

IHCA Opening Statement to the Joint Oireachtas Committee on Health on 11 July 2018

The Association welcomes the opportunity to address the Joint Committee on the ongoing overcrowding issues in hospitals as well as delays in admissions and outpatient appointments.

The fundamental causes of the overcrowding and delays in providing care to patients are the capacity deficits in terms of acute infrastructure, hospital consultant numbers and other resources. Demographic factors including our increasing and ageing population have led to significant increases in demand for health care including acute hospital and mental health services. However, decades of underinvestment combined with one of the lowest number of consultants on a population basis in the OECD has led to significant and growing capacity deficits.

The National Development Plan's (NDP) commitment to provide €10.9bn in capital funding for the health services in the next decade is an important first step in addressing the overwhelming acute hospital capacity deficits that the Association has highlighted for more than a decade. The capacity deficits are one of the main causes of delays in providing acute hospital care to patients. This has been acknowledged in the Capacity Review published earlier this year.

The NDP commitment to fund the expansion of our acute public hospital capacity is long overdue as our acute hospital and mental health services are at breaking point, with unacceptable delays being endured by patients in obtaining emergency and scheduled care. The current shortage of acute, ICU and rehab hospital beds, essential equipment and hospital consultants is preventing the provision of essential hospital care that the population needs and deserves. The NDP's proposal to put in place an additional 2,600 acute hospital beds must be assessed by reference to the current Hospital and Emergency Department crisis. It is important to take account of the fact that acute hospital inpatient beds were cut by 1,400 in the past decade at a time when they should have been increased, at least in tandem with the country's increasing and ageing population.

The deficit in acute public hospital beds will not be remedied in full by the proposed expansion of 2,600. The ESRI projected 37% increase in patient demand for hospital services by 2030 confirms that a greater increase in hospital bed capacity than currently proposed will be required in future. However, it is now vitally important that an Annual Commissioning Plans are agreed to put the additional 2,600 acute beds in place much earlier than the ten-year period proposed in the NDP. This is of paramount importance so that our hospitals can deliver safe high quality hospital care to patients without the unacceptable current reliance on trolleys and increasing waiting lists.

The Association has highlighted that the cost of implementing the proposals in the Sláintecare Report has been understated and will actually cost the taxpayer €20bn if implemented over 10 years; compared with €2.8bn stated in the Report. In its submission to the Independent Review Group in February, the Association also outlined that the removal of private health insurance income from public hospitals will have a devastating effect on hospital operating budgets, crippling their ability to treat an ever increasing number of patients unless central funding fully provides the resources to address the growing capacity and operating deficits while also replacing the insurance income foregone.

It is astonishing that the Sláintecare Report contains an underestimation of this magnitude. The proposal to remove private patient income from public hospitals by itself will cost the public hospitals €6.5bn over a ten year period. When adjusted for inflation the estimated cost will be in the region of €8bn per decade, which is €800m in lost hospital income per year.

Based on our collective experience, the IHCA and its hospital consultant members have no confidence that the loss in private health insurance income will be replaced by the Exchequer. This is especially a concern as the State has for decades struggled to adequately fund the public acute hospital system. In the context of the ESRI projected increase in demand for hospital care by 2030, removing the private revenue stream defies logic and will cripple the public hospital system.

Considering the resultant under-resourcing of public hospitals it would only serve to exacerbate the existing Consultant recruitment and retention crisis. This proposal will cause an exodus of experienced Consultants from the public hospitals thereby reducing the availability of highly specialised clinical services to patients in public hospitals. The difficulties and challenges faced by the public acute hospital system are a consequence of years of underfunding and under-resourcing, which have severely restricted and reduced the capacity of public hospitals to meet growing demand, which means they cannot provide timely care to patients.

The Association's survey in the past week of 317 recently appointed Consultant members confirms acute hospital and mental health services face an escalating and unprecedented consultant recruitment and retention crisis because of the ongoing blatant discrimination by the State and health service employers against new hospital Consultants.

Almost all respondents (99%) agree that the lower salary terms imposed on new consultants are having an adverse impact on the delivery of patient care due to the large number of permanent consultant posts that are unfilled or filled on a temporary basis. Over 70% of new Consultants have confirmed that they will seriously consider resigning from their public hospital posts unless the discriminatory salary terms are corrected. Furthermore, the vast majority of respondents (95%) strongly agree that the lower salary terms do not reflect the importance of the work and level of responsibility that they hold in their public posts.

The survey has provided categorical evidence that our highly trained specialist consultants will not continue to work in our health services if the persistent and blatant discrimination against them continues. Recently appointed Consultants are on salaries significantly below those of their pre-October 2012 colleagues who are currently being paid up to 57% more.

It is not surprising that 72% of new Consultants ranked equal pay for equal work as the most important aspect of their working terms and conditions given the ongoing extreme discrimination they are being subjected to by the State as their ultimate employer.

In addition, 92% of the respondents confirmed that they are personally aware of colleagues working abroad who will not return to work in the Irish Public Health system as a direct result of the lower salary terms.

The results of the survey should set alarm bells ringing at Government level as it is now abundantly clear that consultant delivery of services to patients is on a cliff edge because it is being

fundamentally and critically undermined by the State's persistent discrimination against internationally sought after specialist Hospital Consultants.

The pursuit of this discrimination has resulted in approximately 450 approved consultant posts, a full 15% of the total, which cannot be filled on a permanent basis. About half of the 450 posts are vacant and some are filled on an agency basis, at costs which are up to three times the discriminatory salaries being paid to recently appointed consultants. The age profile of the Consultant workforce suggests this problem will increase dramatically as 25% are over 55 years of age.

The current two tier pay system for consultants is the major obstacle to recruitment of new Consultants. The "New Entrant" salary is not competitive in the global market for Consultants and it is discriminatory in the extreme towards new hospital Consultants.

I thank you for the opportunity to discuss the capacity issues in terms of infrastructure and consultant staffing with the Committee and I look forward to your questions.