- MUST be included under the new system of funding. Otherwise there will be no truly integrated care, a medical model prevails and social care services remain neglected and difficult to access for many.
- Dental health must be prioritised as it influences and can show information about health and ill-health. All treatments must be covered and provided according to need including check up and maintenance. Dental services must be accessible through local health centres.
- Physiotherapy services must be seen as a health speciality in their own right as important as the GP. Huge increases in the number of posts are needed.
- There must be no limit on the number and frequency of physiotherapy sessions that community physiotherapy services can provide. Community physio must provide access to long term physiotherapy and specialist physio with an emphasis on maintenance and prevention and maximisation of health for all with long term conditions. Specialist physio can reduce numbers requiring oral, spinal and other surgeries.
- Physios, dieticians and OTs should be plentiful in hospitals so that each patient staying over 24 hours is offered physiotherapy to help recovery from surgeries including minor, prevent further ill-health and injury and prevent hospital related atrophy. Dietician input should be available to all patients so that meals are suitable and healthy for them.
- There must be no limits of what aids are covered through physio and OT.
- Have seating engineers and specialist custom seating services in all OT areas.
- Allow larger wheelchair budgets so people can get the perfect wheelchair, allowing true equality and quality of life. Better wheelchairs can reduce/prevent scoliosis, pain, pressure ulcers, need for replacement etc.
- Accessing wheelchairs and aids appropriate to needs is a social justice issue
- Everyone should be invited for physiotherapy and dental assessment once per year as well as dietetic, audiology and GP assessments to promote optimum health and early intervention.

Elder People & People With Disabilities Requiring Care:

- Introduce national DEXA scanning programme to all over 50's and all who break a bone unusually easily. Falls and breaks are among the biggest, most expensive preventable health issues in over 50's.

- Physiotherapy input for all with falls or at risk.
- Stop cutting off adult services at age 65.
- Intensive initiative focusing on home based care for ALL AGES. It's less expensive long term and open many vacancies for home carers, intellectual disability nurses, paediatric nurses, nurses in palliative care, Enteral & parenteral tube care, tracheostomy care etc so that all needs are covered by home nursing & care for all hours needed.
- Hospice and Palliative care available to ALL AGES including the unborn and young adults with options for appropriate centre based and home based care available to all.
- De-institutionalisation: While community care is important, high quality, centre based care is necessary for many. Create "retirement village" style neighbourhoods with on-site services and a specialised centre where services operate from which clients can stay in too. This model can suit many older people, people with brain injuries, dementias, intellectual disability, physical disability, mental health issues etc who many have difficulty coping with "community living" so that they can live both with the independence of the community but supported with the services and shelter which a good institution would provide. People should have the opportunity for any length of stay from respite to long term.
- Prioritise early intervention and continuous prevention of regression even if good progress is made.
- Don't exclude those with diagnosis because of lack of apparent need eg "mild" Downs Syndrome, ASD etc because conditions can worsen and regress without regular appropriate intervention.

Mental Health:

- Don't be psychiatry-led. Be holistic and provide easy access to many therapies based on need not limited number/frequency of sessions.
- Like the "cancer centres for excellence", create regional specialist eating disorder units for children, teens, adults, providing inpatient and outpatient care.
- Create specialist services nationwide for people with complex additional needs including trauma, addictions, autism, intellectual disability and neurological issues.
- Have dedicated "young adult" services in all CAMHS and Adult services which overlap in the ages they serve to ensure stability of provision for this at-risk age group.
- All services available in CAMHS must be in AMHS too.
- Create dedicated CAMHS inpatient and day hospitals in every area so they can be accessed instead of adult units or insufficient intervention.

Maternity and Children's Care:

- Home & palliative: see previous section.
- Consider Connolly site for maternity hospital.
- De-centralised children's hospitals and satellite children's hospitals spread intelligently countrywide so far fewer people must travel to Dublin. These should have parkland grounds with plentiful accommodation for families. See Geography & Access.
- Most infant check up appointments should happen in the child's home so the home situation can be seen more closely with referral to support services and/or Tusla where

necessary.

- Any missed developmental check ups/appointments should be followed up with home visits.
- Include dietician and psychology visits in the child health scheme as well as eye, ear and dental.
- Remove excess “red-tape” and assign community midwives to be reachable in all (including remote) areas so that women can give birth safely at home whether by choice or unexpectedly early or rapid labour.
- Better educate midwives and public health nurses to give information and advice about breastfeeding, baby-wearing and skin-to-skin time. Employ many more lactation consultants in all communities.
- Ensure better monitoring of pregnant women who become ill or miscarry in all hospitals as per the findings & recommendations in the reports on Ms Halappanaver and the Portlaoise cases.
- Provide for termination if the woman wishes when miscarriage has already begun (likely constitutional but legislation needed).
- When pregnancy check ups fail to find a heartbeat, allow the woman choice to wait and/or seek second opinion rather than automatic appointment for accelerating passing of miscarriage.

Geography & Access:

- Intensive project focusing on transforming the neglected West of Ireland and providing comprehensive, top class services.
- Partially eliminate “catchment areas” to eliminate “postcode lottery”. Anybody needing provision not available in their local service should be allowed referral without difficulty to somewhere where it's available.
- Allow people attend nearest service even if outside catchment boundary.
- In border counties, work closely with NI on a cross-border agreement so that people can access geographically nearest services.
- Invest much more in the National Ambulance Service but leave the Fire Brigade alone. Enough ambulances can reduce need for hospitalisation.
- Create many vascular emergency units to treat and reduce the morbidity of vascular incidents such as heart attack and stroke. Particularly where larger hospitals aren't feasible. Nobody should be more than 29 minutes from these units. Create hundreds of mobile units with wait times no more than 10 minutes so that nobody's chances of recovery or survival are disadvantages by their distance from hospital.
- Create minor injury and poly-clinic centres all within a certain distance of everyone, rural and urban which deal with fractures, dislocations, stitches, cauterisations and other procedures and scans such as DEXA. This should significantly reduce A&E numbers, waiting times and somewhat reduce numbers waiting for hospital day procedures and appointments.
- Urgently consider Connolly Hospital for the new National Children's Hospital. The James's site already has dangerous, potentially deadly problems especially as Dublin city's population and traffic problems grow. The consequences are long-term. Act now before it's too late. Spacious green sites are conducive to wellness.

Environmental and Planning:

- Always investigate short, medium and long term future service impact and demands and those who will use that service.
- In partnership with relevant government departments, examine impact of nature, parkland to walk in and natural views and ensure this informs planning in <u>all</u> health and education service grounds, workplaces and residential developments.
- Legislation banning nuisance noise. Fines aren't enough, need to ban people/venues/organisations from causing nuisance, no exceptions other than construction within certain hours and emergency noises.
- Create new strict limits in social and entertainment venues to prevent hearing and voice problems and promote ear and voice health. Unreasonable volumes and frequencies are routinely used and increased This must be illegal for health reasons.
- Revise rules on healthcare products and devices in favour of environmental sustainability over price, preventing needless waste. Favour safe sterilisation and washing over disposal. Initial costs can be cancelled out over time through commitment by other departments to clean energy. Rules should be appropriate to each setting setting so relax rules when dealing with much lower infection risks with permission from service user(s) while not compromising dangerously in high risk situations.
- Commission study into the impact of anti-nomadism and other social policies and practices on Traveller health and wellbeing.

Transparency:

- Disallow health service(s) from penalising anyone who speaks out against it. Currently, a culture of fear exists. Prevention of freely speaking out means issues are insufficiently highlighted and therefore unlikely to be promptly addressed which endangers the health of the people including health staff.
- Easy complaints and disciplinary process which should be simple and with a single access point for all complaint types whether or not the complaint is eligible for investigation by the relevant professional Council.
- Appoint a Health Ombudsman for those dissatisfied with complaints outcome.
- Must be easy to make complaints about management including by staff without fearing loss of job or repercussions for staff or patients.
- Accountability must exist for all mistakes, problems and poor outcomes including ill effects on patients, mis-spending of allocated funds etc.
- Easy to access and understand records of all internal and external audits and inspections which must be available from all services on their website, the Irish health service's website and in person on request.
- Easy to access own records and with availability of advocate. Remove the "unless it may harm the person's physical or mental health" exemption this right because it's being abused to conceal incorrect records because such records "may cause distress". Refusal of right to view and legally amend records can devastate.
- Easy to access information about healthcare, care pathways and system in simple language, accessible to those with low literacy or IQ. Also provide easy access to more detailed information for those who find that more helpful.
- <u>Always listen to what staff, service users, carers, families and organisations representing them want/need.</u>

Spinal Injuries Ireland

Spinal Injuries Ireland (SII) is the only dedicated support agency for people who have become lifelong disabled through a spinal cord injury (SCI). An injury to the spinal cord can be sustained either traumatically in sport or as a result of an accident or fall, or non-traumatically, as a result of illness, such as cancer. On average, one person sustains a spinal cord injury every week and it can happen to anyone at any stage.

During 2016 the incidences of spinal cord injury have increased to almost 2 people per week, putting limited & underfunded services under further pressure.

In Ireland there are 1800 people living with a SCI, 76% of whom are unemployed and 40% live on or below the poverty line (Collins 2014). When a life changing injury occurs the consequences are felt right through the local community, the injured person, family, friends, and colleagues. SII estimates that there are 20,000 people impacted by a SCI nationally.

SII provides a pathway of support from onset of injury to inclusion in the local community through a range of services from early days advice and information for families, peer support, vocational advice, a community connect team of 6 officers who provide active support in the home following rehabilitation, counselling and regional meet ups.

In 2014 SII published the largest piece of qualitative research on what it is like to live with a SCI which involved face to face interviews with 25% of people in Ireland living with a SCI. Following this SII has carried out a number of surveys most recently in April 2016 to establish the issues with medical care for people with a SCI. In May, Spinal Injuries Ireland held 10 town hall meetings nationwide to provide a platform for this hidden section of society to voice their stress, frustration & upset at how they are being treated. This submission is based on all this information gathering during 2016.

Neurology services in Ireland have been badly impacted by austerity budgets and urgent investment is required to address the critical situation.

“Of the many forms of disability which can beset mankind, a severe injury or disease of the spinal cord undoubtedly constitutes one of the most devastating calamities in human life” -Sir Ludwig Guttman, founder of the Paralympic Games

What are the issues that people experience – Key Roadblocks identified as a result of SII nationwide roadshow - This is my Life, April 2016

- There are serious delays in admission to the National acute hospital (Mater, Dublin). There are patients waiting in regional hospitals for a bed in the Mater or some may be waiting at home causing stress to the patient and family members.

- Serious delays for some newly injured patients in accessing rehabilitation – in some cases, patients are transferred back to a regional hospital or home to wait for a bed at the NRH.

  'I was sent home from hospital with a catheter and bag without knowing what to do. I got repeated infections while I waited for a bed in the NRH and received no support from the hospital. I was shown how to manage them once I got to the NRH' **Louth**

- There are no rehab facilities in Ireland for those who need to be ventilated. These high level injuries often experience long waits to receive rehabilitation in the UK or Northern Ireland. Once rehab is completed, patients are often re-admitted to the acute hospital or to a regional hospital whilst waiting on care packages;

  'I promised my son that I would have him home by the time we reached the third anniversary of his accident. I let him down. It looks like it is happening now but I do not want any family to have to go through the pain and stress that we have endured over the last 3 years. I know I will have to keep fighting for him.' Tipperary

- Insufficient budget for homecare packages particularly for complex cases. Some young people with an SCI are living in ICU in regional hospitals or nursing homes as care packages are not available to them to live independently.

  'My parents do all my bowel care' **Sligo**

- 60% of people do not feel that hospital and medical staff have enough knowledge and experience of managing someone with an SCI. Poor SCI education can cause misdiagnosis or create additional medical issues.

  Particularly in relation to bowel and management care which is essential for people with SCI.
  40% of people are not comfortable with their bowel and bladder management at regional and community level.

  'My husband was in hospital and I had to stay with him to do all his personal care as the staff were not trained to do it' **Donegal**

  'The nurse in A&E did not understand why I had cold legs. I had to explain' **Dublin**

- Shortage and post code lottery of community services such as PA hours, physiotherapy, occupational therapy and counselling.
  54% of those with an SCI do not feel they receive adequate *counselling* in the community
  48% do not feel they receive adequate *physiotherapy*.

'You have to fight for everything – you receive no appointments or services unless you keep fighting' **Cork**

'I have been waiting 18 months for an OT appointment' **Clare**

- Limited education programmes for PA's & carers.
  58% of people with an SCI feel that their Personal Assistants/Carers do not have *sufficient training* to deal with their needs;

Examples of best practice as outlined by World Health Organisation

Many of the consequences associated with spinal cord injury do not result from the condition itself, but from inadequate medical care and rehabilitation services, and from barriers in the physical, social and policy environments.

Implementation of the UN Convention on the Rights of Persons with Disabilities (CRPD) requires action to address these gaps and barriers.

Essential measures for improving the survival, health and participation of people with spinal cord injury include the following.

- Timely, appropriate pre-hospital management: quick recognition of suspected spinal cord injury, rapid evaluation and initiation of injury management, including immobilization of the spine.

- Acute care (including surgical intervention) appropriate to the type and severity of injury, degree of instability, presence of neural compression, and in accordance with the wishes of the patient and their family.

- Access to ongoing health care, health education and products (e.g. catheters) to reduce risk of secondary conditions and improve quality of life.

- Access to skilled rehabilitation and mental health services to maximize functioning, independence, overall wellbeing and community integration. Management of bladder and bowel function is of primary importance.

- Access to appropriate assistive devices that can enable people to perform everyday activities they would not otherwise be able to undertake, reducing functional limitations and dependency. Specialized knowledge and skills among providers of medical care and rehabilitation services.

Recommendations

1. Over 500 people with a spinal cord injury attended the 'This is my life' roadshow nationwide in May 2016. There was one strong and consistent message. 'Tell us what is happening'. There would be an acknowledgement by families that there may be delays in the health service but it is the 'not knowing or not being told what is

happening' that causes the most stress and anxiety to the whole family. One quick fix would be to put a central strategic approach to case management. Spinal Injuries Ireland is willing to work in partnership with the HSE to implement this service.

2. Investment to address staff shortages and training for healthcare professionals in both inpatient and community settings.

3. Increased and ring fenced budget for homecare packages for complex cases to clear the pathway of care and free up beds at acute and rehabilitation stages.

4. Grant medical cards based on medical need, not income.

St. Patrick’s Mental Health Services

St Patrick’s Mental Health Services (SPMHS) is Ireland’s largest, independent, not-for-profit mental health service provider.[264] It is committed to the provision of the highest quality mental health care, the promotion of mental health, advocacy and the protection of the rights and integrity of those experiencing mental health difficulties.[265]

The prevalence of mental health problems in Ireland is well documented, with one in seven adults experiencing a mental health difficulty in the past year.[266] Recent studies suggest that young people in Ireland may have a higher rate of mental health problems than similarly aged young people in other countries.[267]

This submission outlines key guiding principles for the healthcare system, particularly relevant to the mental health sector. It examines the need for a rights-based strategy which adequately reflects the needs and views of all stakeholders including service users and the independent sector. SPMHS also addresses some of the key challenges in mental healthcare provision and provides concrete recommendations on the integration of care, funding models and identifies potential solutions in the form of evidence-based examples of best practice.

Recommendations

- A rights based approach to healthcare should be adopted into the 10 year plan for the health strategy encompassing the four essential elements of availability, accessibility, acceptability and quality.
- The right to good health, healthcare and mental health should be enshrined in law. Everyone should have access to basic healthcare services as a right. The exact services to which people should be entitled to access should be set out in law so that it is clear to both service providers and service users that legal obligations exist and that a right of remedy exists where these are not provided.
- Implement the *Vision for Change* recommendation that the mental health budget represent 8.24% of the overall health budget.
- Ensure access to services for disadvantaged groups
- The strategy must be rights-based with a focus on recovery.
- It must be informed by and inclusive of all stakeholders and be conducted in a way to ensure buy-in from service users and their families.

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[264] Through multi-disciplinary teams of highly-qualified mental health professionals, St. Patrick’s Mental Health Service provides in-patient and day care services to over 3,000 people each year and over 12,000 out-patient appointment based interventions. For more information see https://www.stpatricks.ie/.

[265] St Patrick’s Mental Health Services, *Mental Health Matters: Empowering Recovery 2013-2018*, (SPMHS 2014).

[266] Mental Health Reform *Submission for Budget 2016*, (MHR 2015) p.19. <https://www.mentalhealthreform.ie/wp-content/uploads/2015/07/MHR-pre-budget-submission-2016_Final.pdf> [accessed 25 August 2016].

[267] Mary Cannon and others, *The Mental Health of Young People in Ireland: A report of the Psychiatric Epidemiology Research across the Lifespan (PERL) Group* (RCSI 2013) p.7. Statistics indicate that 15.4% of children aged 11- 13 years and 19.5% of young adults aged 19-24 years having a mental health disorder.

- Formal supports for family members should be introduced for families caring for a person with mental health difficulties.
- Ensure that all children under 18 have access to age-appropriate services in a timely manner.
- Continue to educate young people on mental health issues to raise awareness of available services and to reduce stigma.
- Research evidence-based treatments using new technologies that are efficient and cost-effective that could be used in the Irish context.
- Establish a national specialist independent, advocacy service for all children under 18 years who are engaging with mental health services.
- Begin research into the types of services that may be required to address the mental health needs of an increased older population.
- Identify the challenges in recruiting and retaining staff in mental health services and take steps to address this shortfall.
- Consult with Health Service staff in relation to any proposed changes and ensure that they are sufficiently supported to carry out their roles.
- Ensure that any proposals to integrate primary, secondary and community healthcare services are informed by the key principles identified.
- Consult with SPMHS to discuss the potential for using the Dean Clinics as a best practice model for integration of primary and community services.
- The Department of Health should allocate funding to develop and deliver a comprehensive stigma reduction programme.
- Consult and engage with the independent sector to ensure service delivery in a cohesive way that responds to emerging demands and service users' needs.
- Introduce a value based system of healthcare focusing on health outcomes per euro spent. This system should be achieved by the introduction of a bundled payment model.

Key Guiding Principles for the Healthcare System

Take a Rights-Based Approach to the Healthcare System

The right to health, healthcare or mental health treatment is not clearly defined in Irish law.[268] The Convention on the Constitution made a recommendation to enumerate a number of economic, social and cultural rights, including the right to essential healthcare, in the Constitution of Ireland.[269] However, the 2016 *Programme for a Partnership Government* commits only to refer the recommendation to the Housing Committee but does not address the recommendation in the context of the right to health, healthcare or mental health treatment.[270]

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[268] This lack of clarity hinders the fulfilment of Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which requires State Parties to 'recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'

[269] Convention on the Constitution, *Eighth Report of the Convention on the Constitution: Economic, Social and Cultural Rights,* (Convention on the Constitution 2014) p.6.

[270] Government of Ireland, *A Programme for Partnership Government*, (Government of Ireland 2016).

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health has been recognised in a number of international human rights treaties.[271] The goal of a human rights-based approach is that all health policies, strategies and programmes are designed with the objective of improving the enjoyment of all people to the right to health. There are four key elements for the introduction of a rights based healthcare system; availability,[272] accessibility,[273] acceptability[274] and quality.[275]

Recommendations:

- A rights based approach to healthcare should be adopted into the 10 year plan for the health strategy encompassing the four essential elements of availability, accessibility, acceptability and quality.
- The right to good health, healthcare and mental health should be enshrined in law. Everyone should have access to basic healthcare services as a right. The exact services to which people should be entitled to access should be set out in law so that it is clear to both service providers and service users that legal obligations exist and that a right of remedy exists where these are not provided.

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[271] WHO Constitution (1946) Preamble, Universal declaration of Human Rights (1948) Article 25 and International Covenant on Economic, Social and Cultural Rights (1976) Article 12.

[272] "Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs" UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

[273] Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. This includes the principles of non-discrimination, physical accessibility and affordability. UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

[274] "All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned" UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

[275] "As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation" UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

Key priorities for inclusion in a 10 year plan for the health service

Provide adequate resourcing and develop mental health services

In 2015 mental health funding fell significantly below the recommended level contained in *A Vision for Change*.[276] Despite an allocation of €160 million between 2012 and 2016 to the development of community based mental health services and supports, progress on recruitment is slow with less than a 7% increase in staff between 2012 and the beginning of 2016.[277]

In 2015, the UN Committee on Economic, Social and Cultural Rights (CESCR) noted its concern in the Irish context at the "overall deterioration in health-care services due to significant budget cuts in public health in recent years"[278] and notably the negative impact on access to health services by disadvantaged groups.[279] *A Vision for Change* also recognises the need for extra funding in certain geographical areas of social and economic disadvantage which have an associated high prevalence of mental ill health.[280]

Recommendation:

- Implement the existing recommendation that the mental health budget should represent 8.24% of the overall health budget.
- Ensure access to services for disadvantaged groups.

Publish and implement a comprehensive new rights-based national strategy in consultation with key stakeholders outlining clear lines of accountability

Any new strategy should be rights-based and grounded in a recovery ethos. The Donabedian model of healthcare aligns with the recent approach adopted by the Office of the High Commissioner for Human Rights (OHCHR) in developing human rights indicators to measure progress on a particular rights issue.[281] Both models use structural, process and outcome indicators.

SPMHS supports the Mental Health Commission's vision of a "quality mental health service that is founded on the provision of recovery-based care, dignity and autonomy for service users".[282] To achieve this type of service and to ensure adequate accountability, stakeholders including staff,

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[276] Minister of State for Disability, Equality, Mental Health and Older People, Kathleen Lynch T.D., Parliamentary Questions, Written Answers, 6 October 2015 [34623/15].

[277] Mental Health Reform, Pre-Budget submission 2017 [unpublished].

[278] UN Committee on Economic Social and Cultural Rights, 'Concluding Observations on the third periodic report of Ireland' (19 June 2015) UN Doc E/C.12/IRL/CO/3.

[279] UN Committee on Economic Social and Cultural Rights, 'Concluding Observations on the third periodic report of Ireland' (19 June 2015) UN Doc E/C.12/IRL/CO/3.

[280] Department of Health and Children, A *Vision for Change - Policy Document*, (HSE 2006) p.184.

[281] UN Office of the High Commissioner for Human Rights, *Human Rights Indicators: A Guide to Measurement and Implementation* <http://www.ohchr.org/Documents/Publications/Human_rights_indicators_en.pdf> [accessed 25 August 2016].

[282] Mental Health Commission, *Strategic plan 2016 – 2018* (Mental Health Commission 2016) p. 4.

service users and representatives from the independent and voluntary sector need to be consulted in developing the strategy.

Recommendations:

- Ensure the strategy is rights-based with a focus on recovery.
- Ensure it is informed by, and inclusive of, all stakeholders and be conducted in a way to ensure buy-in from service users and their families.[283]

Provide better family education and supports

A Vision for Change recognises the importance of supporting carers and children of service users[284] but does not make a specific recommendation on assessing and meeting their mental health support needs. Currently supports for families caring for a person with mental health difficulties are provided on an ad hoc basis around the country by different voluntary groups such as Shine which has developed useful guidelines underpinned by the principle of providing family support to help minimise the significant adverse effect of caring for a person with mental health difficulties.[285]

Recommendation:

- Introduce formal supports for family members caring for a person with mental health difficulties.

Develop and progress the full range of Child and Adolescent mental health services

SPMHS notes that in its 2016 Concluding Observations, the UN Committee on the Rights of the Child highlighted that the full range of Child and Adolescent Mental Health Services (CAMHS) needs to be further developed to ensure that children and young people receive age-appropriate supports and are not continually placed in adult facilities.[286] In April 2016, of the child and adolescent patients admitted to hospital, only 69.2% were admitted to dedicated child and adolescent inpatient units, despite this being considered a priority issue.[287]

The 2013 *Guidelines for Mental Health Promotion and Suicide Prevention* for post-primary schools is a welcome step in addressing the need for education and awareness-raising of mental health issues amongst young people. However, it is also important to reduce the associated stigma around mental health services by taking practical steps to ensure that young people engage in the issue. For example, in this context SPMHS has developed a Transition Year programme which gives second-level students educational placements in its services.[288]

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[283] This echoes the recommendation in A Vision for Change that Service users and carers should participate at all levels of the mental health system. Department of Health and Children, A *Vision for Change - Policy Document*, (HSE 2006) p.25.

[284] Department of Health and Children, A *Vision for Change - Policy Document*, (HSE 2006) p.31-32.

[285] Shine, Guidelines For Realising A Family Friendly Mental Health Service (2014) p. 3.

[286] UN Committee on Economic Social and Cultural Rights, 'Concluding Observations on the third periodic report of Ireland' (19 June 2015) UN Doc E/C.12/IRL/CO/3.

[287] Health Service, *Performance Report March/April 2016*, p.57 <http://www.hse.ie/eng/services/publications/performancereports/marchaprpr.pdf> [accessed 25 August 2016].

[288] St Patrick's Mental Health Services, Transition Year Project https://www.stpatricks.ie/transition-year-project [accessed 25 August 2016].

Recommendations:

- Ensure that all children under 18 have access to age-appropriate services in a timely manner.
- Continue to educate young people on mental health issues to raise awareness of available services and to reduce stigma.

Harness new technology

In a 2014 report the OECD concluded that the "increased use of innovative evidence-based treatments, such as psychological treatments and eMental Health will help address the treatment gap for mild-to-moderate disorders".[289]

'Beating the Blues', a computerised Cognitive Behavioural Therapy (CBT) treatment used by the British National Health Service (NHS) to treat depression and anxiety, is a prime example of an evidence-based and effective technological intervention in mental healthcare with proven results in overcoming depression. Research demonstrates that patients report 'significantly higher treatment satisfaction' while the programme itself is also cost-effective.[290] It can be carried out through primary care services[291] while it also addresses 'the enormous need for evidence-based psychological treatment of common mental health problems in the context of a severe shortage of trained therapists to meet that need'.[292]

Recommendation:

- Research evidence-based treatments using new technologies that are efficient and cost-effective that could be used in the Irish context.

Develop advocacy and information services for children

An independent advocacy and information service exists for adults with mental health difficulties,[293] but there is no equivalent national, independent service for those under 18 years, particularly those using in-patient services as recommended by the UN Committee on the Rights of the Child in its examination of Ireland in January 2016.[294] This is a violation of the child's right to access

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[289] OECD, *Making Mental Health Count: The Social and Economic Costs of Neglecting Mental* Health Care, (OECD Publishing 2014). <http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/making-mental-health-count_9789264208445-en#page1.> [accessed 25 August 2016].

[290] McCrone, P., Knap. M.,Proudfoot & Ors. (2004) *Cost-effectiveness of Computerised Cognitive Behavioural Therapy for Anxiety and Depression in Primary Care*, British Journal of Psychiatry, 185, p. 55-62.

[291] Fox, E., Acton, T., Wilding, B. & Corcoran, (2004) S. *Service development report*: Wilding, B. & Corcoran, S. *Service development report: an assistant psychologist's perspective on the use of computerised CBT in a GP practice in Barnet* (2004) Quality in Primary Care, 12, p.161-165.

[292] S. Van Den Berg, D.A Shapiro, D. Bickerstaffe, & K. Cavanagh, Computerized cognitive-behaviour therapy for anxiety and depression: a practical solution to the shortage of trained therapists. (2004) Journal of Psychiatric and Mental Health Nursing, Vol 11, Issue 5, p 508.

[293] Irish Advocacy Network <http://irishadvocacynetwork.com/wp/> [accessed 25 August 2016].

[294] Such a service is needed to support a child experiencing mental health difficulties to know how to get the help they need and to ensure they are aware of their rights and entitlements. St Patricks' Mental Health Service established

information,[295] to be heard in decision-making,[296] and to participate fully as service users in mental health service provision.[297]

Recommendation:

- Establish a national specialist independent, advocacy service for all children under 18 years who are engaging with mental health services.

1. Key challenges to achieving a universal single tier health service

Service demand

Demand continues to exceed availability as evidenced through waiting lists for different services including mental health services. The Child and Adolescent Mental Health Services (CAMHS) waiting list is of particular concern as latest figures indicate that 9% of those awaiting treatment have been waiting for more than 12 months.[298]

It is clear that the lack of coordinated services is also impacting on service demand as in the case of one CAMHS service which has “identified that the majority of their cases require Primary Care Service such as Psychology and Occupational Therapy”.[299]

Recommendation:

- Provide the necessary resources to address waiting lists and increase efficiencies so that demand does not exceed the capacity of services available.

2. Actions needed to plan for future demographics

Ageing Population

As the number of over-65s is set to almost treble by 2046,[300] the State will need to address the increasing health needs (including mental health needs) of older people and ensure that people can

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the Youth Empowerment Service to provide an advocacy service, independently staffed, to children who are accessing its in-patient care.

[295] Article 17 UN Convention on the Rights of the Child, A/RES/44/25 (20 November 1989).

[296] Article 12 UN Convention on the Rights of the Child, A/RES/44/25 (20 November 1989).

[297] UN Committee on the Rights of the Child (2009) General Comment No. 12: The right of the child to be heard, CRC/C/GC/12, para. 36.

[298] Health Service, *Performance Report March/April 2016*, p.55 <http://www.hse.ie/eng/services/publications/performancereports/marchaprpr.pdf> [accessed 25 August 2016].

[299] Health Service, *Performance Report March/April 2016*, p.55 <http://www.hse.ie/eng/services/publications/performancereports/marchaprpr.pdf> [accessed 25 August 2016].

[300] Central Statistics Office, Population and Labour Force Projections 2016- 2046 (CSO 2013) p.33 <http://www.cso.ie/en/media/csoie/releasespublications/documents/population/2013/poplabfor2016_2046.pdf> [accessed 25 August 2016].

achieve healthy and successful ageing,[301] a concept reflected in the *National Positive Ageing Strategy*.[302]

Recommendation:

- Commission research into the types of services that may be required to address the mental health needs of an increased older population.

Integrated Primary and Community Care

Roadblocks in the mental health service

Lack of cohesive approach between statutory, voluntary and independent services

A *Vision for Change* does not recognise the important role that the independent sector plays in delivering mental health services despite accounting for almost a quarter of all mental health admissions in 2015.[303] Any new strategy must involve the independent sector.

Recommendation:

- Consult and engage with the independent sector to ensure service delivery in a cohesive way that responds to emerging demands and service users' needs.

Lack of adequate resources and staffing

In 2015 mental health funding represented 6.4% of the overall health budget. This falls significantly below the recommended 8.24% contained in *A Vision for Change*.[304]

Overall, the HSE recognises that "recruiting and retaining motivated and skilled staff remains vital for the delivery of increasingly demanding and challenging mental health services to an expanding and varying demographic population".[305] However, a shortfall in staff remains a particular challenge to the delivery of mental health services especially in relation to "nursing and medical staff".[306]

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[301] SPMHS highlights that 'successful ageing' can be 'achieved through medical, psychological and social inputs which optimise health and result in a fulfilling engagement with life'. See https://www.stpatricks.ie/blog/guide-successful-ageing [accessed 25 August 2016].

[302] Department of Health, National Positive Aging Strategy (HSE 2013) < http://health.gov.ie/wp-content/uploads/2014/03/National_Positive_Ageing_Strategy_English.pdf> [accessed 25 August 2016].

[303] Health Research Board, Activities of Irish Psychiatric Units and Hospitals 2015 Main Findings, Table 3.1.

[304] Minister of State for Disability, Equality, Mental Health and Older People, Kathleen Lynch TD, Parliamentary Questions, Written Answers, 6 October 2015 [34623/15].

[305] Health Service Executive, *Mental Health Division Operational Plan, p.22* <https://www.hse.ie/eng/services/publications/performancereports/Mental%20Health%20Division%20Operational%20Plan%202016.pdf> [accessed 25 August 2016].

[306] Health Service, *Performance Report March/April 2016* <http://www.hse.ie/eng/services/publications/performancereports/marchaprpr.pdf> [accessed 25 August 2016].

Recommendation:

- Identify the challenges in recruiting and retaining staff in mental health services and take steps to address this shortfall.

Steps needed to move to a model based on integrated primary, secondary and community healthcare

There is no definitive model of an integrated healthcare system to ensure that patients will have access to a high-quality and efficient system,[307] however, research indicates that there are a number of principles associated with successful integration processes and models.[308] These include: "(i) Comprehensive services across the care continuum (ii) Patient focus (iii) Geographic coverage and rostering (iv) Standardized care delivery through inter-professional teams (v) Performance management (vi) Information systems (vii) Organizational culture and leadership (viii) Physician integration (ix) Governance structure (x) Financial management".[309]

Recommendation:

- Ensure that any proposals to integrate primary, secondary and community healthcare services are informed by the key principles above.

Best Practice Model: Dean Clinics

SPMHS current strategy *Mental Health Matters: Empowering Recovery (2013-2018)* reinforces the organisation's commitment to the development of community based mental health clinics. Since 2008, SPMHS has established a nationwide network of seven multi-disciplinary community mental health services known as Dean Clinics. These are based on an Integrated Care model – aimed at providing a seamless pathway to integrate all services involved in SPMHS. The model is based on international evidence and recommendations regarding reducing barriers to early intervention and providing integrated services to ensure continuity of care.

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[307] J. Grant *What does it take to make integrated care work?* (McKinsey&Company 2010) <http://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/what-does-it-take-to-make-integrated-care-work> [last accessed 15/8/2016]. The author gives the example of Polikum, the largest provider of integrated outpatient health services in Germany. Its guiding philosophy is that patients should be able to obtain all types of outpatient care under one roof. At its polyclinics in Berlin, patients can consult primary care physicians, specialists, nutritionists, and other health professionals; they can also undergo diagnostic tests and have prescriptions filled citing "Die Optimierer" (an interview with Wolfram Otto), *McKinsey Wissen,*2008, Volume 19, pp.44-49.

[308] Esther Suter, Nelly D. Oelke, Carol E. Adair and Gail D. Armitage, Ten Key Principles for Successful Health Systems Integration Healthc Q. 2009 Oct; 13(Spec No): 16–23.

[309] Ibid.

The network provides free of charge multi-disciplinary mental health assessments to improve access to service users.[310] In 2013, the expansion of the community network continued with the establishment of a number of Associate Dean Clinics, where new assessments are carried out on behalf of SPMHS.

In implementing this development and the location of the clinics SPMHS recognised the need for "congregate care settings" to provide the full continuum of mental health care. The extent to which SPMHS relies on annual data and clinical outcomes data in maintaining and developing services is an exemplar of how the future of mental health care in Ireland needs to progress.

Recommendation:

- Consult with SPMHS to discuss the potential for using the Dean Clinics as a best practice model for integration of primary and community services.

Key barriers to moving to a model of integrated primary, secondary and community healthcare

Recognise stigma as a key barrier

Stigma continues to be a key barrier to the integration of services. Negative societal attitudes towards mental health issues persist with the SPMHS 2015 attitudes survey finding that 67% of respondents consider "that Irish people view being treated for a mental health difficulty as a sign of personal failure".[311] SPMHS welcomes the recognition in the *Programme for a Partnership Government* that tackling mental health stigma "will require a wider and more concerted effort across all aspects of society, not just focussed upon our health services".[312] However, a societal failure to understand the true nature of mental health difficulties clearly persists.

See Change, the national stigma reduction partnership works to address and reduce stigma, funded by a number of organisations including SPMHS. However, the initiative should be developed to become a fully funded comprehensive programme. For example, the Scottish Government prioritised action to tackle stigma and the associated discrimination faced by people who suffer from mental ill health. In 2013 it allocated multi-annual funding of £4.5 million, in conjunction with Comic Relief, over three years to the See Me stigma reduction programme and reframed it to focus on impact and outcomes rather than outputs.[313]

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[310] The Dean Clinics carry out assessments in relation to mood disorders; major depression and Bipolar Affective Disorder; adjustment disorders with low mood and/or anxiety; anxiety disorders: OCD spectrum, Social anxiety, Panic and Agoraphobia and Generalised Anxiety disorder; eating disorders: Anorexia Nervosa, Bulimia Nervosa, Binge eating Disorder and eating disorders not otherwise specified; addiction disorder; Dual Diagnosis – addiction and mood or anxiety disorders; second opinion and transfer of care assessments; psychoses; and personality disorders.

[311] St Patrick's Mental Health Service, *Survey: only 53% agree people with a mental health difficulty are trustworthy,* [press release], 10 September 2015 < https://www.stpatricks.ie/survey-only-53-agree-people-mental-health-difficulty-are-trustworthy> [accessed 25 August 2016].

[312] Government of Ireland, *A Programme for Partnership Government*, (Government of Ireland 2016).

[313] Government of Scotland, *Taking action to end stigma*, 9 August 2013(press release) http://news.scotland.gov.uk/News/Taking-action-to-end-stigma-2ed.aspx [accessed 25 August 2016].

In the experience of SPMHS, service users do not always want to receive treatment for mental health issues in the same place as they attend for treatment for physical complaints. However, the World Health Organisation has long recommended the integration of services as:

> ... primary health care services are not associated with any specific health conditions, stigma is reduced when seeking mental health care from a primary health care provider... making this level of care far more acceptable - and therefore accessible - for most users and families.[314]

Despite recommendations to improve access to mental health services through primary care, GPs continue to find it difficult to communicate with specialist mental health services.[315] However, it is clear that GPs and other primary care providers operate differently to community services so this must be taken into consideration when planning for further integration.

Recommendation:

- The HSE should allocate funding to develop and deliver a comprehensive stigma reduction programme.

Ensure buy-in from healthcare professionals

In putting in place any plan to further integrate services, staff buy-in will be essential. According to the 2014 Health Services Employee Survey, while many employees across the Health Service indicated that they were fairly satisfied in their role, 40% of those working in the HSE did not feel their work performance was recognised, while a further 60% were dissatisfied with the extent to which the Health Services value their work.[316] There were also concerns about strategy and change management[317] which will need to be addressed and managed in order to ensure staff confidence at all levels. Exposure to risk is an area of concern for staff and they must feel supported in their roles to ensure that they have full confidence in their ability to carry out their job.

Recommendation:

- Consult with Health Service staff in relation to any proposed changes and ensure that they are sufficiently supported to carry out their roles.

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[314] World Health Organisation, *Integrating mental health services into primary health care* (World Health Organization 2007) http://www.who.int/mental_health/policy/services/en/index.html.

[315] Independent Monitoring Group for A Vision for Change, *Sixth Annual Report* (HSE 2012) p.44 cited in S. McDaid, *Mental Health in Primary Care in Ireland: A Briefing Paper*, (Mental Health Reform 2014).

[316] Health Service Executive, *Health Services Employee Survey* (HSE 2014) p.11 <http://hse.ie/eng/services/publications/corporate/EmployeeSurveyHealthServices2014WrittenReport.pdf> [accessed 25 August 2016].

[317] Ibid.

Funding Model

A value based system of healthcare

A value based system of healthcare focuses on increasing value for service users which involves moving away from volume and profitability of services provided[318] and shifting to measuring patient outcomes achieved per euro spent.[319] A value based system is an effective way to contain costs as the focus is on improving outcomes. In a value based model achieving and maintaining good health is less costly than dealing with poor health.[320] Outcomes are the ultimate measure of quality of healthcare, and measurement of value should focus on how well the care delivered meets the individual patients' needs. This requires following the patient through the entire process of care, looking at medical conditions and patients holistically, and recording all outcomes of treatment.[321]

The key components of a value based healthcare system are the creation of integrated practice units,[322] measuring outcomes[323]and costs[324] and moving towards a bundled payments system.[325]

Bundled Payment System

One of the fundamental drivers of escalating health care costs relates to having no system for measuring service user's value of care.[326] Providers do not know how much it costs to deliver service user care, or how those costs relate to service user outcomes. Many participants in the health care system don't even agree on

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[318] Robert S. Kaplan and Michael E. Porter, *The Big Idea: How to Solve the Cost Crisis in Health Care*, Harvard Business Review, September 2011 < https://hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care> [accessed 5 August 2016].

[319] Michael E. Porter and Thomas H. Lee, MD, *The Strategy That Will Fix Health Care*, Harvard Business Review, October 2013 < https://hbr.org/2013/10/the-strategy-that-will-fix-health-care> [accessed 5 August 2016].

[320] M Porter, *A Strategy for Health Care Reform – Toward a Value Based System*, N Eng J Med 2009; 361; 109-112 at 109.

[321] Institute for Strategy & Competitiveness, Harvard Business School, *Measure Outcomes & Costs for Every Patient* <http://www.isc.hbs.edu/health-care/vbhcd/Pages/measuring-outcomes.aspx> [accessed 5 August 2016].

[322] This involves reorganising care delivery around medical conditions. This structure is organised around the needs of patients and involves creating facilities that incorporate all types of care needed to treat a specific condition, including outpatient, inpatient, and rehabilitative care as well as supporting services. For further information see: Institute for Strategy & Competitiveness, Harvard Business School *Integrated Practice Units, Organizing Care Around Patient Medical Conditions* <http://www.isc.hbs.edu/health-care/vbhcd/Pages/integrated-practice-units.aspx> [accessed 5 August 2016] and M Porter, *A Strategy for Health Care Reform – Toward a Value Based System*, N Eng J Med 2009; 361; 109-112 at p.110.

[323] Institute for Strategy & Competitiveness, Harvard Business School, *Measure Outcomes & Costs for Every Patient* <http://www.isc.hbs.edu/health-care/vbhcd/Pages/measuring-outcomes.aspx> [accessed 5 August 2016].

[324] Institute for Strategy & Competitiveness, Harvard Business School, *Measuring Costs* < http://www.isc.hbs.edu/health-care/vbhcd/Pages/measuring-costs.aspx> [accessed 5 August 2016]

[325] M Porter, *A Strategy for Health Care Reform – Toward a Value Based System*, N Eng J Med 2009; 361; 109-112 at p.110.

[326] Ibid at p.111.

what they mean by 'costs.' By standardising the measurement of health care costs, a determination of the value of a service user's care can be made.[327]

Bundled payments cover the entire cycle of care[328] for a service user with costs being aggregated over the full cycle of care for the patient's medical condition, not for departments, services, or line items.[329] By covering the entire cycle of care it will ensure that there is continuity of care for the patients.

For a bundled payment to maximise value it must; cover the overall care required to treat a condition, be contingent on delivering good outcomes, be adjusted for risk, provide a fair profit for effective and efficient care and should limit provider responsibility for unrelated care or catastrophic cases.[330] Implementing a bundled payment system will reward providers for delivering better value, lead to greater integration of care, hold providers accountable for achieving outcomes and result in cost reduction[331] that occurs not at the expense of quality.[332]

Examples of the bundled payment systems for consideration by the Committee are:

- The OrthoChoice programme introduced in Stockholm, Sweden.[333]
- The Maternity Pathway Bundled Payment in the UK.[334]

Recommendation:

- Introduce a value based system of healthcare focusing on health outcomes per euro spent. This system should be achieved by the introduction of a bundled payment model.

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[327] Institute for Strategy & Competitiveness, Harvard Business School, *Measuring Costs* < http://www.isc.hbs.edu/health-care/vbhcd/Pages/measuring-costs.aspx> [accessed 5 August 2016]

[328] This would include all the services, procedures, tests, drugs and devices used to treat a patient.

[329] M Porter, *A Strategy for Health Care Reform – Toward a Value Based System*, N Eng J Med 2009; 361; 109-112 at p.112.

[330] For more see: Michael E. Porter and Robert S. Kaplan, *How to Pay for Health Care*, Harvard Business Review July–August 2016 <https://hbr.org/2016/07/how-to-pay-for-health-care> [accessed 5 August 2016].

[331] Porter suggests that savings of 20-30 percent are feasible for many medical conditions. Michael E. Porter and Robert S. Kaplan, *How to Pay for Health Care*, Harvard Business Review July–August 2016 <https://hbr.org/2016/07/how-to-pay-for-health-care> [accessed 5 August 2016].

[332] Ibid.

[333] This resulted in a 17 percent reduction in cost and 33 percent reduction in complications over two years. Michael E. Porter and Robert S. Kaplan, *How to Pay for Health Care*, Harvard Business Review July–August 2016 https://hbr.org/2016/07/how-to-pay-for-health-care [accessed 5 August 2016] For more see: Institute for Strategy & Competitiveness, Harvard Business School, *Move to Bundled Payments for Care Cycles* < http://www.isc.hbs.edu/health-care/vbhcd/Pages/bundled-prices.aspx> [accessed 5 August 2016].

[334] OECD, *Maternity Pathway Bundled Payment, Country Background Note: United Kingdom (England),* May 2016 https://www.oecd.org/els/health-systems/Better-Ways-to-Pay-for-Health-Care-Background-Note-England-Maternity-pathway-bundled-payment.pdf [accessed 5 August 2016].

Súil Eile

I am part of a campaign for Universal Healthcare in Ireland and have experience of working in the health services in Ireland and in other countries. As part of our campaign for Universal Healthcare we have researched health services and systems in other countries and also looked at how health services are developing policies and plans to meet the significant challenges facing all health services in the future.

Ireland has a two tier health service in which the private and public sector are competing for resources both financial and human and in which there is significant duplication of assets and resources. Furthermore, the health insurance sector is growing, private health services are creeping into emergency medicine and senior care as well as elective procedures. There is an increasing creep also of those working in the public sector into the private sector. Moreover, there is very little regulation in the private sector and the private insurance bodies are remiss in their lack of monitoring or evaluation of the services for which they pay, or rather the procedures and services for which the public who have taken out private health insurance pay.

Too often approaches to addressing the issues of the weaknesses in the health services and systems in Ireland focus purely on the public system or the HSE whereas we must focus on both the public and private in order to being in a more equitable health service that has the necessary resources across the spectrum of prevention, primary and community services and acute and aftercare services. Maintaining a focus on the public health services and systems is easier than confronting the private system and the vested interests at play including in the medical profession, the nursing profession, pharmacists and other allied health professions.   Maintaining a focus on the public system also ignores the party political politics at play which for years has studiously skewed the discussion on health services.

It is a nonsense that each time a new government is formed they tinker around with the public health services but do nothing about the private system or private health insurance industry except of course what happened over the past five years in ensuring that there was an increase in PHI policies to attract more people to take out PHI but with policies that may have initial low premiums but have very high co - payment costs which virtually make them useless.

We are very supportive of the work of Professor Charles Normand, his research and writing on the introduction of Universal Healthcare in Ireland and believe that his approach illustrates a plan which is worth careful consideration and debate by all. Professor Normand also makes the point that leadership is a key component of introducing Universal Healthcare and we hope the report drafted by the Oireachtas Committee will demonstrate this leadership in not only producing a report but also describing how a system can be put in place to ensure it will be implemented.   It is a challenging and mammoth task to change and improve our health services so that we have equitable one pathway universal healthcare but it is achievable. Many countries have done so, the most recent are those who have recently accessed the European Union which though starting from a different base to us are useful models and one of their key success factors was that of leadership.

Alice O' Flynn
Súil Eile Consultancy

Tom Beegan & Associates

The purpose of this suggested Integration Plan is to provide an outline of the information necessary for the **Committee on the Future of Healthcare**, to make a recommendation on implementing a more integrated and collaborative approach in the management and delivery of Disability service's.

Significant system change is now required to address the concerns identified in past reports and to make sure the Disability sector is agile enough to anticipate and respond to current and future needs. The Boards, CEOs and staff of the current Agencies together with the H.S.E. need to show leadership, courage, and foresight in crafting the strategies necessary to implement this change and in making the progress required to meet the individual needs of people with a disability.

The Voluntary sector has made and will continue to make a major contribution to the overall development of services to people with disability in Ireland. Many services owe their existence to the work of parents, friends, religious groups and volunteers. We must acknowledge their ongoing hard work and celebrate their achievements and success in building the current level of services.

The current structure within the system and funding model of services makes it difficult to shift existing resources from current arrangements to where a need for more system intervention is required. The quest for greater efficiency, quality of service and integration of Agencies is rooted in the operational and financial management challenges faced by the Health care system and the recommendations as set out in:

The Time to Move On from Congregated Settings, Report (HSE 2011). The Disability Policy Review and subsequent Implementation Framework published by the Department of Health. New Directions – Personal Support Services for Adults with Disabilities Report. *National Quality Standards: Residential Services for People with Disabilities (H.I.Q.A.) Lansdowne Road and other National Agreements, recommendations and Internal Audit reports, to name but some.*

It is also evident that with over 380 service providers having a total of €1,2b (approx.) in 937 service/grant agreements, an unnecessary level of fragmentation, duplication and non – value adding activity is current within the system. To the service user the current system is complex, difficult to access, lacks consistency, is not sufficiently integrated in planning or service delivery and requires significant navigation to secure service provision. To address these issues and the need to implement better value for money, accountability and transparency, a re-alignment and consolidation of the system is required.

Consolidation within the H.S.E Funded Disability Agencies:

A realigned structure would place several complementary service providers within a single service provider thereby reducing the number of Agencies needed to service people with disabilities.

The combining of several Agency Boards, their administration and management within an Agency will allow for the reinvesting of savings made to provide better access to specialized services and greater flexibility in allocating resources where most required.

The consolidation of existing agencies and the integration of back office support functions will provide:

An opportunity to significantly increase investment in front-line services by reallocating savings from reduced management/ administration.
Extended service to areas where there is unequal access as determined by need.
Provide service users with continuity in services provision through better integrated planning and innovative service responses based on individual need.
Greater accountability achieved through revising the current Governance Framework.
Implementing good corporate governance, including the revised service/grant agreements,
Eliminate unnecessary duplication and non-value for money activity
Provide the sector with a scalable I.T. infrastructure
Generate policies to reflect the new relationship between Agencies, H.S.E., D.O.H, its system partners,
Allow for a new funding model to link performance and activity with stated H.S.E. and Department of Health policies

The establishment of a **Due *Diligence Team*** to:

Better understand the current cost structure.
Assess the potential for future savings.
Identify opportunities that exist to leverage the existing system capability and capacity to meet identified need.
Identify opportunities to enhance service delivery integration and support across Agencies.
Do an inventory and assess Agencies current assets and systems in use from an IT, HR, Finance and business process perspective.

The complexity of this change and integration, involving independent agencies, their limited resource capacity in some cases, will mean that Agencies will need the active encouragement, direction and participation of the H.S.E. in the process. It will require a facilitated and negotiated approach towards such change and integration of the services. It is the mandate and obligation of the H.S.E. to promote integration opportunities that enhance both the client experience and achieve greater value for money.

The current challenges do provide a unique opportunity to integrate services within the broader range of services provided in a region. It is expected that these integrated “ models of services” available in a region will not only improve ease of access and navigation to person led, needs driven services for people, but will leverage existing local governance, management, back office support(e.g., IT, scheduling), volunteerism and fund raising organized by Agencies.

The movement toward consolidation of services is seen as preferable for people over models that foster single, stand-alone service provision. These consolidated services would supplement, not supplant, existing services provided. To find opportunities to integrate services and in doing so improve the quality, cost effectiveness and range of such services may seem straight forward. However efforts to uncover and implement viable options will need to move beyond collaboration, cooperation and knowledge transfer and to deliver structural reform.

Guiding the Integration Process:

Agencies can integrate in several ways.

Coordinate services and interactions between different Agencies through a centralised, co- managed facility, which provides a range of back office/ support services in finance, H.R., I.T., transport, maintenance, purchasing and direct services to users.

The options available for a centralized model are:

The H.S.E shared services to provide such a service with service users input by means of an Advisory Committee to comment on quality and adequacy of services provided, or
An out sourced service provider for all or part of functions identified, or
The creation of an entity with elected Directors from its users, to provide such a service.

Formal *Partnership with another Agency in providing services that are more comprehensive and serve a wider range of service users*.

In "partnering" arrangement's for the provision of a service the relationship of the participants is established and is subject to applicable laws. A written contract that sets out the terms and conditions of the "partnering" arrangement is required. The contract should set out the mandate, accountability, decision making process, and dispute resolution process, conduct of affairs and rights and responsibilities of each participating health service provider.

Transfer, Merger or Amalgamation of Services, Operations of Entities.

In their most general sense, the terms "transfer", "merger" and "amalgamation" of services, operations or entities refer to some form of integration of services. In the current context, integration might take the form of:

Amalgamation: This involves a statutory amalgamation of two or more Agencies, who have the same or similar objects and who continue their operations as a single corporation under the terms and conditions of an amalgamation agreement. Upon amalgamation, the newly amalgamated entity has all the rights and assets, and is subject to all the debts and liabilities, of the amalgamating Agencies. The amalgamating Agencies automatically cease to exist. One of the most significant areas for discussion in an amalgamation is the establishment of a new governance structure for the amalgamated Agency.

Transfer: This involves a transfer by one Agency of some or all of its assets to another. The transfer could be preceded by the incorporation of a new or existing corporation to which the assets are transferred. The transfer could also be followed by the winding up or dissolution of a transferring Agency. That is they cease providing services, dissolve or wind up the operation and transfer all resources to another Agency.

Suggested Principles.

All parties recognise at the start of this process that specific details, strategies and tactics supporting this integration process, will evolve and that the principles suggested are foundational guides subject to revision in light of the experience gained and progress made. They also recognise National policy and in no way limit the legal authority of the H.S.E. or that which is contained in company law.

The following is a set of suggested foundational principles to guide the integration process, dialogue and outcomes. These principles will be put forward for discussion and agreement, at a working session for all Boards of Directors and their C.E.O. which will be organised to commence this process.

Vision for Services:

We will provide person focused needs driven services that are rights based, flexible, accountable and cost effective and that actively promotes the voice of and social inclusion for service users in the communities where they live.

Client Centred:

The integration process will be guided and motivated by a continuous focus on National and International standards and on how to best to meet the individual needs of service user. Restructuring is required for services to be more responsive, efficient, inclusive, empowering and life enhancing.

Quality Service:

Efforts will be made by all parties to minimize service disruptions during this process and to provide consistent standards and high quality services to clients throughout the regions. Accreditation to H.I.Q.A standards is the recognized standard of excellence in residential care as are the soon to be published standards for day services and other recognised 3rd party auditing systems. Results of all audits will be made available to service users and members of the public.

Accountability and Transparency:

Agencies that receive state funding will have in place the systems and protocols to ensure full accountability and transparency on a standardised basis, for all revenue received and the services provided. This will be set out in the service level and grant agreements. Value for money will be achieved by reducing the overall cost of providing the service, making it financially more efficient and redirecting scarce funding away from unnecessary overhead. Duplication of management and administrative functions will be restructured with resulting savings reinvested in front line support services.

Access:

Access to services is determined based on assessment of individual need and not constrained by geographical location or individual needs or means. Service users will have easier access to complimentary services from the same agency. Individuals will have access to the support required to assist with informed decision making and in using existing resources in new and innovative ways to maximise the achievement of their goals.

Governance:

The Boards of Directors, staff and service users, of each agency will be encouraged to take an active role in the consultation, planning, timing and sequencing of the planned service improvements. Boards of Directors must act in the best interests of their respective Agencies and ensure that it is managed, operated and administered prudently, diligently and in full compliance with its funder's requirements, its financial, regulatory and legal obligations. These governance duties are guided by national policies, funder's requirements, and owed to the people for whom the Agency was established to serve, its staff and the wider community.

The factors that can lead to success are categorised into four main headings. They are:

1. **Leadership:** leadership, Governance, and clarity of vision among Agencies.
2. **Risk Assessment:** Community acceptance, adequacy and sustainable funding, and human resources
3. **Enablers:** Clear communications strategy, content expertise, conflict resolution, and documented accountabilities.
4. **Results**: Evaluation process and outcomes.

***Leadership:** leadership, Governance, and clarity of vision among Agencies.*

Criteria	Definition	Rationale
Leadership	Successful integration is dependent on the involvement of visible, strong and cohesive leadership throughout the integration process. Leaders in a back office integration activity are individuals with the ability to affect changes toward the desired end state of the integration activity. Leaders must have the capacity, tenacity and authority to steer the initiative to completion and change course when necessary.	Change starts with a champion or change agent with fundamental qualities of effective leaders: motivating, visioning, empowering, and managing.
Governance	The responsibility of making decisions on integration activities. The Governance body is held accountable by the community it serves for those decisions.	Governance is critical within an environment that promotes collaboration and integration across agencies and integration across agencies. In-ward looking, risk-adverse boards will be challenged in preserving integration opportunities. Conversely, boards not committed to the organisations vision and mission may be taken off course through poorly planned and executed integration opportunities. For integration to be a success, boards must possess the capacity to: ▪ Work effectively with management in setting clear goals for the organisation. ▪ Measure and monitor the organisations impact on the community, puts it trust and reputation. ▪ Monitors the organisations performance through established

		indicators. - Effectively ascertain the organisations capacity to implement an integration strategy. - Build strategic relationships/partnerships on behalf of the organisation.
Clarity of Vision Among Agencies	Partner agencies share a common understanding of what the initiative is attempting to achieve, of the positive benefits the change is expected to achieve, and the underlying values.	The partnership agencies must be able to clearly articulate the vision of the integration activity by describing the end-state. Included in the description of the benefits, challenges and opportunities for the integration activity, within an overall strategy on how the end state will be achieved provided.

Risk Assessment: *Community acceptance, adequacy and sustainable funding, and human resources*

Criteria	Definition	Rationale
Community Acceptance	Community is defined as clients, their families, volunteers and the community at large. Collaboration with and involvement of as many of those affected by the change as early as possible and on an ongoing basis.	Agencies will have defined the benefit to the community in the proposal and communicated it as widely as possible.
Adequacy & Sustainability of Funding	The integration initiative should assess the need for the allocation of designated resources to support and coordinate the transition activities.	The current funding base of the participating agencies should be sufficient to support the integration activity. Any funding request must clearly demonstrate the need for funding to support the integration activity. The participating agencies need to demonstrate support for the integration activity from other sources of funding.
Human Resources	Human Resources is the function within an organisation that focuses on recruitment of, management of, and providing direction for the people who work in the organisation. Human Resource Management is the organisational function that deals with issues related to people such as compensation, hiring, performance management, organisation development, health and safety, wellness, benefits, employee motivation, communication, administration, labour relations, and training. The term labour relation is intended to include unions.	Agencies must develop a human resource plan that describes the impact on staff as a result of the integration activity. The human resource plan should be clearly articulated to all staff and unions and should be a focus from the beginning.

Enablers: *Clear communications strategy, content expertise, conflict resolution, and documented accountabilities.*

Criteria	Definition	Rationale
Clear Communication Strategy	A communication strategy outlines who, why, what, when and how of information regarding the integration activity. The following questions should be considered in the development of the plan; ▪ What information needs to be made known? ▪ What are your objectives? ▪ What stakeholders would be interested in this knowledge? ▪ What are the needs of these stakeholders? What elements of your knowledge are most interesting to them? ▪ What communication tools do you want to use for these various target groups? ▪ What is your timeframe? ▪ What financial and human resources are available to you? The integration initiative is dependent upon ongoing communication that is varied, factual, open, honest, timely and preferably face-to-face.	A communication plan must be in place before initiating the integration activity (both internal and external). The plan must identify the stakeholders to receive information on the integration initiative. The plan must also include the timing of release on information and draft communiqués containing information on the integration activity. Clear on-going communication at all levels within the organisation, and with external partners and the community is key to the success of any integration activity.
Content Expertise	Use of a skilled facilitator with knowledge of the relevant subject matter as required to guide the implementation of the integration initiative towards the desired future state.	Subject matter experts are required to move the integration process forward. Experts provide added value in their area of expertise. Participating agencies must agree on the subject matter expert. For example, if the integration activity involves the sharing of information technology, an IT expert is necessary to advise the participating agencies on software options. There is a separation between content and decision making. For example, the presentation of software options is the responsibility of the content expert. The decision making or selection responsibility rests with the H.S.E. on receipt of a proposal from the Planning Team.
Conflict Resolution Process	Conflict resolution is a process that is defined to identify and resolve disputes between parties. In any integration activity, conflict (or disagreements) may arise during the planning and the implementation phase. Resolution techniques may encompass many different methods, with differing degrees of empowerment, neutral intervention, timeliness and cost. The	A conflict resolution process should be agreed upon by all parties involved in the planning and implementation of the integration activity, and should be formally articulated through the written agreement.

	process must be defined early in the planning phase of the integration activity.	There should be several levels of conflict resolution, beginning with the parties who are initially in conflict with one another. All conflicts and the steps taken to resolve them should be documented.
Documented Accountabilities	Statement of what the integration initiative is trying to accomplish and the responsibility and commitment of the partner agencies. A formal Board resolution by the Agencies involved to the effect that they are willing to enter discussions on the Integration process.	A memorandum of understanding among the participating agencies outlining the end-state and process to achieve it should be developed and signed by each participating agency. The roles and responsibilities of each participating agency as well as the resources each is contributing to the integration activity should be articulated in the agreement. The agreement will also outline the implementation of each of the due diligence criteria.

***Results**: Evaluation process and outcomes.*

Criteria	Definition	Rationale
Evaluation Process	An ongoing process to help measure how effective the initiative is in achieving the intended outcome. Indicators are used to measure short, medium and long term outcomes.	Identified metrics to evaluate process, outcome and long-term impact of the integration activity.
Outcome	A measurable benefit of the integration activity will be: Person focused effective, efficient services that are easy to access and are Value For Money. Improved navigation for service users through the planned continuum of individualised support services that they require. Quality of services provided are ensured through audits and the formal inclusion of the voice of service users in all services provided. Fewer and more aligned Agencies providing better services. Re-investment of efficiencies realized into front line services.	Documentation of the results of the integration activity. This may include efficiencies, savings and redeployment of savings to front-line services, the opinion of service users.

Items for consideration by the Integrated Planning Teams

The Principles outlined in this document will guide the process and outcomes and will be used to test options and ideas throughout.

__The foremost principle should be a focus on the client and how best to meet their needs while paying due attention to the following:__

Recognize and plan for the "emotion" of stakeholders when faced with integrating a longstanding independent community service. The emotion is based on a deep rooted and often personal attachment to the service, its community history and its creation by volunteer's to fill gaps in service provision.

Formalize the process – Ensure everyone on the team and their respective sponsors agree to the scope of the exercise. Manage the integration activity using basic project management best practices and tools wherever possible and include a change management strategy in the plan.

Boards of small service providers may not have a full understanding of their fiduciary responsibilities – it may be necessary for the Planning Team to help the Boards better understand their roles and responsibilities as they apply to integration.

The Integration Plan is a formal document that tells the story of why the integration is occurring, describes the "current state", identifies and analyses options, describes the "end state", and the risks, activities, processes and responsibilities to transition to the end-state. The Integration Plan demonstrates that due diligence has been performed and it provides the information necessary for the Boards of Directors of all organizations to make an informed decision about the integration.

Engage stakeholders and communities at the appropriate time based on the time available. Be prepared for criticism on the process, level of engagement undertaken, end state integrated service – not everyone will support what is being proposed.

Communications resources are part of the Planning Team and will ensure appropriate communications methods and tactics are employed.

Ensure all communications are coordinated and agreed to and are on message – the H.S.E. is likely best positioned to coordinate all communications on behalf of the team.

Take input willingly but always understand the source and the perspective from which it is given – it is not necessary to act upon all input especially if the input is inconsistent with the broader strategy and the principles that have been established at the onset of the process.

Operational and financial due diligence of the "current state" is key to understanding the options available and conducting a legitimate analysis of all possible options for integration. The preferred model for the integrated service should meet the needs of clients and be aligned with the priorities and aims of the H.S.E.

Establishment of good collaborative working relationships between the parties is a key factor to achieving a successful integration of services. The role of the chairperson and facilitator is vital in this regard.

Volunteer based services providers recognize that the volunteer – client relationship is a key success factor to ensuring the services are integrated in a way that retains the commitment of the volunteers and does not disrupt the service to clients.

The Integration Planning Team

It is proposed to establish a Planning Team to engage with Agencies under the direction of the National Integration Project Office, for the following categories:

Those Agencies that have a National reach and operate in more than one region and are in receipt of funding from the H.S.E. greater than €10m. (One Integrated planning team)

Appendix A

Agencies that operate in one region. (One per region, four in Total)

Suggested Criteria for use to select possible agencies that would benefit from a formal alliance, consolidation or merger:

More than one, service provider, in the same geographical region, providing a similar range of services.
>6% of overall budget spent on back office management/ administration.
Current status as either S38 or S39.
Will provide continuity and enhance the service offering to service users.
Will provide access to services and staff competency, not currently available within an Agency.
Will address, a current or pending governance, or service delivery gap, within an Agency.
Will address a pending retirement or vacancy at C.E.O. and or senior management level.

Role of the Planning Team

The work of the Planning Team will focus on identifying cost effective, client centered solutions for the design of an integrated disability service, identification of activities to transition the services to the new model, identification of strategies to mitigate risks and liabilities and identification of communications and community engagement strategies to inform stakeholders about the integration.

This Plan will include:

A description of the "current state" and the required new structure, process and the range of services to be provided;
Details on how the services will be delivered and who is responsible for delivering the services;
Details on the activities and timelines to transition the services from the current arrangements to the new integrated model.
Actions/measures to address any outstanding liabilities and risks associated with or uncovered during the planning process.
An accompanying Communications and Community Engagement Plan.

Scope:
The Integration Planning Team is concerned with the planning and implementation of systems and activities to support a facilitated integration of Disability services currently provided by various independent Agencies into a model of integrated services that are more responsive, effective, efficient and greater value for money.

What is in scope?
Consider all related services currently provided by Agencies funded, in full or in part, by the H.S.E. to identify opportunities for the elimination of duplication and significant cost reduction in the management and administration of such Agencies.

Take full consideration of the recommendations of the various reports on the sector and the requirements as agreed through the Croke Park 2 process.

Financial, H.R. status and due – diligence on all operations and the identification of all sources of costs and revenues.
Liaise with other organization and service user's representatives to clarify information, test planning assumptions and receive feedback on proposed actions/measures.

Propose solutions, including mergers, transfers and partnering arrangements, for the elimination of duplication and the significant reduction in the management and administration of such Agencies.

Propose best practice in the governance, management and operations of Agencies funded by the H.S.E.
Identify the risks and service gaps in current offerings of services provided and propose solutions within the current financial framework and the proposals for greater integration of services.
Identify improvements required in the planning, coordinating, delivery and the Auditing of services provided.

Devise a communications and community engagement strategy.

Devise the Integration **Implementation** Plan that includes the creation the new model of services integration, timelines, responsibilities, within the notified ongoing operating budgets.

Recommend the Integration Plan to the H.S.E. and the Boards of Directors of the each Agency involved, within the timelines set by the H.S.E.

Oversee the Implementation of the plan.

The Integration Implementation plan should be completed within three months of the Planning Team commencing its work.

The Planning Team does:

Have the authority to share information about organizations services, governance, management and operations.
Have the authority to recommend plans and actions associated with the integration of services.
Have the Authority to establish working groups as to explore specific issues related to the integration of services (i.e. legal, H.R. I.T. etc.).
Not have the authority to approve the Integration Plan as this is reserved for the H.S.E. in consultation with the Boards of Directors of each organization.

Membership:

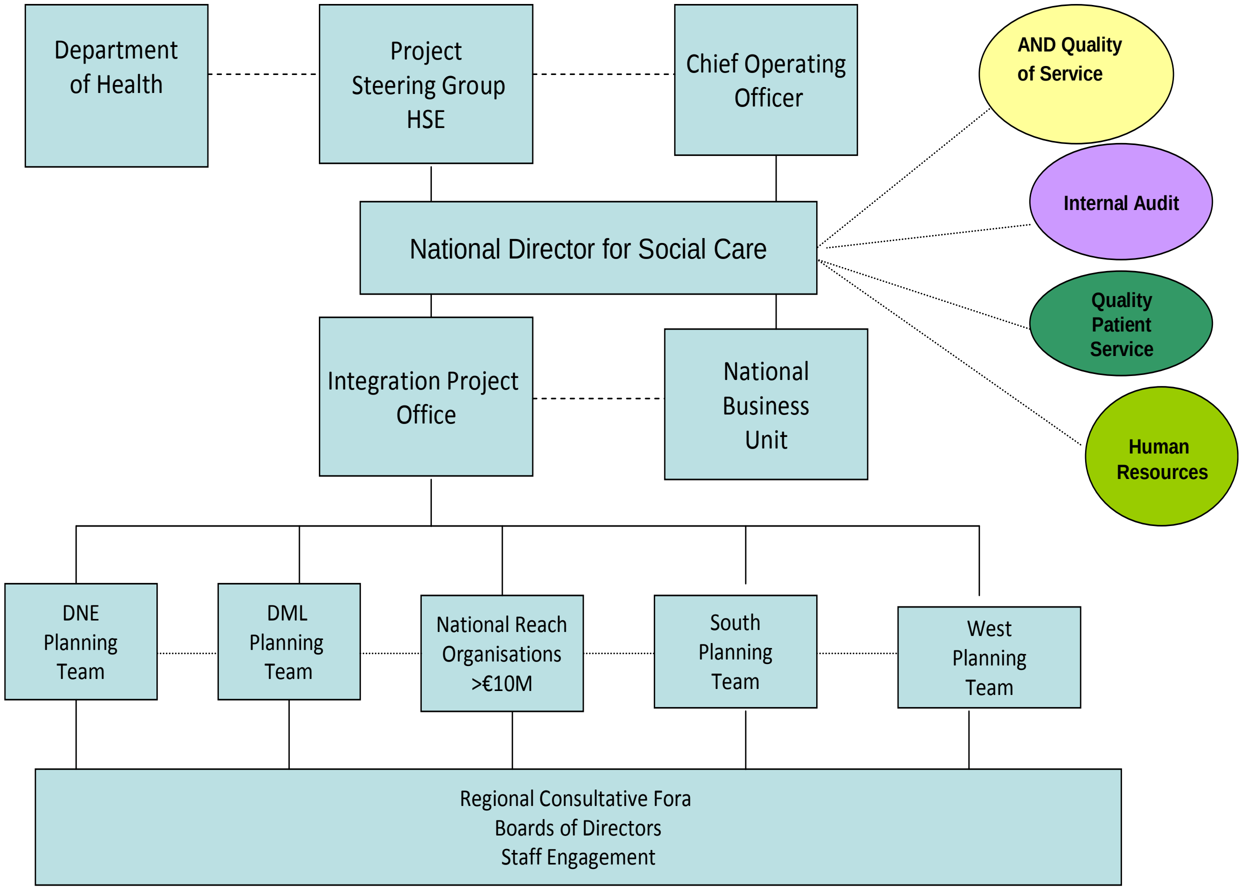
The Planning Team membership will be composed of senior managers from the H.S.E., and representatives from a cross section of the Agencies identified. Membership will reflect the expertise required to successfully complete the plan and its implementation. (i.e. Finance, Senior Service Manager, H.R., Governance, Service Policy, Service user advocate and communications) and will be nominated as a result of the joint working session of Boards of Directors.
The appointed chair (by the H.S.E.) in conjunction with an external facilitator will determine the dates, time and location for meetings together with approving the Agenda.

To commence this process, a joint working session will be held with the representatives of the individual Boards of Directors, their C.E.O. the H.S.E. and the D.O.H. At this working session the case for change, the process to facilitate the creation and implementation of the various integration plans and the expectations of the H.S.E. and D.O.H. will be presented. The participants will have the opportunity to discuss, in groups, their views on the case for change, their hopes for the future, together with their suggestions for inclusion in the discussions of the planning teams. They will also agree on their representatives to the various Planning Teams.

The outcome of this working session will be:

Agreement on the process to follow.
Agreement on the timeframe to approve the various Integration Implementation Plans
Suggested themes for consideration by the planning teams.
Nominations to the various Planning Teams.
The date on which the Integrated Implementation Plan will be presented to this group.

Diagram of the Integration Planning Teams.



Activities and Milestones	Target Dates 2017
Establish the Transition Team, in NBSU, regional dedicated contact staff, to guide 2013 S.L.A. and Grant Agreements	April 11th
Steering Group approves Guiding Principles and engagement approach to establish Planning teams, their mandate and timeline to produce their Integration plan. Steering Group approves Communications Plan	April 12th
Commence SL/Grant agreement process	April 16th
Commence Due- Diligence process with on-line survey and work with transition Team.	April 16th
Organise and hold joint working sessions for Boards of Directors' and their C.E.O.'s of National Reach Agencies and those in receipt of <€10m funding from H.S.E.	April 23rd
Organise Regional joint working sessions for Boards of Directors and CEO's of Agencies that operate within the current regional structure of the H.S.E.	April 24th, 25th, 26th 29th.
Commence , National Reach, Planning Team meetings	May 7th
Commence, Regional Planning teams meetings	May 8th, 9th, 10th, 11th.
Complete signing of S.L.A's with National reach Agencies	May 15th
Complete signing of S.L.A/Grant agreements with all Agencies	May 17th
Receive National reach Planning team report	July 16th
Receive Regional Planning Teams Reports	July 19th
Approval of Implementation recommendations by H.S.E.	July 30th
Commence Implementation of recommendations	September 3rd

The Community Platform

The Community Platform
c/o EAPN Ireland, 100 North King Street, Smithfield, Dublin 7, Ireland;
Phone: +353 (0)1 8745737
email: communityplatform@eapn.ie Website: www.communityplatform.ie

Six Principles for an inclusive Health Policy

1. The State takes responsibility for delivering the right to a high level of health and wellbeing for all. All social, economic and environmental policies will promote this right by identifying and addressing the social determinants of health across all Government Departments and policy through undertaking health and health equity assessments.

2. Adequate resources are available to develop a universal, publically funded healthcare system, free at the point of access.

3. A fully functioning primary and community healthcare service is a core part of the health system and the first point of contact for most people.

4. Everyone has equal access to high quality healthcare. This should be regardless of socio-economic status, gender, civil or family status, sexual orientation, religion, age, disability, race or membership of the Traveller community. There should be a requirement to pay particular attention to groups or sections of society where health and wellbeing is below that of the rest of the population.

5. Everyone is able to participate in the design, implementation and evaluation of all health policies and programmes and be empowered to claim and enforce their right to health and wellbeing. Members of groups experiencing the highest levels of health inequalities and their organisations will need particular supports to achieve this.

6. The State defines its responsibilities in relation to the health of people beyond its borders, including through:
- pooling and allocating resources to health;
- ensuring adequate investment in research and development; and
- not harming the health of people in other countries (for example, as a result of pollution and climate change).

The Community Platform is a network of 29 national networks and organisations in the community and voluntary sector working to address poverty, social exclusion and inequality.

Why these 6 Principles are essential for Ireland's Health Policy?

The Community Platform members represent a wide range of groups and communities, many who experience poorer levels of health and lower levels of wellbeing than the general population.

The Community Platform believes that health policy must address the causes and costs of poorhealth for those experiencing poverty, social exclusion and inequality and ensure equality of access to all forms of health care.

We support the Government's commitment to reduce health inequalities outlined in **Healthy Ireland***:*
'Health and wellbeing are not evenly distributed across Irish society. This goal requires not only interventions to target particular health risks, but also a broad focus on addressing the wider social determinants of health-the circumstances in which people are born, grow, live, work and age-to create economic, social, cultural and physical environments that foster healthy living.' (p.7)

Healthy Ireland presents the Government's vision:
'A Healthy Ireland, where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone's responsibility'.
The Platform's members agree that the six principles are essential to ensuring better health for all and more inclusive health services.

Health as a Human Right

The Irish Government has signed a number of important international commitments to upholding the right to health, but these are not reflected in current social and health policies.

The United Nations Universal Declaration of Human Rights adopted in 1948 says that *"Everyone has the right to a standard of living adequate for the health and wellbeing of himself (and herself implied) and of his family*." **The International Covenant on Economic, Social and Cultural Rights** further states that everyone has the right to '*the enjoyment of the highest attainable standard of physical and mental health*.' All states are obliged to take steps to realise the right to health and cannot use straitened economic circumstances as an excuse not to do so.

All states are expected to implement this right, taking account of the availability of resources and their stage of development. Ireland has also signed up to the **European Social Charter** which says that members must take appropriate measures to:

1. remove as far as possible the causes of ill-health
2. provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health
3. prevent as far as possible epidemic, endemic and other diseases.

The **Charter of Fundamental Rights in the European Union Treaties** says: *"Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities."*

Delivering the Right to Health

However the right to health is currently being denied to many people in Irish society.
· Travellers experience low life expectancy and high rates of mortality in Ireland. Life Expectancy at birth for male Travellers has remained at the 1987 level of 61.7 years, which is 15.1 years less than men in the general population, representing a widening of the gap by 5.2 years. Life expectancy for females is now 70.1 which are 11.5 years less than women in the general population (All Ireland Traveller Health Study, 2010).
· 40% of Irish people have limited health literacy (EU Health Literacy Survey 2012).

This means that four out of ten Irish adults who use health services have difficulties understanding and acting on health information such as following instructions on medication labels and fully understanding consent issues.

· While the use of sign language interpreters is recommended in National HSE Guidelines, it is common for Deaf people to experience health services without interpreters. In the first half of 2016, Sign Language Interpreting Service received 201 'Access cases' where Deaf people reported significant barriers in accessing services. 2 out of 3 of these (64%) related to health contexts.
· For people living in rural areas the cost of accessing specialist care is higher as there are extra costs incurred such as travel costs, cost of caring and in some cases cost of

accommodation.

We need fundamental changes in policy to deliver the right to health for all and to end the scandal of inequalities in health and health care in our society. These include:

· **Replacing the current two-tier health system with a single-tier, equitable system free at the point of access**

There are different services and waiting times for people with private or public access. The fact that the 40% of the population with private health insurance can push past others in the queues is unacceptable. Examples include:

- public patients face a wait of up to 480 days for important tests to diagnose cancer;
- waiting times for MRI brain scans were estimated to be on average 20 times longer in the public system than the private; and
- the difference in average waiting times between public and private systems for abdominal and pelvic ultrasounds is 70 days. The Medical Card scheme is unfit for purpose and leaves many vulnerable patients without adequate care and support. The current system is meant to avoid 'undue hardship' butdoes not operate in the best interests of wellbeing and equity. People who have medical cards have to pay prescription charges of €2.50 per item up to a maximum of €25 per month (€20 from March 2017).

· **Prioritisation of Community & Primary Health Care** should be reflected by restructuring the budget allocation, from a bias towards secondary care to at least 35% of the noncapital healthcare budget to community care. This is the most efficient and effective way to move towards preventing illness. It is also more accessible and results in more equal outcomes for all members of society.

· **Identifying and investing in removing the causes of poor health and health inequalities.**
This would include incorporating the right to health in housing, welfare, education and related policies. This would result in better health outcomes and save future resources to address the consequences further down the line in the health system.

· **Avoiding the privatisation of healthcare**. There needs to be a focus on investing in the public health system that provides essential healthcare to all and avoiding privatising healthcare.

· **Designing a public policy for preventative health.** The benefits in using a social model include healthier lifestyle choices and attitudes. We must ensure correct interventions are made at the right time, in the most culturally appropriate ways to communities. In order to achieve this, communities themselves must be involved in the design, planning and delivery of services. This is also central in ensuring accountability. Health literacy should be taken into account as policies and interventions are designed and implemented.

· **Community Participation in Health** should be a core principle of all health services. Mechanisms to engage with stakeholders need to be identified and a strategic framework for the inclusion of a community development approach to health, which can be applied to all current strategies and services e.g. Primary Care Services.

The Community Platform is a network of 29 national networks and organisations in the community and voluntary sector working to address poverty, social exclusion and inequality.

- Age Action Ireland
- All Together in Dignity (ATD) Ireland
- Community Action Network
- Community Work Ireland
- Cairde
- Debt and Development Coalition
- European Anti-Poverty Network (EAPN) Ireland
- Focus Ireland
- Gay & Lesbian Equality Network
- Immigrant Council of Ireland
- Irish National Organisation of the Unemployed
- Irish Penal Reform Trust
- Irish Refugee Council
- Irish Rural Link
- Irish Traveller Movement
- Migrant Rights Centre Ireland
- National Adult Literacy Agency
- National Collective of Community based Women's Networks
- National Traveller Women’s Forum
- National Women’s Council of Ireland
- Pavee Point
- Rape Crisis Network Ireland
- Safe Ireland
- Sign Language Interpreting Service
- Simon Communities of Ireland
- Threshold
- Voluntary Drug Treatment Network
- Vincentian Partnership for Justice
- Women’s Aid

Voluntary Health Insurance Group

Voluntary Health Insurance Group (hereafter referred to as 'Vhi') welcomes the Minister's initiative to develop a 10 year strategy for Ireland's Healthcare system and welcomes the opportunity to make a submission to the Committee on the Future of Healthcare. Ireland is facing a very serious demographic and healthcare provision challenge. Currently our country has the youngest population in the European Union (EU) but it is expected that our population will age faster than any other EU country over the next number of years. While people are now living longer which is welcome, a consequence of this is that the incidence of chronic disease in Ireland is expected to rise dramatically in future years. These developments have major implications for the healthcare system as a whole. For Vhi in particular with the largest share of older and sicker customers in the private health insurance market, they present real challenges. Given these future trends in ageing, the increase in prevalence of chronic diseases, the systemic importance of the private health insurance market to the overall health system in Ireland, it is absolutely essential that the Private Medical Insurance (PMI) Market is adequately legislated for, that Community Rating is protected and that the Risk Equalisation Scheme (RES) is strengthened and made more effective.

The PMI market peaked in 2008 with a membership of 2.3 million. Following the economic downturn, PMI membership took a sharp decline and it is only in the last year (2015) that this decline was reversed. This was due in part to the recovering economy but also to a number of positive initiatives introduced by Government which acted as a stimulus to the market. Government initiatives by way of introducing Lifetime Community Rating and Young Adult Discount rates in May 2015 have helped attract and retain younger customers into the market. We must continue to build on this and to continue to encourage young people to take out private health insurance if we are to sustain the much valued Community Rated Private Health Insurance market for the longer term.

Currently, PMI plays an integral role in the overall national healthcare system. Ireland's mix of both public and private provision is not unusual in an international context and the fact that there is a thriving private healthcare sector alleviates much of the pressure from the public system. Currently, 46% of the population have private health insurance and there are many advantages to having a dependable private healthcare sector. These include funding for the public health system to the tune [redacted] alleviating pressure from the public hospital system, significant cost savings for treatment in a private hospital setting and the provision of facilities by the private sector to the public sector for those who have been on waiting lists for extended periods of time i.e. NTPF.

Vhi supports all initiatives that safeguard a sustainable and thriving PMI market and have made the following recommendations to the committee:

- Expand Young Adult Discounts
- Reduce Risk selection Incentives- make community rating work effectively. We need a comprehensive RES that helps deliver claims efficiency and innovative product design rather than the current focus on the management of the age/health profile of its customer's portfolio. An effective RES places the customer at the heart of all decision making whereby health insurers are incentivised to focus more on the effective management and care of patients.
- Allow private health insurance companies to contract directly with Public Hospitals in order to increase efficiencies, drive down costs and stimulate innovation.

Introduction

Ireland currently has the youngest population in Europe but it is projected to age faster than any other European country over the next 20 years. This will raise many challenges for Ireland with the delivery and funding of high quality healthcare being among the most prominent and immediate of these challenges. Healthcare utilisation is strongly correlated with age and the projected increases in Ireland's population of over 65 year olds, coupled with projected increases in the prevalence of chronic diseases are going to present profound challenges to Ireland's healthcare system. The pace of ageing is likely to overwhelm the already stretched health system unless there is significant planning and forethought on tackling this challenge in advance. To be successful, Ireland will need to harness all resources and parties involved in the delivery and receipt of healthcare. This will not be easy and will, above all else, require strong consensus among all key stakeholders.

Vhi very much welcomes the Minister's initiative to develop a "ten year view of the direction of Ireland's healthcare system" and welcomes the opportunity to make a submission. Vhi, as the largest health insurer in Ireland with over 1 million customers, has some very unique insights into the development and funding challenges our healthcare system will face into the future. Vhi believes it can make a meaningful contribution to the work of the Committee on The Future Healthcare.

Demographic Challenges

National Healthcare Challenges

In the past decade, Ireland has seen growth of its population from 4.2 million to 4.6 million, an increase of ca. 9% - largely attributable to an increase in life expectancy. Looking to the future, it is projected that Ireland's population of over 65's will grow at a rate of ca.60%, twice the rate at which it grew for the previous ten years[335]. Consequently, Ireland's significant population ageing will give rise to an increased burden of chronic disease for those living longer which has fundamental implications for future health and planning for the Irish Healthcare system.

Figure 1: Changes in the 65+ year olds in the last 10 years compared to the next 10 years.

Health In Ireland- Key Trends 2015

Additionally, Ireland's healthcare budget has reduced significantly since 2008 and while we recognise the substantial efficiencies that have already been made, it is difficult to see how the healthcare system can manage the impact of our demographic changes without significant system wide changes.

Private Medical Insurance

The key challenges and pressure facing the public healthcare system mirror those of the private healthcare sector- the current healthcare delivery model and its projected cost per person is going to significantly challenge affordability and by extension PMI participation. Like in all other developed countries, underlying healthcare costs continue to increase well in excess of general inflation. Historical claims inflation of ca. 4% (before ageing) is expected to continue into the foreseeable future. In addition, ageing of PMI membership currently adds another ca.3%[336] to claims inflation and this ageing effect is set to increase as the number of over 65 year olds and over 85 year olds increases.

Vhi has projected future healthcare claims cost based on historical trends and its best sense of the medium term outlook. Vhi have estimated the following PMI market development if managed through the current healthcare delivery model:

[Redacted Section]

It is difficult to see the market can withstand such additional costs. The PMI market is already seeing significant numbers of customers downgrading their cover, with many cancelling their PMI policies due financial constraints.

The PMI model will struggle to sustain itself in the longer term given these challenges. Furthermore, should the PMI market contract and membership decline, the public health

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[335] Health in Ireland- Key Trends 2015

[336] Report to the Minister for Health on an evaluation and analysis of returns for 1 July 2014 to 30 June 2015 including advice on risk equalisation credits 2015.

system will find itself under even more pressure to cater for the uninsured. Given that the private healthcare sector plays a crucial role in the national healthcare system with nearly half the population electing to purchase PMI, there is a growing need for the government to continue to support and ensure we have a sustainable PMI market which is strongly focused on delivering high quality, affordable healthcare to its customers.

The Role of Private Medical Insurance

The Private Healthcare Sector (private providers and health insurers) in Ireland plays an integral role in the overall national healthcare system. Ireland's mix of both public and private provision is not unusual; many countries have a mix of both public and private healthcare sectors. In recent years access to public hospital services have become more difficult as waiting lists have increased i.e. wait times are up 45% in two years[337]. The Private Healthcare Sector has made and continues to make substantial contributions to the public healthcare system, for example:

- **Alleviate Public Hospital Pressures**: The private hospital sector treats a significant proportion of PMI customers, resources and capacity are subsequently freed up in public hospitals for the care and treatment of more public patients.
- **Additional Funding:** The PMI market contributes ca. [redacted] to the public sector through the payment of claims from private patients treated in public hospital for which they are already entitled through general taxation.
- **Expedited treatment for public patients:** The HSE purchase's treatment from private hospitals for public patients who have been on a public waiting list over a certain period of time. Vhi notes the Minister for Health's plans to reactivate the NTPF to tackle waiting lists in addition to a new immediate initiative to provide additional endoscopy services[338]-ca. €15m will go towards the NTPF in 2017.
- **Consultant Retention:** The private sector has allowed consultants with dual contracts (ca. 60%) to work in the private sector supporting the retention of highly skilled/high calibre consultants in Ireland.
- **Driving Cost Efficiencies:** Vhi has been very active in driving cost efficiencies among private providers to help influence and contain the escalation of healthcare costs. Key elements of this include:
    - Vhi continually examines the re-configuration of treatment settings based on the latest international guidelines and protocols which has meant our customers are treated in the most appropriate and cost effective setting.
    - Vhi's Special Investigation Unit (SIU) was established in 2009 to ensure incidences of error or overcharging by healthcare providers are fully investigated and rectified - this year alone the SIU recovered more than €18.5m.

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[337] Irish Times 2016, http://www.irishtimes.com/news/politics/oireachtas/hospital-waiting-lists-up-45-in-two-years-says-miche%C3%A1l-martin-1.2712386

[338] Irish Times 2016, http://www.irishtimes.com/news/health/wind-down-of-treatment-purchase-fund-was-regrettable-says-harris-1.2717994

    - Vhi only contracts with providers who hold a recognised accreditation that awards high quality service provision. Vhi continually pushes for the best value and quality for our customers.
    - Vhi provides hospital-in-the-home services exclusively for its members. Vhi Homecare treats patients in their own home who would have otherwise received their treatment in a hospital. Since its inception in 2010, this service has delivered €23.8 million in savings and saved 65,000 hospital bed days.

Health Insurers are important advocates for customers and play an influential role in supporting the national healthcare system in Ireland. The Vhi Swiftcare clinics are one such example, whereby patients are treated for urgent care, minor injuries and illness that may otherwise have attended an A&E Department.

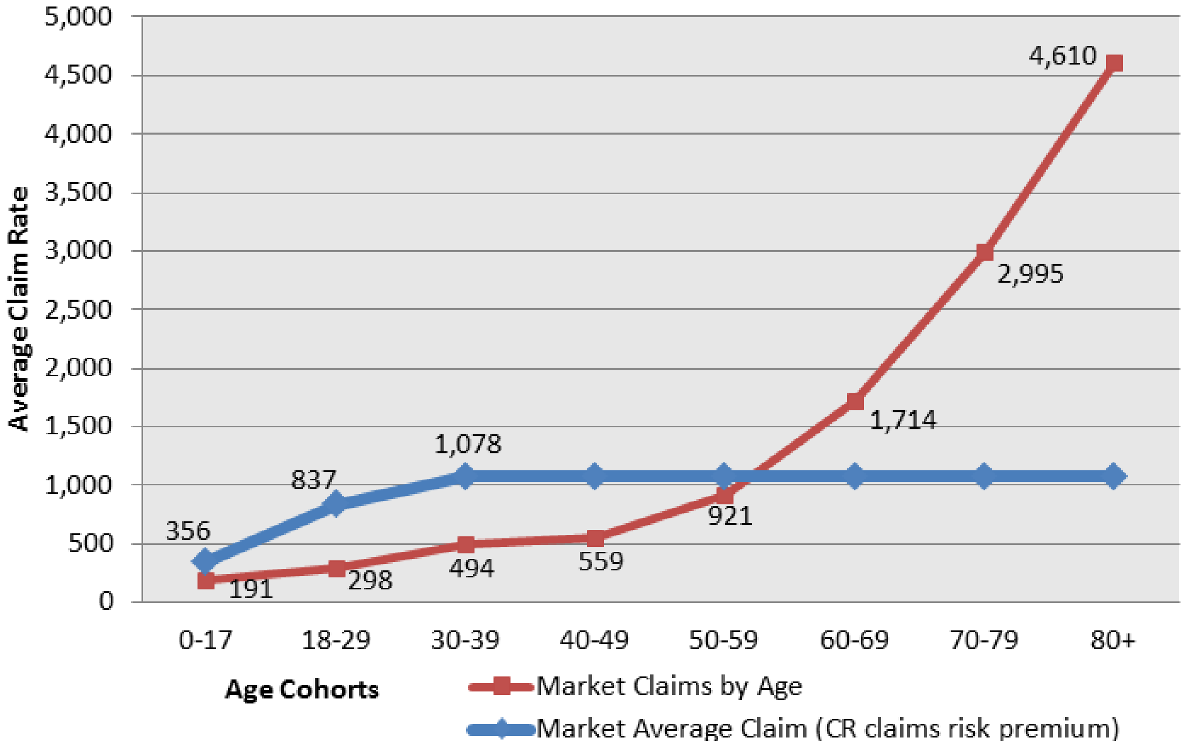
Internationally, health insurers have demonstrated the ability to add value, drive change and compete on value-based healthcare outcomes (Sanitas Spain, Kaiser Permanente USA, Southern Cross New Zealand and Medibank Australia). However, the current market dynamics in Ireland do not fully incentivise such behaviours as currently, health insurers compete on risk pool selection, seeking to attract the younger, profitable age segments, with less of a focus on the cost effective management of more high cost claimants. The RES will require continued enhancement to ensure the industry is focused on healthcare management and cost savings for customers.

The Private Medical Insurance Market

Nature of the Market

The PMI market in Ireland is heavily regulated with a community rated system in place – unlike other insurance’s, such as car insurance, premiums cannot be varied by age, gender or health status regardless of the customer’s risk profile. The requirement to charge a community rated premium creates incentives to only compete for certain segments of the market i.e. the younger healthier cohorts, and therefore such challenges give rise for a RES. Community rating in Ireland relies upon a RES to compensate competing health insurers for differences in relative risk profile of their customers.

Figure 3: PMI Market Claims

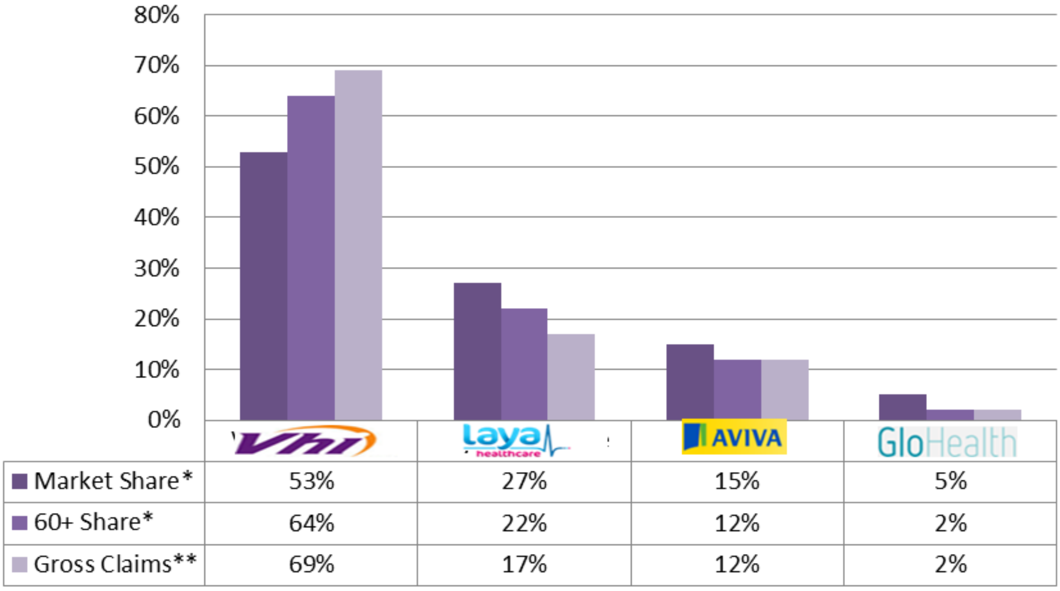


(HIA 2014)

Figure three shows how 2014 market claims increase with the age of the insured member (see red line). The community rating obligations force insurers to charge the same premium for all adults (some structured discounts are available for young adults between ages 18 to 25 years). Charging the same premium implies that all members have the same underlying claims risk (see blue). However, strong risk selection incentives exist within the current RES structure (difference between blue and red lines). As a result current market dynamics incentivise insurers to target younger/healthy and avoid older/sicker customers. This is not in the long term interest of managing a national and growing healthcare problem and not in the interest of maintaining a stable vibrant PMI market. Health Insurers should not be incentivised to avoid older and sicker customers.

Figure 4: Market Share Data 2015

Market Share Data 2015 (HIA)



	Vhi	laya healthcare	AVIVA	GloHealth
■ Market Share*	53%	27%	15%	5%
■ 60+ Share*	64%	22%	12%	2%
■ Gross Claims**	69%	17%	12%	2%

*HIA Annual Report 2015
**Report to the Minister on an Evaluation and analysis of returns for 1 July 2014 to 30 June 2015

The table above demonstrates the imbalance between health insurers relative market share of older and sicker customers. Vhi has persistent age risk imbalances versus its competitors; with a disproportionate share of the 60+ age cohort and market share of the 70 -79 year olds and 80+ year olds standing at 69% and 83% respectively. Vhi has higher claims compared to its competitors as a result of health risk imbalances i.e. Vhi have 53% of the PMI market but pay 69% of market claims. The RES as it currently stands does not compensate for risk imbalances.

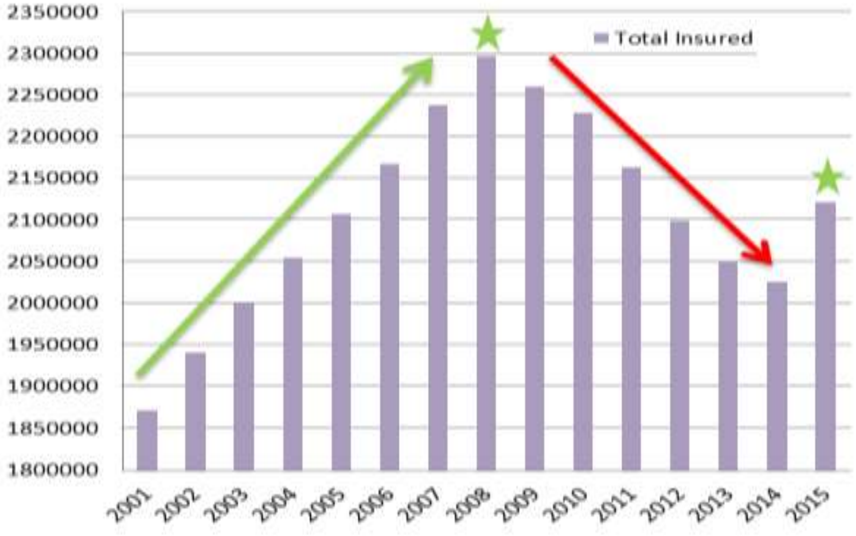
In the absence of an effective RES, risk selection opportunities arise. All health insurers aspire to maximise claims efficiency however, risk selection incentives are much more attractive as health insurers can identify and make certain profits from risk selection opportunities. In the current market, risk selection incentives are strong, whereby insurers are incentivised to reduce or avoid predictable losses for high risk individuals.

An effective RES is essential to promote market stability by equitably spreading the higher risks associated with the older and sicker customers across private health insurers proportionate to their customer base. The more the improvement of health status credits, the less insurers are incentivised to risk select and focus more on the effective management and care of patients versus current market behaviour of risk avoidance and claims exposure.

Market Performance

Private medical insurance membership steadily increased from 2001-2008 peaking at ca. 2.3m in 2008 (See figure 5). Following on from the economic down turn, the PMI membership took a sharp decline with estimated customer losses of ca.12% between the years 2008-2014. This decline was reversed in 2015.

Figure 5: Number of people with PMI cover



In addition to the recovery in the economy, 2015 was a positive year for the PMI market with the introduction of a number of significant initiatives which had a very positive impact on the market namely, Lifetime Community Rating ‘LCR’ and Young Adult Discounting ‘YAD’ - the PMI market increased by ca. 97,000 during 2015.

A sustainable PMI market that is community rated relies on the principle of intergenerational support i.e. young and healthy customers supporting older and sicker customers. Therefore, the PMI market requires a constant stream of younger members to retain their plans and new entries into the market

Both LCR and YAD will continue to support the PMI market overtime providing strong incentives for young people to purchase health insurance plans and remain in the market helping PMI affordability.

Vhi welcome these initiatives and believes there is an opportunity to do more.

Integrated Healthcare

Vhi supports the move towards a more integrated model of care in Ireland - a healthcare continuum that joins up acute secondary, primary and community care services. Vhi agrees with the Government’s principles as set out in the DoH report, *Better Health, Improving Healthcare* (see appendix 1). The national healthcare model in Ireland requires significant reform in order to meet the growing healthcare needs of our ageing population.

A significant consequence for those living longer is the increased incidence of chronic diseases and patients living with multi-comorbidities.

People living with chronic diseases consume a significant amount of health care resources with reports estimating that 75% of Ireland's healthcare expenditure is allocated to the management of people suffering with chronic diseases[1].

The costs associated with addressing and managing the growing incidence of chronic diseases pose a major challenge for both the Government and Health Insurers. Given Ireland's predictable ageing population, it is imperative that there is a strategy in place to effectively manage the healthcare needs of people living with such conditions.

Chronic disease management is an area where the primary/community care sector has the potential to significantly improve outcomes for patients, reduce hospital admissions and acute hospital length of stay. Ireland's current 'hospital centric model' has meant that there is an over reliance on acute hospitals to provide the majority of people's healthcare requirements. There needs to be more of a focus on relocating the care of patients from a hospital environment to a primary/community care setting which is often better equipped to meet the requirements of patients who have one or more chronic diseases.

The successful launch of the Public Diabetes Cycle of Care programme and diabetes register is one such initiative that we believe should be complemented by the private sector. We believe that the RES could be utilised as a mechanism to facilitate the financial requirement of providing a service similar to the diabetes cycle of care, available for private patients.

In the longer term, health insurers will be incentivised to play a more significant role in keeping their customers healthier, chronically ill patients will receive targeted coordinated care close to home and the Government will have supported the transition of services to a primary care setting as set out in national policy.

Healthcare Funding

Vhi supports the DoH in their next phase of a more detailed comparative analysis of the costs and benefits of alternative healthcare funding models. The identification and establishment of prospective healthcare funding models is a matter for Government. However, health insurers and relevant stakeholders should be involved on a consultation basis. It is imperative that any healthcare funding model considered should not add costs into the system.

Recommendations

Vhi supports all initiatives that safeguard a sustainable and thriving PMI market which is focused on managing our projected healthcare needs and would make the following recommendations:

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[1] http://health.gov.ie/wp-content/uploads/2014/03/tackling_chronic_disease.pdf,
http://www.publichealth.ie/files/chronic_main.pdf

1. Expand Young Adult Discounts

Young adult discounts was a measure introduced by the Government offering reduced rates to young adults up to and including age 25 and has been a positive contributor to the increase in young adults taking up and retaining their PMI cover. The approach eased the effect of price increases experienced when student rates no longer applied. Building on the recent success of this measure[339] we believe the structure of discounts should extend up to the age of 35.

The number of students remaining in college has increased with students graduating at older ages. The average age of individuals taking out PMI is 25 years[340] of age; young adult discounts should reflect these trends. Family formation happens in the 30s and extended discounts would enhance this group's ability to purchase health insurance at a time of growing financial constraints.

2. Reduce Risk Selection incentives:

The current RES structure in Ireland has created significant risk selection opportunities for health insurers. A fully effective RES is necessary to ensure a stable and vibrant market reducing the current market behaviour of cherry picking the younger healthier customer's and avoiding predictable losses from high risk individuals. In the absence of a DRG based health status credit, insurers continue to be incentivised to risk select against high-risk members.

Vhi has made several proposals which together will reduce risk selection incentives. Vhi is proposing that enhanced Health Utilisation Credits be paid to high-risk members and specifically in relation to procedures used to treat cancer patients and acute psychiatric inpatient admissions. Vhi is also proposing a high-risk high cost sharing pool which will share a portion of the high costs of members who require extensive healthcare treatment throughout the year. In both proposals health insurers will retain strong incentives for claims efficiencies.

3. Private Health Insurers contracting with Public hospitals

Health insurers have demonstrated that the best way to drive down costs and stimulate innovation is to contract with hospital providers in an effort to increase efficiency, improve quality of care and drive down costs to the benefit of the consumer e.g. negotiating volume discounts and examining rates for package procedures.

Health insurers are precluded under legislation from any negotiations with public providers. More competitive prices for services and cost management initiatives could be achieved by allowing health insurers the opportunity to contract and purchase care with public providers.

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[339] There has been an increase of 6,951 in the numbers of lives insured in the PMI market aged between the years 18-25 during 2015

[340] Vhi Internal Finance 2016

Appendix

Changing the Model of Care- Key Principles

- Our aim is to enhance health and well-being, not just to provide services. Prevention is therefore a vital part of any strategy
- When people become ill, their illness should be managed at the lowest possible level of complexity, starting with self-management
- The vast majority of health-care needs should be addressed by a comprehensive range of primary care services
- More integration of care is needed and this should be supported by the assignment to primary care of an explicit coordination and case management role for all but the most complex of cases
- Patient safety and greater choice and voice for service users in their dealings with the health service should underpin planning and delivery of all services.

Voluntary Hospices Group

- Palliative care is focused on providing patients with relief from the symptoms, pain and stress of a serious illness- whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.
    - Palliative care is considered by the World Health Organisation to be an essential component of universal health coverage.
    - The economic case for investment in palliative care is well established, evidence-based and firmly grounded. It demonstrates that fully developed inpatient hospice services alongside properly resourced community services, can substantially reduce the level of acute admissions for patients with both malignant and non-malignant diseases particularly in the last three months of life – in these instances the number of people being cared for at home significantly increases. This leads to cost savings within acute hospitals, as well as a reduction in inappropriate hospital admissions, a more appropriate care pathway, and an improved experience for patients and their families.
    - Palliative care services in Ireland are internationally recognized as being of an advanced stage of maturity and to be of high quality meaning that we have a solid base that will reward investment.
    - Much of this development of services has been achieved through a strong voluntary and statutory partnership which has evolved over the years. It is imperative that this relationship is both maintained and nurtured into the future.
    - Palliative care services in Ireland are guided by the 2001 Report of the National Advisory Committee on Palliative Care (NACPC), which to this day continues to represent Government policy for the Sector.
    - A 2006 study assessed progress in implementing the various recommendations in the NACPC Report, and found that significant problems with access and equity remained, as there continued to be major parts of the country without a specialist palliative care inpatient unit and with underdeveloped community services, and other areas did not have the recommended bed complement and/or the recommended staffing levels.
    - A five year development framework was published by HSE in 2009, but the economic slowdown hindered its implementation. Some progress was achieved, particularly in community-based services, but many of the deficits identified in 2006 and 2009 have still to be remedied.
    - In recognition of the fact that deficits in service provision remain, the HSE has produced a document, supported by the Voluntary Hospices Group, (Palliative Care Service, Three-Year Development Framework, (2016-2018) that has been submitted to the Department of Health for consideration.
    - This Framework, in our view, if approved by the Department of Health provides a measurable roadmap to future development of services. Importantly, it offers a realistic pathway to transformative whole-system change when the reach and impact of palliative care on chronic disease management is considered.

Submission:

Palliative care as a key priority for inclusion in a ten-year plan:

Palliative care is a vital intervention to relieve the suffering of people living with, and dying from, life-limiting conditions. It is fundamental to health and human dignity and many consider it to be a basic human right. [1] The United Nations Committee on Economic, Social and Cultural Rights asserted that "States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons . . . to preventive, curative and palliative health services."[2] The World Health Organization defines Universal Health Coverage as ensuring that all people can use the promotive, preventive, curative, rehabilitative and **palliative** health services they need, which are of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.[3] The Report of the 67th World Health Assembly additionally addresses the strengthening of palliative care as a component of comprehensive care throughout the life course.[4]

Palliative care is focused on providing patients with relief from the symptoms, pain and stress of a serious illness- whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment. This integrated model of palliative care provision is broader than the original idea of 'terminal' or 'end of life' care but does still include end of life care. As Cicely Saunders, the founder of the modern hospice movement, stated 'You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die'.[5]

As a result of Ireland's ageing population, the annual number of deaths in Ireland is projected to rise from a current 30,000 per year to 34,000 per year by 2030. The majority of these individuals will die as a result of chronic disease and will have experienced a period of significant ill-health and palliative care need prior to death. In the international arena, particular attention in healthcare reform debate is focused on the fact that healthcare resource utilization and costs are concentrated on a small proportion of the population and policy proposals frequently identify and target these 'high-cost' groups. Analysis by Aldridge and Kelley[6] in the United States identifies the three main high-cost groups as:

- Population at the end of life- individuals who have high health care costs because it is their last year of life (11%);
- Population with persistently high costs- individuals who persistently generate high annual health care costs due to chronic conditions, functional limitations, or other conditions who are not in their last year of life and who live for many years, generating high health care expenses (40%); and
- Population with a discrete high-cost event- individuals who experience a significant health event in one year but who return to normal health (49%).

Palliative care has a key role to play in health system reform as it offers a way to help re-tool the system to meet the challenges experienced by the first two groups while improving quality of care provision. It does this by addressing the following issues:

- Palliative care relieves pain and other debilitating effects of life-limiting conditions and orientates care towards the individual patient and their family (as the unit of care) rather than towards a specific disease.
- By responding in a holistic manner to the episodic nature of chronic illness, it helps patients and families live well - despite (and during) illness.

- By increasing integration between hospital and community care settings, providing co-ordination of care across professions and across agencies and providing care as close to home as possible, it assists in appropriate re-orientation of the health system.
- By supporting communication, including consideration of prognosis and trajectory of illness, it promotes discussion of medically appropriate goals of treatment and development of advance care plans.
- By including families in the focus of care provision, it supports informal care giving and improves carer well-being.

It is generally acknowledged that for most countries, the achievement of a single tier health service where patients' needs are comprehensively met in an integrated manner remains a journey, rather than a destination. In reality, Universal Health Coverage is achieved incrementally and over relatively long periods. Hutchison, Abelson and Lavis noted in 2001 that in a policy environment constrained by policy legacies unfavourable to sweeping health system change, an incremental and pluralistic approach is the only feasible strategy for achieving health system reform. [7]

Acknowledging the contextual constraints of Irish healthcare reform, palliative care offers a critical pathway to advancing the development of a single tier heath service. This is because palliative care services have already been established on the basis of universal access according to need. Also, cover across the country has become more comprehensive in recent years despite the economic downturn. For example:

- Twenty-three community palliative care teams offer universal access to specialist palliative care services in the patient's home in all local health organisations across the country;
- Hospital specialist palliative care teams offer universal access to specialist palliative care services across each hospital group;
- Specialist palliative care beds are available in eight of the nine Community Healthcare Organisations. Gaps in service provision remain as bed numbers are currently inadequate to meet need, however planning is at an advanced stage to address these deficits between the period 2016 to 2021.

Deficits in service provision remain; for example, services are variably resourced and specialist palliative care beds remain significantly below those recommended in national policy. [8] However, the Three-Year Development Framework 2016-2018 (developed by the HSE and submitted to the Department of Health for consideration) provides a measureable guide to addressing identified gaps across all service settings. With a clear roadmap available to us, including palliative care as a key priority in a ten-year strategy, the achievements and momentum that have been observed to date can be harnessed. Importantly, it offers a realistic pathway to transformative whole-system change when the reach and impact of palliative care on chronic disease management is considered.
The Framework contains two key recommendations as follows:

- The Department of Health to give consideration to a recommended revision of the 2001 NACPC Report to take place in 2017 – 2018
- Development of a new Strategic Plan for Palliative Care, to commence in 2019, which could be based on the NACCPC Report (Revised)

Palliative care as a method of supporting the re-orientation of our current model of healthcare towards a model based on integrated primary, secondary and community health care:

As outlined in the Committee's terms of reference, demographic and fiscal challenges necessitate fundamental re-shaping of the Irish healthcare system. Focusing on the development of an integrated healthcare system where people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money offers our best path forward to achieve our objective of a world-class health system. Different levels and forms of integrated care provision exist, and it is important to recognize that integrated care is not necessary for all forms of care. However, there is clear evidence that for older people, people with chronic disease and life-limiting conditions and for other populations with complex needs, integrated care models offer higher quality care, often at a lower cost than traditional models of care.

Again, palliative care has much to offer in supporting the re-orientation of our current model of healthcare as palliative care provision in Ireland already demonstrates many of the features of virtual macro-level integration. A population-based approach informs the provision of an integrated model of palliative care in a manner that is analogous to the Kaiser Permanente triangle of population-based health needs. Following the diagnosis of a life-limiting condition, the population may be sub-divided into three groups: those with an ongoing illness but low/ intermediate levels of need; those with intermittent complex need; and those with persistent complex need. As yet, our estimates of the proportions of the population that correspond to each level of need are crude. However, it has been suggested that for patients with advanced cancer, 10% have low/ intermediate need; 70% have intermittent complex need and 20% have persistent high need. For those with advanced non-malignant disease, it has been suggested that 50% have low/ intermediate need; 30% have intermittent complex need and 10% have persistent high need. [9]

A stratified population-based approach informs the following service responses:

1. Primary care with indirect support from the specialist palliative care team (which may take the form of staff support, education, involvement in guideline, policy and protocol development or engagement in community-based palliative care quality improvement projects).
2. Assistive care management where specialist palliative care teams support the primary care team by directly engaging with patients to manage periods of increased need and then discharge the patient from the specialist palliative care service.
3. Intensive case management and specialist palliative care provision which is horizontally integrated within organisations and vertically integrated across hospital, community and hospice settings.

Clinical and normative integrative processes in palliative care are well advanced. This is of key importance as both are key to securing buy in for integrated care provision. Rosen et al [10] consider the three critical normative integrative processes as effective leadership, clear communications and high trust and specialist palliative care has built these relationships over years with primary care and acute hospital services. Clinical integrative processes that have been established include the fact that multidisciplinary teamwork is deemed central to palliative care provision; guidelines are increasingly used to promote best practice and reduce unwarranted variations in care; and a culture of clinician leadership and clinician-management partnership has developed with the advent of the National Clinical Programme in Palliative Care.

Informational integrative processes remain a key barrier however. Health information systems facilitate data management and effective tracking of utilization and outcomes. They also enhance communication capacity and information flow across integrated pathways. At present, the lack of effective deployment of digital technology in palliative care means that there are gaps in health data and information management capacity. In order to realise a fully integrated palliative care system, it is essential that this barrier is dealt with.

Recommendations for action:

1. Palliative care should be considered as a priority for inclusion in a ten-year strategy.
2. Palliative care should be supported to realise its potential as a fully integrated service within the health system- key facilitators to achieving this goal are detailed in the Three Year Framework document.
3. Approval of the Framework by the Department of Health is essential.
4. The 2001 NACPC Report as national policy should be revised.
5. A proper statutory core funding model for Palliative Care should be developed.
6. The voluntary / statutory partnership service provision / development in Palliative Care should be maintained and optimised into the future.
7. An action plan for developing electronic health record and clinical information systems in palliative care should be compiled.
8. A new Strategy for Palliative Care should be considered from 2019 onwards.

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West Cork Arts Centre

There is a clear need to increase the opportunities for older people in residential care and those attending day care to actively participate in the social, creative and cultural life of their community.

As far back as 1948, the Universal Declaration of Human Rights (UDHR) recognised that ‘Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits’ (article 27). This entails the basic understanding that when circumstances leave a person without the ability to actively seek out cultural and artistic experiences - as is the case for older people in residential care - that an ‘Arts organisation and local authority which are funded to serve the whole community should consider, in their annual planning, the needs of those in long-stay facilities’. (Jennifer Russell UCC Department of Epidemiology and Public Health. CONVERSATIONS IN COLOUR: Evaluation of an Arts for Health Partnership Programme 2005/6)

In addition to being our right, Jennifer Russell also acknowledged: ‘The provision of an arts programme in these long-stay facilities (West Cork Community Hospitals) has very significantly enhanced the lives of a large portion of patients, staff and family members, even those who did not overtly engage in the activities provided. The improvements reported include pleasure in the activity, increased socialisation, reduction of isolation, improved memory and eye-hand coordination, enhanced relationships with family members and staff and increased self esteem.’

There are several examples of arts and health partnership programmes across the nation, each exemplifying the intrinsic nature of the partnership between the two agencies resulting in embedded programmes that make creativity intrinsic to life within residential and day care settings. Where high-quality and best practice methods are respected, the reports are of an enhanced quality of life and self-esteem resulting in improved overall health and wellbeing for all those taking part.

The most current document minding our nation’s wellbeing, Healthy Ireland A Framework for Improved Health and Wellbeing 2013 – 2025, seeks an Ireland “where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone’s responsibility”, a vision that clearly supports the potential for creative activity to maximise the ability of all individuals to both maintain dignity and independent living in older age. Thus, quality arts provision is and should also remain, a pivotal component of Day Care Centre and community work provision in Ireland in addition to residential services.

Ideologies outlined in the Learning for Life: White Paper on Adult Education highlight: ‘the role of adult education in enabling individual members of the society to grow in self-confidence, social awareness and to take an active role in shaping the overall direction of society – culturally and socially’ (2000, p.29). The goal is to enhance awareness about the importance of maintaining a contributory role in society, even when mobility and access are severely restricted by personal health.

“Commissioners for older people need to take account of older people with mental health problems, long term conditions such as dementia and other disabilities, and older people who are ‘hard to reach’, such as people living alone, living in care homes.” (An Evidence Review of the Impact of Participatory Arts on Older People, Mental Health Foundation, 2011) Inclusion of older people with disabilities and cognitive differences are recognised as hard to reach. Extra provision is needed to ensure equity of choice, discrimination, isolation and mobility do not act as barriers to accessing arts and cultural activities.

Arts and health partnership programmes specifically designed for older people in healthcare, such as Arts for Health Partnership Programme, West Cork critically responds to the 2013 National Positive Aging Strategy Positive Ageing Starts Now, which 'seeks to promote the development of opportunities for engagement and participation of people of all ages in a range of activities including the arts. Furthermore, the work of the Arts for Health Partnership is congruent with the Healthy Ireland framework for actions with its emphasis on partnership and cross-sectoral working, empowering people and communities, through research, evidence, monitoring, reporting and evaluation. This strategic approach ensures that an active meaningful and meaning-making life can be enjoyed through to older age across the eleven settings in which the programme operates.' (Arts for Health, West Cork Strategic Plan 2013-2016).

Arts for Health

Partnership Programme, West Cork

https://vimeo.com/81618736

Arts for Health Partnership Programme is based in West Cork and provides a managed and integrated arts programme for older people in healthcare settings.

The Arts for Health programme is based on an inter-agency partnership between West Cork Arts Centre, Cork County Council's Arts Office, Cork Education & Training Board and the HSE. The HSE is represented by Cork Arts + Health Programme, the Health Promotion Department, the Nursing Directors of Community Hospitals and the Day Care Centres, West Cork.

The delivery of the programme is through an Arts for Health artists' team which is managed by West Cork Arts Centre, They have established a close, professional working relationship with the staff and management of each care setting. The artists, each with distinctly different practices, have developed their professional expertise in working with older people and numerous individual and collaborative projects have been undertaken since it began in 2005.

Key to the programme integration are the healthcare professionals based in each location. Known as Site Coordinators they act as a liaison and link person connecting participants, other staff and family members with the artists and with the ethos of the Arts for Health programme. Welcoming the artists into the care setting, the site coordinators share up to date information, help navigate and lend their expertise to support meaningful art sessions that meet the needs of participants.

By being integrated into the culture of the care setting, the programme allows ideas and the individual creative interests of the participants to be nurtured, developed and implemented over time.

The programme takes place in eleven geographically widespread rural locations including five day care centres: Castletownbere, Clonakilty, Dunmanway, Schull, Skibbereen; five Community Hospitals: Castletownbere, Clonakilty, Dunmanway, Schull, Skibbereen; and Bantry General Hospital, Care of the Elderly Unit and serves over 400 healthcare service users.

We estimate that annually the Arts for Health programme will have provided over seven and a half thousand arts engagements across the 11 healthcare settings in West Cork. This breaks down to approximately 1780 day care service users and 148 staff participating in over 80 sessions held across

5 day care centres and 5632 community hospital residents and 186 visitors, collectively participated over in 352 session held in Community Hospitals (full year figures are estimated based on 9 months of programming).

Majority of participant are aged 65 years and over. Most residents in the Hospital settings are highly dependent and need significant levels of help with physical care. There is an increasing level of dementia and most participants are deemed high or maximum dependency. All day care clients are older people aged 60 years and over. Most are independent and need some level of help with physical care. There is an increasing level of dementia and some participants are deemed medium dependency.

In addition to annual evaluation reports, the partnership have commissioned two documents, the first in 2005 at the outset of the programme Conversations in Colour: Evaluation of an Arts for Health Partnership Programme 2005/6, by Jennifer Russell 156 5179 -Art and health-Final.pdf and the second in 2010 when the programme expanded to include five Day Care Centres, Arts for Health Partnership: Day Care Centre Evaluation Report by Ann O'Connor and Charlotte Donovan.WCAC_day care centre evaluation report_final report Nov2010 (2).pdf

As evidence of the partnership's commitment to 'maintain and improve communications and advocacy' (AfH strategy 2013-2016) the partners commissioned film maker and animator Jane Lee to document their effective partnership model. This short animation playfully demonstrates the roles and responsibilities of the partnership and stakeholders in supporting, managing and implementing the programme https://vimeo.com/81618736.

Testimonials

"It is an hour of pure pleasure as far as I am concerned…this is what you are looking forward to all week"

"The Arts for Health project keeps our patients 'alive'! We very much welcome the sense of joy and purpose it brings to our continuing care patients and those on respite."

''Our artist knows our patients so well and over time has developed a great relationship with them. She has many projects on the go and has gone to great lengths to equip our new development with paintings and decorative art that has real meaning for our patients, staff and visitors alike. We involve as many patients as possible out of our 23 and rotate them from week to week depending on their liking and suitability for the planned activity. Over 70% of our patients are involved in activities.''