IRISH MEDICAL
ORGANISATION
Ceardchumann Dochtúirí na hÉireann

No Future of Healthcare without Doctors

IMO Pre-Budget Submission 2018

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Ireland's healthcare system is reeling from decades of underinvestment and is ill-prepared to meet the challenges it faces, with a growing and ageing population, increased prevalence of chronic disease and resourcing advances in medical technology.

In May 2017, the Oireachtas cross-party committee on the Future of Healthcare published the *Sláintecare Report* laying out an ambitious ten-year plan for reform of the healthcare system. Like previous plans for reform, the report recommends shifting care away from the acute sector to care in the community, but with an unrealistic time frame for the expansion of universal GP care. A major omission from the report is its failure to address the key medical manpower and acute bed capacity issues facing our system.

Compared to our European counterparts we have among the lowest number of doctors employed in our health services and the number of acute beds is amongst the lowest. Insufficient capacity in our health system has left us with unprecedented and growing waiting lists. Our young doctors are fleeing the system, no longer willing to tolerate current working conditions.

In order to address the healthcare needs of a growing and ageing population, the healthcare system requires a substantial increase in funding both capital and operational. The commitment in the *Programme for a Partnership Government* to increase public health spending by 3% will be insufficient to maintain current services let alone provide for any expansion. In particular the Government needs to invest in medical manpower. **Without doctors there is no future of healthcare.**

In this year's budget submission the IMO is calling for a substantial increase in the budget to address the manpower and capacity gaps in the health system.

In particular the IMO is calling for:

- Urgent investment in General Practice to ensure ongoing viability and that the full benefits of GP care can be realised;
- An increase in consultant staffing and reinstatement of the 1500 inpatient beds removed from the system to reverse growing waiting lists and Emergency Department overcrowding;
- Ring-fenced funding to support the roll-out of electronic health records to improve efficiencies and quality of care across the health system;
- Investment in public health services and increased taxes and pricing policies on unhealthy goods to reduce consumption of tobacco, sugar sweetened drinks and alcohol and to raise much needed funds for preventive and curative care;
- The establishment of a working group to examine pharmaceutical expenditure and to recommend effective measures to ensure affordability and access to essential medicines in Ireland.

Investment in General Practice

The effect of GP care on individual patients, population health, and the healthcare system has been demonstrated to be both positive and profound. A significant body of research exists to demonstrate that continuity of care and the patient-centred approach in general practice, along with a strong supply of GPs, is associated with improved health outcomes, reduced disparities in health, and lower total health costs. [1]

However the full benefits of general practice cannot be obtained without significant investment. In Europe, Kringos *et al.*[2] found that countries which are considered to have a strong Primary Care system exhibit the following traits:

- universal access to GP care with little to no out-of-pocket payments;
- appropriate economic conditions and the distribution of resources equitably based on medical need;
- strong governance arrangements, including compulsory registration with a GP and a GP gatekeeping role; and
- a comprehensive range of services in General Practice and the community.

With Ireland's growing and ageing population, the prevalence of chronic disease is expected to increase by 4-5% per annum. Currently care for patients with chronic conditions is fragmented, with the majority taking place in hospital settings at significant expense to the tax payer. A coordinated patient-centred approach to the management of chronic conditions in General Practice can result in better outcomes for patients and reduced hospital admissions.

In line with international evidence, the cross-party group reached consensus on the need to re-orientate care towards General Practice and care in the community. A key recommendation of *Houses of the Oireachtas Committee on the Future of Healthcare Sláintecare Report* is the expansion of free GP care to the whole population over the next five years. Specifically, the Committee proposes expanding free GP care to 500,000 people per year on the basis of means at a cost of €91m, based on existing PCRS payments which are unsustainable at current levels. However the timetable is unrealistic given the resources needed to increase capacity, improve and support infrastructure and deliver a wider range of services.

Unfortunately *Sláintecare* fails to adequately address the current and impending shortage of GPs, the significant underinvestment in GP services to date and the urgent need to negotiate and resource a new GP contract.

- Currently there are 666 GPs over the age of 60 who will be retiring in the next five to seven years, of which 244 GPs over the age of 65 are likely to retire in the next two years. With current difficulties in recruiting GPs, rural areas are likely to be most affected;
- The HSE Health Service Planning Office estimates that with the introduction of the under 6 GP visit card demand for GP consultations in this population will have increased by 65.7% in 2017 and by 42.4% by 2022; [3]

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[1] B. Starfield, L. Shi, and J. Mackino, 'Contribution of Primary Care to Health Systems and Health', *The Milbank Quarterly*, Vol. 83, No. 3, September 2005, pp. 457-502.
[2] Kringos DS et al, The Strength of Primary Care in Europe, NIVEL 2012
[3] B. Smyth *et al.*, *Planning for Health, Trends and Priorities to inform Health Service Planning 2017*, HSE, 2017,

- Based on conservative estimates by the HSE National Doctors Training and Planning Office, by 2025 Ireland will need and an additional 1,380 GPs to meet current demand while an additional 2,055 GPs will be needed to expand free GP care to the entire population;[4]
- FEMPI cuts of up to 38% to General Practice has had a significant impact on GP moral and their ability to recruit additional staff. A recent survey by the Irish College of General Practitioners highlights a number of causes of general practitioners' dissatisfaction with their working conditions. Roughly half of all general practitioners rate their morale as either poor or very poor, three-quarters report their stress levels to be either high or very high, and more than half of those who tried to recruit a sessional doctor or assistant during the past year were unable to do so;[5]
- 17% of newly qualified GPs work abroad[6] with many more planning to emigrate. A survey of GP trainees found that more than half are undecided as to whether they will remain in Ireland, one-eighth are resolved to leave Ireland, and just one-third plan on remaining to practise in Ireland;[7]
- The most recent national system of health accounts released, those for 2015, demonstrate that just 3.5% of public current expenditure on health is spent in general practice.[8] By contrast, the United Kingdom's National Health Services spends 8.1% of its budget on general practice, and has committed to increasing this proportion to 11% of its budget.[9] In Australia this figure sits at approximately 6.4% of public current expenditure.[10] Ireland is losing its newly qualified GPs to countries where the value of GP care is recognised and where Governments apportion a greater percentage of public spending to GP care.

Without a significant increase in GPs and investment in General Practice services, the expansion of GP care will be impossible to implement and lead to further poor morale and burnout among GPs, and accelerated difficulties in recruiting GPs, while patients will rapidly begin to experience waiting lists for GP appointments.

The IMO warns the Government against proposals to address GP shortages with community-based nurse-led clinics. As per the IMO Submission to the Department of Health on Draft Policies to Enhance Roles for Nurses and Midwives there is insufficient evidence to support such a move and rather than complementing GP care, an alternative model of nurse-led community health services will undermine continuity of care in general practice and risk further fragmentation and duplication of care.[11]

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[4] HSE, *Medical Workforce Planning: Future Demand for General Practitioners 2015-2025*, September 2015,

[5] C. Collins and M. O'Riordan, *The Future of General Practice: ICGP Member Survey 2015*, ICGP, Dublin, 2015,

[6] Collins C. et al, *Planning for the Future Irish General Practitioner Workforce – informed by a national survey of GP Trainees and Recent GP Graduates*, ICGP, 2014.

[7] G. Mansfield *et al.*, *Bridging the gap – How GP trainees and recent graduates identify themselves as the future Irish general practice workforce*, Irish College of General Practitioners, Dublin, 2015, p. 1.

[8] Central Statistics Office, *Ireland's System of Health Accounts, Annual Results 2015*, Cork, 2017; HSE, *Primary Care Reimbursement Service: Statistical Analysis of Claims and Payments 2015*, Dublin, 2016, p. 62.

[9] N. Roberts, 'GP funding rising but still just 8.1% of NHS spend, official data show', *GP Online*, 21 September 2016; D. Millett, 'GP share of NHS funding will rise to 11% by 2020, RCGP says', *GP Online*, 19 October 2016; NHS England, *General Practice Forward View*, London, April 2016, p. 12.

[10] Productivity Commission for the Steering Committee for the Review of Government Service Provision, *Report on Government Services 2015, Volume E: Health*, 2015, pp. e8 and 10.7.

[11] IMO Submission to the Department of Health on Draft Policies to Enhance Roles for Nurses and Midwives May 2017 available at http://www.imo.ie/news-media/publications/IMO-Submission-on-the-Development-of-Community-Nursing-and-Midwifery-Final.pdf

The IMO is calling for urgent investment in General Practice and community services to ensure that the full benefits of GP care can be realised. FEMPI cuts should be urgently reversed pending negotiation with the IMO of a new fit for purpose GP contract. Targeted incentives are needed to support the development of infrastructure in General Practice and the community. Indecon carried out an analysis of potential measures to encourage the provision of primary care facilities and recommended a multi-faceted approach involving HSE-leased or built premises, GP-led centres and incentives for GPs to invest in premises and equipment. Targeted incentives would ensure the development of facilities would be GP-led and could significantly reduce exchequer costs and enhance health outcomes.[12]

Key Points:

- A large body of international research has shown that strong general practice improves patient outcomes, reduces patient hospitalisations, and drives down healthcare costs.
- 666 GPs over the age of 60 will be retiring in the next five to seven years.
- The HSE predicts a shortage of up to 2,055 GPs in Ireland by 2025.
- FEMPI cuts of up to 38% to General Practice has had a significant impact on the viability of the GP model and their ability to recruit additional staff.
- 17% of newly qualified GPs work abroad[1] with many more planning to emigrate.
- Ireland is losing its newly qualified GPs to countries where the value of GP care is recognised and where Governments invest more in GP care.
- Proposals to address the shortage of GPs with community-based nurse-led clinics are not evidence-based, undermine continuity of care in general practice and risk further fragmentation and duplication of services.

The IMO Recommends:

- The FEMPI cuts to General Practice, which depresses practice finances, should be immediately reversed, to stabilise the financing of General Practice
- Resources must be provided for the agreement of a new GP contract that:
  - (i) contains terms sufficient to attract and retain GPs,
  - (ii) provides support for the employment of expanded practice staff, and
  - (iii) facilitates a resourced expansion of services in general practice, including evidence-based chronic disease management programmes.
- A workforce action plan must be drafted to address the growing shortage of GPs which provides measures to ensure a GP workforce to meet the needs of our growing and ageing population.
- Access to diagnostics and allied health and social care professionals in the community.
- Tax incentives should be introduced for GPs to encourage the development of practice infrastructure (as per the recommendations of the Indecon Report).
- Expansion of GP care to the population must be planned and expanded as capacity allows taking into account income and medical need.

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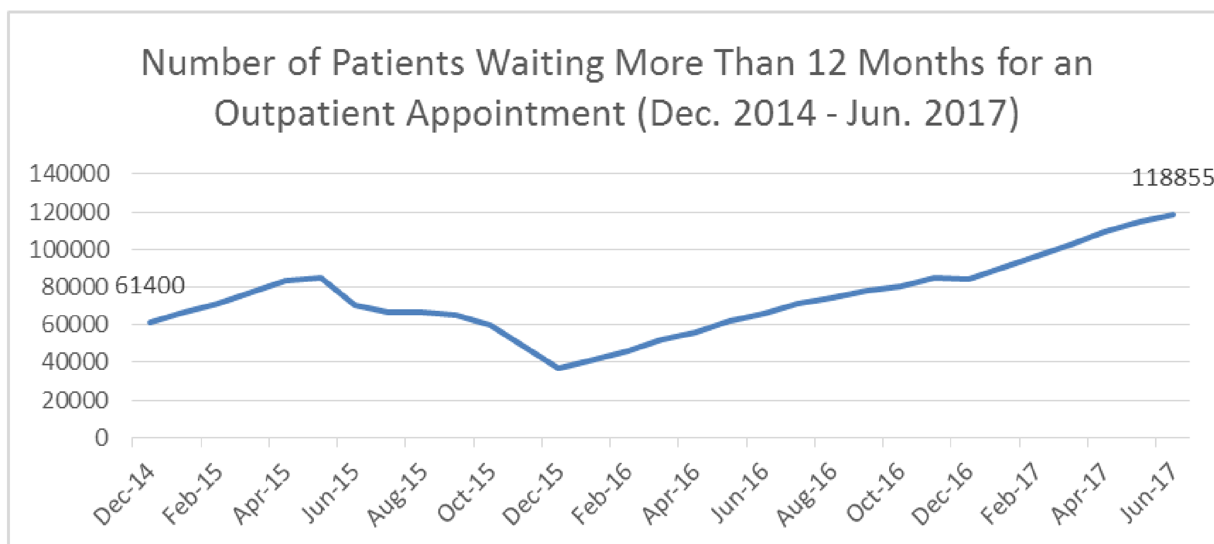
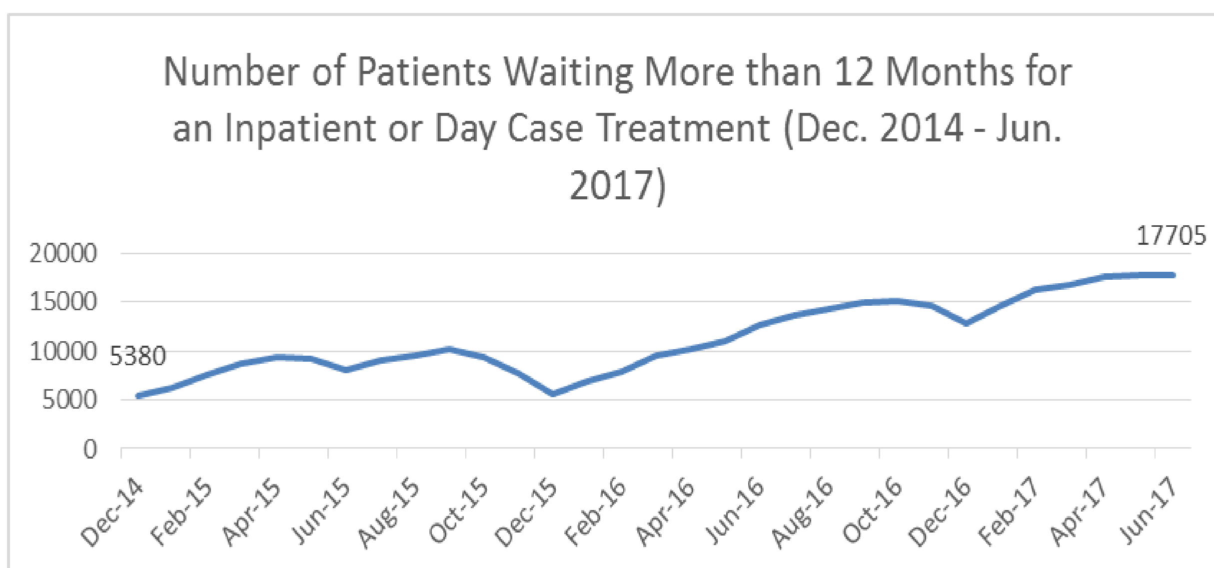
[12] Indecon International Economic Consultants, *Analysis of Potential Measures to Encourage the Provision of Primary Care Facilities*, Department of Health, 2015, pp. 80-81.

Waiting Lists and Acute Hospital Capacity

More patients are waiting longer to access treatment in Ireland than ever before. In June 2017 the National Treatment Purchase Fund published its more recent waiting list figures, which demonstrate the inability of the Irish public health system to provide timely care for patients. Just under 120,000 patients have been waiting over a year for an outpatient appointment, amounting to 25% of all those on outpatient waiting lists. This is approximately four times the number who were waiting more than a year in June 2014 (31,813), and around double the number of those waiting more than a year in June 2016 (65,863).



Waiting lists have similarly deteriorated for inpatient and day case care, where 17,705 patients have now been waiting more than a year for a treatment. This is a rise of 41% over June 2016's figure, and a rise of 118% of June 2015's figure. 21% of those waiting for an inpatient or day case treatment have been on the waiting list for over a year.



It is self-evident that delays in treatment create significant risks of poorer outcomes for patients unable to access care in a timely fashion. Under *Sláintecare* no one will wait more than twelve weeks for an inpatient procedure, ten weeks for an outpatient appointment or ten days for a diagnostic

test. In addition a maximum four hour target waiting time will be introduced in Emergency Departments. *Sláintecare* sets some welcome goals in relation to waiting times however the report falls significantly short on describing how the targets are to be achieved. Access to care in the public hospital system is primarily a capacity issue both in terms of the number of consultants employed in our health services and the number of acute hospital beds available. In order to increase capacity in the public hospital system, *Sláintecare* recommends that private activity in public hospitals is to be phased out over a five year period between year two and year six with an allowance for the recruitment of an additional 593 consultants only from year four. While no provision is made to expand the number of acute beds pending the acute bed capacity review that has been commissioned by the Minister for Health.

There is no evidence that the removal of private care from public hospitals will increase capacity. No indication is provided in the report that these patients are likely to obtain their care elsewhere, within the private health system nor is any indication given that the private hospital system has the capacity to treat some, or all, of the patients who present. Rather than addressing capacity issues the move is likely to simply change the funding mechanism for these patients accessing care in the public system while the potential adverse impact of such a move on the recruitment and retention of hospital consultants is unknown.

Waiting lists and emergency department overcrowding are at their highest levels ever and cannot be addressed without a significant increase in the number of consultant posts and an increase in the number of acute beds available within the health system.

Recruitment and Retention of Medical Manpower

A significant contributor to long waiting times, and thus poor access to care in Ireland, is medical understaffing. In contrast to its international comparators, Ireland possess a low number of medical and surgical specialists, employing just 0.59 medical specialists and 0.46 surgical specialists per 1,000 populations. This compares to an EU average of 1.1 and 0.7 specialists per 1,000 population respectively, with Ireland employing the lowest number of medical specialists per capita and the third lowest number of surgical specialists per capita in the EU, as per statistics compiled by the OECD.[13]

The *Report of the National Task Force on Medical Staffing*, often referred to as the Hanly Report, set out ratios of consultant to population that would need to be met to provide a consultant-delivered health service. Based on current population, Ireland would require approximately 4,400 consultants working in the public health service to meet these recommendations, however at present only about 2,800 are employed. Many specialties are experiencing a severe shortage of consultants, a large number of which employ less than half the number of consultants recommended in the Hanly Report. Overall, the State employs only about two-thirds the number of consultants required to provide an adequately staffed, consultant-delivered service.

While the figures provided in the *Report of the National Task Force on Medical Staffing* provided for an important guideline to necessary consultant staffing, it is also crucial to engage with clinical programme leads nationwide to gain an understanding of the staffing requirements of the various

[13] Organisation for Economic Co-operation and Development, Health Statistics 2017, Health Care Resources, Physicians by Category, (available at: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT).

components of the public health service. As set out by Dr. Stephen Kinsella during his presentation to the Oireachtas Committee on the Future of Healthcare, workforce planning must be informed by a qualitative understanding of the system from service-level inputs, developed through a structured dialogue with health professionals. This is necessary to correctly inform and contextualise all data and modelling employed in workforce planning.[14] To better provide for workforce planning, systems for regular structured dialogue of this nature must be put in place, in addition to a commitment to collect and retain a quantitative data set, including, but not limited to, the supply, demand, and geographical flow of patients, treatment complexity, health professional immigration and emigration patterns, as well as graduate availability and workforce attrition."

As has been well publicised, the health services in Ireland experience profound difficulties in recruiting and retaining medical staff. Up to 400 approved consultant posts remain unfilled or filled on a temporary basis by locum staff. This is, in large part, due to remuneration, and working conditions, lagging significantly behind those available elsewhere in the English-speaking world. In 2015 alone the Irish medical register experienced an exit rate of 8.7% of doctors aged between 25 and 34, a figure which amounts to roughly one in every eleven doctors within this age bracket leaving our shores.

A recent report published by the Royal College of Surgeons in Ireland (RCSI) found that "[r]esearch on health professional emigration in the Irish context indicates that much recent emigration has been driven by dissatisfaction with working conditions in the health system and uncertain career progression opportunities, aggravated by austerity-related staff reductions, salary reductions and taxation increases".[15] The RCSI report also notes that there has been a change in the pattern of emigration in recent years, with more doctors leaving at an earlier stage in their training, many within one or two years of graduation, and more doctors staying abroad rather than returning. An exploratory study of 388 health professionals, including 307 doctors, who had trained at undergraduate level or who had worked in Ireland but had subsequently emigrated, revealed that only 24% intended to return to practise medicine in Ireland in the future. 90% of respondents were Irish-trained doctors who had emigrated to Australia, the United Kingdom and the United States of America. Respondents described their main motivation for emigration as the working conditions and environment in Ireland, and the availability of better training and research opportunities abroad.

In its submission to the Public Service Pay Commission the IMO noted pay for non-consultant hospital doctors in Ireland is between 5% and 19% behind that offered in other English-speaking jurisdictions. Additionally, a lack of appropriate training support structures compounds pay-related problems, as doctors in training are often required to pay for their training from their own wages while 55% state that they have been unable to take their full entitlement of study leave due to there being insufficient staff at their hospital to enable them to take this leave. These doctors work in a health system where they are under-staffed, under-resourced, and which places barriers in the way of successful completion of their training.

[14] S. Kinsella, *Strategic Health Workforce Planning*, 14 September 2016, (available at: http://stephenkinsella.net/WordPress/wp-content/uploads/2016/09/Kinsella_Oireachtas_FutureofHealth_14_Sept_2016.pdf).

[15] A. Walsh and R. Brugha, *Brain Drain to Brain Gain: Ireland's Two-Way Flow of Doctors*, Royal College of Surgeons in Ireland, Dublin, 2017, p. 13.

The present consultant contract can be viewed as similarly unattractive, containing neither the strong supports, nor additional payments contained contracts offered in jurisdictions such as Australia, Canada, and New Zealand. The full reversal of the 30% pay cut imposed unilaterally on consultants in 2012 would be required to render the remuneration available under the Irish consultant contracts as sufficiently attractive in an international marketplace.

However, unless radical action is taken to resolve the recruitment and retention crisis within the health services in Ireland, these services will continue to buckle under the various pressures placed on them, ultimately endangering patient welfare. The IMO calls on the government to recognise medical understaffing as a central cause of capacity issues within the health services, and to provide the necessary funding to the HSE to improve salaries, working conditions, and staffing to levels which will ensure the effective recruitment and retention of medical practitioners.

Key Points:

- The number of patients waiting more than a year for an outpatient consultant appointment has doubled since last year.
- Ireland has the lowest number of doctors per capita in the European Union,
- Based on the recommendations of the Hanly Report, an additional 1,600 consultants are needed to deliver a consultant provided hospital service.
- Up to 400 approved consultant posts remain unfilled or filled on a temporary basis by locum staff.
- One in eleven doctors aged between 25 and 34 left the Irish medical register in 2015, to take up medical work abroad. Research indicates the overwhelming majority do not plan to return.
- Independent research has revealed that doctors are emigrating from Ireland in large numbers due to poor pay, difficult working conditions, and low staffing levels in the public health service.

The IMO Recommends:

- Significant investment must be made in workforce planning, and recruitment and retention efforts, to ensure the Irish health services are fully staffed with appropriately experienced medical professionals.
- Consultant staffing should be expanded to the levels required to provide consultant-delivered healthcare, in a timely manner, in the public health service.
- The 30% unilateral pay cut imposed on new-entry consultant doctors in 2012 must be completely reversed, to restore pay parity among colleagues.
- The negotiation of new Consultant and NCHD contracts to ensure that working conditions in Irish hospitals can compete with other English-speaking countries.

Investment in Acute Bed Capacity

A major omission in the recently published *Sláintecare Report* was its failure to recommend any immediate remedial action to address the chronic bed capacity issues in Irish hospitals. Ireland possesses 276 inpatient and day-case beds per 100,000 population. This compares to a Western European average of 449 per 100,000. Again even when including private hospital beds, Ireland's figure still rises only to approximately 358 hospital beds per 100,000 population. In terms of inpatient beds alone Ireland needs an additional 3,500 inpatient hospital beds to bring us up to the West European average.

Bed occupancy rates published in 2016 found that bed occupancy in Ireland had risen 97%, and sat at an average of 104% in Model 4 hospitals.[16] This far exceeds the recommended 85% bed occupancy, and is well above the identified 92.5% tipping point that has been shown to result in significantly higher patient mortality, due to rationing of resources and elevated stress levels.[17] Additionally, this winter has been the worst yet in terms of emergency department over-crowding as a record average of 511 patients a day were cared for in beds, trolleys or chairs, on inpatient wards or units above the stated complement of that ward or unit in January 2017, an all-time high.[18]

Just 10,643 public in-patient beds currently exist within the Irish health system,[19] 1,480 less than a decade ago, when in-patient bed numbers stood at 12,123.[20] While there has been some increase in the number of day-case beds since 2007 (1,545 to 2,150), this does not compensate for the overall loss of beds to the system over the past ten years.[21] All of this has occurred while the number of persons aged 65 years of age and older has increased by close to 158,000 people, or just over one-third.[22] Patients in this age cohort represent the majority of users of in-patient beds, yet the HSE's Acute Services Operational Plan for 2017 only contains a proposal to increase current in-patient bed numbers by a mere 38 in 2017, with no proposal to increase the number of day-case beds during the year.[23] The health service bed capacity review must include a comprehensive assessment of bed capacity needs across the health system including acute hospitals, inpatient mental health services as well as rehabilitative and long-term care services.

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[16] Department of Health, *Interim Report and Recommendations by the Taskforce on Staffing and Skill Mix for Nursing*, Dublin, February 2016, p. 27.
[17] L. Kuntz, R. Mennicken, and S. Scholtes, 'Stress on the ward: evidence of safety tipping points in hospitals', *Management Science*, Vol. 61, pp. 754-771.
[18] Irish Nurses and Midwives Organisation, *Emergency Department Trolley and Ward Watch*, January 2017.
[19] Health Service Executive, *Acute Services Operational Plan 2017*, Dublin, 2017, p. 21.
[20] Department of Health, *Health in Ireland: Key Trends 2016*, Dublin, 2016, p. 36.
[21] Ibid.
[22] Ibid, p. 6.
[23] Health Service Executive, *Acute Services Operational Plan 2017*, Dublin, 2017, p. 21.

Key Points:

- Ireland needs 3,500 acute hospital beds to bring us up to the West European average.
- Irish hospitals are operating at close to 100% capacity and are in a state of perpetual overcrowding that is risking patients' lives.
- The number of in-patient beds in Ireland has declined by approximately 1,500 since 2007.
- The number of persons in Ireland aged 65 years and older has increased by one-third, or 158,000 since 2007.
- The HSE plans to add only 38 beds to the hospital system this year.

The IMO Recommends:

- An immediate replacement of the roughly 1,500 in-patient beds removed from the public hospital system since 2007, with further financial provision made for additional beds, pending the outcome of the Department of Health's bed capacity review.
- Funding for the NTPF should be diverted to support the elective surgery programme.
- Resources for improved hospital infrastructure must be provided to bring facilities up to the required standard.
- The health service capacity review must include a comprehensive assessment of bed capacity needs across the health system including acute hospitals, inpatient mental health services as well as rehabilitative and long-term care services.

Improving Efficiency with Information & Communications Technology

Information and communications technology (ICT is widely considered a key tool for supporting integrated health care systems, facilitating the "seamless" transfer of patients between clinical settings and enhancing patient safety and quality of care, by reducing repetition and errors in diagnostics and treatments. The collection of data also allows for the advancement of medical knowledge, management of disease and health service planning. Plans are currently underway to introduce individual health identifiers for patients in Ireland by 2018, and to develop electronic health records for all patients in Ireland. *Sláintecare* recognises the need for investment in electronic health records, however, the HSE has identified a lack of finance as the most significant barrier to eHealth.[24] Initiatives such as these can aid the provision of integrated care for patients, but are fraught with data collection and privacy challenges. A cost of between €647m and €875m has been estimated for the roll-out of Electronic Health Records over a five year period, and budgetary provision and commitment must be made to ensuring the timely implementation of this initiative, in the interest of improving integrated patient care.[25]

[24] Health Service Executive, *EHR Strategic Business Case*, Office of the Chief Information Officer, Dublin, February 2016, at [25].

[25] S. Harris, Dáil Éireann Written Answers, Department of Health - Electronic Health Records, 31 May 2017.

Issues relating to patient confidentiality, security and the secondary use of information need to be addressed through legislation, where necessary, and supported by adequate funding to ensure the accuracy and confidentiality of patients' data are secured. Challenges can also arise if new systems are not capable of capturing clinically relevant information, cannot be easily embedded into existing ICT systems and add to the administrative workload of physicians. Investment is required to ensure that electronic Health Records and critical IT infrastructure in healthcare are adequately protected, including from cyber-attacks which may come from within or outside the jurisdiction, as was the case during the recent cyber-attacks levelled against the United Kingdom's National Health Service.

Key Points:

- The use of ICT can offer benefit in the provision of better informed and more integrated care for patients.
- Plans are currently underway to introduce individual health identifiers and electronic health records for patients in the coming years.
- The expansion of the use of ICT however can place patient data at greater risk of privacy breaches.

The IMO Recommends:

- Appropriate funding be provided to ensure that current ICT and eHealth projects undertaken in the Irish health services be completed on time, so that patients may benefit from these initiatives.
- Funding be assigned and ring-fenced to ensure the timely roll-out of Electronic Health Records for all patients nationally, at a cost of between €647m and €875m over a five-year period.
- Resources must also be put in place to ensure that the accuracy and privacy of patients' data are protected from infringement.

Investment in Prevention

With just 1% of Government spending on healthcare allocated to prevention, *Sláintecare* recommends a greater focus on prevention with an increase in spending on Health and Well-being of €233m over the next ten years. Furthermore prioritising disease prevention, health promotion and public health services has been highlighted by the World Health Organisation as a key action to ensure the economic, social and environmental sustainability of healthcare systems.[26] Public health capacity in the health system is under-resourced and over 40% of public health specialists approaching retirement. Immediate action is needed to expand public health capacity and attract medical graduates to this discipline.

[26] WHO, Environmentally Sustainable Health Systems: A Strategic Document , Copenhagen 2017

Taxation and Pricing Policies

Taxation and pricing policies are effective tools for reducing the consumption of unhealthy goods that contribute to poor health such as tobacco, alcohol and sugar sweetened drinks while at the same time raising funds for much needed preventive and curative healthcare services.

Tobacco Consumption

18.7% of adults aged 15 years and older smoke one or more cigarettes each week.[27] This is considerably lower than the 29% of the population who identified as smokers just ten years ago,[28] however present levels remain close to one-in-five adults, and thus unacceptably high. The inverse relationship between tobacco price and levels of consumption is almost universally acknowledged among policy researchers. The World Health Organization acknowledges the benefits of pursuing increases in taxation on cigarettes as a means of reducing tobacco consumption in Article 6 of its Framework Convention on Tobacco Control, which advocates for "tax policies and … price policies on tobacco products, so as to contribute to the health objectives aimed at reducing tobacco consumption."[29] The World Health Organisation predicts that a 10% increase in tobacco prices can reduce consumption by 4% in high income countries,[30] while a €1 increase in the price of a packet of cigarettes would yield up to €125.6m in revenue in 2017.[31] Accordingly, the IMO suggests an increase in taxation of €1.00 on all cigarette products in the forthcoming budget.

Sugar Sweetened Drinks

60% of Irish adults are now overweight or obese, while just 37% are considered to have normal body weight.[32] A recent projection of obesity and overweight in Ireland 89% are likely to be overweight or obese, and 48% are estimated to be obese, by 2030, while 85% of women are likely to be overweight or obese, and 57% obese, by 2030.[33] Obesity and overweight represent serious health public health challenges in Ireland, and are associated with increased risk of diabetes, cardiovascular disease, stroke, hypertension, and respiratory problems. In Ireland the healthcare and societal costs associated with obesity were estimated at €1.13bn for 2009.[34] Increased population, rates of obesity, and healthcare costs all mean that total is likely to be higher today. The direct healthcare costs associated with increased levels of obesity and overweight are estimated to amount to €5.4 billion by 2030.[35]

While there are a complex array of factors that lead of obesity and overweight, sugar-sweetened drinks alone can have a significant effect on weight gain. For example, a 20-year study on 120,000 men and women found that those who increased their sugar-sweetened drink consumption by one

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[27] Health Service Executive, *Smoking Prevalence Tracker 2016*, 2017, p. 3.

[28] R. Brugha *et al.*, *SLAN 2007: Survey of Lifestyle, Attitudes and Nutrition in Ireland. Smoking Patterns in Ireland: Implications for policy and services*, Royal College of Surgeons in Ireland, Dublin, 2009, p. 5.

[29] World Health Organization, *Framework Convention on Tobacco Control*, Geneva, 2003, Article 6.

[30] WHO, *Raising tax on Tobacco, What you need to know*, 2014.

[31] Department of Finance, *General Excise Paper – Tobacco Products Tax, Alcohol Products Tax and Betting Duty*, July 2017, p. 16.

[32] Ipsos MRBI, *Health Ireland Survey 2015: Summary of Findings*, The Stationery Office, Dublin, 2015, p. 5.

[33] World Health Organization Regional Office for Europe European Congress on Obesity in Prague, Czech Republic, 5-6th May 2015.

[34] Keaver *et al.*, 'Application of the UK Foresight Obesity Model in Ireland: The Health and Economic Consequences of Projected Obesity Trends in Ireland', *PLoS ONE*, November 2013, doi.org/10.1371/journal.pone.0079827.

[35] Ibid.

12-ounce serving per day (roughly the equivalent of one 330ml can) gained, on average, an extra pound every four years, than people who did not change their intake.[36] There is also a strong link between the consumption of sugar-sweetened drinks in children and obesity, with one study finding that, for each additional 12-ounce soda children consumed each day, the odds of becoming obese increased by 60% during the eighteen months of follow-up.[37] In October 2016, the government announced plans to introduce a sugar-sweetened drinks tax in April 2018. Studies estimate that a 20% tax increase on sugar sweetened drink could reduce obesity by between 1.3%[38] and 3.5%,[39] while a 20c increase on a 330ml can of sugar-sweetened soft drinks would have yielded up to €202.6m for the exchequer in 2017.[40] This measure must be included amongst the provisions of Budget 2018 to ensure that this tax commences in April, as originally set out.

Alcohol Consumption

Alcohol consumption is once again on the rise in Ireland, with per capita intake during 2016 for those aged 15 years and older rising to 11.5 litres of pure alcohol, from 10.9 litres in 2015, a rise of 5%.[41] This figure is all the more troubling when it is considered that approximately 21% of all Irish adults report abstaining from alcohol entirely, which is a significantly higher number than in many other west European countries, and indicates that the average consumption of alcohol per adult who drinks is a deal greater than the 11.5 litres average for all those aged 15 years and older.[42]

According to a major report released by the Health Research Board, Ireland's statutory health research agency, in 2013 alcohol-related discharges accounted for 160,211 bed days in public hospitals, that is 3.6% of all bed days that year.[43] This compared to 56,264 bed days or 1.7% of the total number of bed days in 1995.[44] The direct healthcare costs of alcohol-related discharges to the health service, and thus tax payers, was €1.5 billion in 2012, roughly equal to €1 for every €10 spent on public health in that year.[45] This excludes the cost of emergency cases, GP visits, psychiatric admissions, and alcohol treatment services.

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[36] D. Mozaffarian *et al.*, 'Changes in diet and lifestyle and long-term weight gain in women and men', *New England Journal of Medicine*, 2011, Vol. 364, No. 25, pp. 2392-2404.
[37] D.S. Ludwig, K.E. Peterson, and S.L. Gortmaker, 'Relation between consumption of sugar-sweetened drinks and childhood obesity: a prospective, observational analysis', *The Lancet*, Vol. 357, No. 9255, February 2001, pp. 505-508.
[38] A.D.M. Briggs *et al.*, 'Overall and income specific effect on prevalence of overweight and obesity of 20% sugar
sweetened drink tax in UK: econometric and comparative risk assessment modelling study' *BMJ* 2013;347:f6189.
[39] O. Mytton, D. Clarke, and M Rayner, 'Taxing unhealthy food and drinks to improve health', *BMJ* 2012;344:e2931.
[40] Department of Finance, *General Excise Paper - Tobacco products Tax, Alcohol Products Tax and Tax on Sugar-Sweetened Drinks*, July 2016, p. 36.
[41] Alcohol Action Ireland, *Ireland's Per Capita Alcohol Consumption Increased in 2016*, February 2017, available at http://alcoholireland.ie/irelands-per-capita-alcohol-consumption-increased-2016/.
[42] J. Long and D. Mongan, *Alcohol Consumption in Ireland 2013: Analysis of a National Alcohol Diary Survey*, Health Research Board, Dublin, 2014, p. 25; World Health Organisation, *European Status Report on Alcohol and Health 2010*, Copenhagen, 2010, p. 21
[43] D. Mongan and J. Long, *Alcohol in Ireland: consumption, harm, cost and policy response, HRB Overview Series 10*, Health Research Board, Dublin, 2016, p. 11.
[44] Ibid.
[45] Ibid.

There are significant economic, health, and societal cases for making a concerted effort to reduce alcohol consumption in Ireland. The IMO supports the urgent introduction of minimum unit pricing for alcohol, and the introduction of a levy on the alcohol industry for the treatment of alcohol-related harm. It is estimated that a €1 minimum unit price would reduce alcohol-related deaths by 75 and hospital admissions by 2,295 in year one increasing to a reduction of 197 deaths and 5,878 hospital admissions after 20 years.[46] Additionally, Alcohol Action Ireland have estimated that a 5 cent levy per standard unit of alcohol would raise up to €151m for the exchequer.[47]

Support for Vaccinations

Given the recent substantial decline in the percentage of girls in their first year of second level schools who have received the HPV vaccine, from 87% in 2014/2015 to 72% in 2015/2016,[48] concerted efforts must be made by government to reverse this trend. Though anecdotal, it is believed that this decline can, in large part, be attributed to recent unsubstantiated claims that the vaccine can cause chronic and negative health consequences amongst those vaccinated. There is no scientific basis for such claims, a view supported by the European Medicines Agency, which found in a review published in November 2015 that there was no evidence that the vaccine is linked to chronic fatigue, or similar ailments.[49] The IMO calls on the government to provide appropriate resources to ensure the general public are fully informed of the benefits of vaccinations and their safety, including the HPV vaccine. Furthermore, the IMO recommends that the HPV vaccine be extended to boys of equivalent age to establish greater immunity to the HPV among young adolescents.

Key Points:

- Just 1% of Government spending on healthcare is allocated to prevention.
- Public health capacity in the health system is under-resourced and over 40% of public health specialists approaching retirement.
- Taxation and pricing policies are effective tools for reducing the consumption of unhealthy goods such as tobacco, alcohol and sugar sweetened drinks while at the same time raising funds for much needed preventive and curative healthcare services.
- Despite falls in tobacco consumption, around one-in-five Irish adults smoke cigarettes every week.
- 60% of Irish adults are now overweight or obese, while just 37% are considered to have normal body weight.
- Per capita alcohol consumption in Ireland grew in 2016 to 11.5 litres of pure alcohol and remains at a level far above the WHO's recommended maximum intake.
- Vaccinations, such as those against the HPV, have been subject to unsubstantiated claims about their safety, despite all scientific evidence disproving such claims.

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[46] C. Angus *et al.*, *Model-based appraisal of minimum unit pricing for alcohol in the Republic of Ireland: An adaptation of the Sheffield Alcohol Policy Model version 3*, University of Sheffield, September 2014, p. 68.
[47] Alcohol Action Ireland, *Pre-Budget Submission 2015*, p. 11.
[48] Department of Health, *National Healthcare Quality Reporting System: Third annual report*, National Patient Safety Office, Dublin, 2017, p. 34.
[49] European Medicines Agency, *Assessment report: Review under Article 20 of Regulation (EC) No 726/2004 - Human papillomavirus (HPV) vaccines*, 2015, London, p. 39.

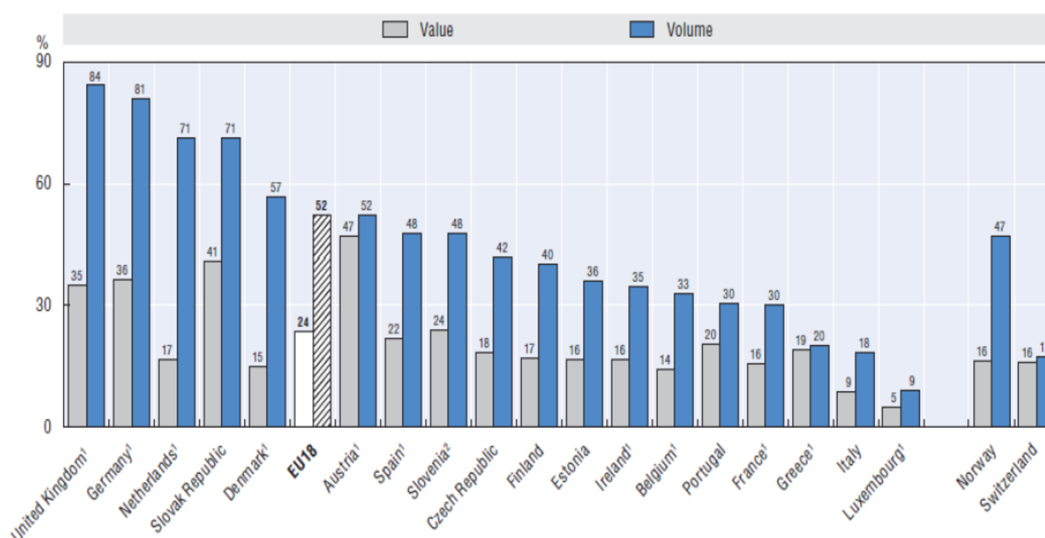
The IMO Recommends:

- Investment in prevention and public health capacity.
- A price increase of €1.00 per packet of cigarettes, to reduce tobacco consumption.
- The introduction of a tax on sugar-sweetened drinks in 2018, as set out in Budget 2017.
- The urgent introduction of minimum unit pricing on alcohol, to reduce the availability of low-cost alcohol products and the introduction of a levy on the alcohol industry for the treatment of alcohol-related harm.
- That the government provide appropriate resources to ensure the general public are fully informed of the benefits and safety of vaccinations, including the HPV vaccine.
- That resources are provided to extend the HPV vaccination programme to teenage boys.

Pharmaceutical Spending and Access to New Medicines

The Government spends almost €2billion annually on pharmaceuticals and medical devices representing 14% of Government expenditure on health. Broadly pharmaceutical pricing in Ireland is negotiated with the pharmaceutical industry based on cost-effectiveness, the cost of existing medicines and the average manufacturing prices of medicines in a basket of nine reference countries. Recent negotiations with pharmaceutical industry representatives has led to average price reductions of 30% while the introduction of generic substitution and reference pricing has increased the level of generic penetration it remains low compared to our European counterparts[50]

Share of generics in the total pharmaceutical market, 2014 (or nearest year)



1. Reimbursed pharmaceutical market.
2. Community pharmacy market.

In recent years the IMO has become increasingly concerned at the cost of innovative new medicines and their potential to threaten the stability of health care spending as recent debates over the

[50] OECD Health Systems at a Glance 2016.

reimbursement of Orkambi and Sofosbuvir have demonstrated. Innovative new drugs have the potential to change the lives of hundreds of patients however they often come at a prohibitive cost.

In 2016 the report of the UN Secretary-General's High level panel on Access to Medicines examined some of the incoherencies between trade and intellectual property rights and public health objectives and made a number of recommendations to UN members to enhance policy coherence. The recommendations included:

- Making use of the flexibilities in the TRIPS Agreement to promote access to health technologies when necessary. The flexibilities include compulsory licensing whereby the Government can impose the terms under which a patented product can be used or produced in generic version without the consent of the patent holder.
- Public funders of research must require that knowledge generated from research is made freely and widely available and universities and research institutions in receipt of public funding must prioritise public health objectives over financial gain in their patenting and licensing practices.
- Increased Government investment and incentives for research and development of new technologies to ensure that funding for research and development addresses unmet need.
- Assuring appropriate governance, accountability and transparency. In relation to R&D, pricing and distribution of health technologies, governments should require manufacturers and distributors of health technologies to disclose information pertaining to R&D costs, production, marketing distribution as well as any public funding received including tax credits, subsidies and grants.

Pharmaceutical pricing requires a multifaceted approach. The IMO is calling on the Government to establish a working group to examine pharmaceutical expenditure in Ireland and to recommend effective policies to ensure affordability and access to essential medicines in Ireland.

Key Points:

- 14% of Government expenditure on health is spent on pharmaceuticals and medical devices.
- The level of generic penetration remains low compared to our European counterparts.
- Innovative new drugs have the potential to change the lives of hundreds of patients however they often come at a prohibitive cost.

The IMO Recommends:

- The establishment of a working group to examine pharmaceutical expenditure in Ireland and to recommend effective policies to ensure affordability and access to essential medicines in Ireland.
- Initiatives should include but not be limited to the full implementation of the recommendations outlined in the UN Secretary-General's High Level Panel report on Access to Medicines. In particular the IMO calls upon the Government to
    - make use of the flexibilities in the TRIPS Agreement, such as compulsory licensing, to promote access to health technologies when necessary;
    - institute legislation to attach conditions to the public funding of medical research in order to ensure affordability of the end products of biomedical research;
    - insist on transparency from the pharmaceutical and medical device industry in relation to the manufacturing, research & development, marketing and distribution costs of new medicines as well as any public funding received such as tax credits, subsidies and grants.

Conclusion

The Irish health system requires a significant increase in funding if it is to address the challenges of a growing and ageing population, increased prevalence of chronic disease and advances in medical technology. Investment in general practice, consultant manpower, acute bed capacity and information and communication technology must be prioritised in this year's budget if any progress is to be made in reforming our health services. Measures must be taken now to prevent further growth in healthcare expenditure, greater focus is needed on prevention measures while at the same time greater attention must be paid to addressing the high cost of innovative new medicines.

Summary of Recommendations

Investment in General Practice

The IMO recommends:

- The FEMPI cuts to General Practice, which depresses practice finances, should be immediately reversed, to stabilise the financing of General Practice
- Resources must be provided for the agreement of a new GP contract that:

    (i) contains terms sufficient to attract and retain GPs,

    (ii) provides support for the employment of expanded practice staff, and

    (iii) facilitates a resourced expansion of services in general practice, including evidence-based chronic disease management programmes.

- A workforce action plan must be drafted to address the growing shortage of GPs which provides measures to ensure a GP workforce to meet the needs of our growing and ageing population.
- Access to diagnostics and allied health and social care professionals in the community.
- Tax incentives should be introduced for GPs to encourage the development of practice infrastructure (as per the recommendations of the Indecon Report).
- Expansion of GP care to the population must be planned and expanded as capacity allows taking into account income and medical need.

Waiting Lists and Acute Hospital Capacity

Recruitment and Retention of Medical Manpower

The IMO recommends:

- Significant investment must be made in workforce planning, and recruitment and retention efforts, to ensure the Irish health service is fully staffed with appropriately experienced medical professionals.
- Consultant staffing should be expanded to the levels required to provide consultant-delivered healthcare, in a timely manner, in the public health service.
- The 30% unilateral pay cut imposed on new-entry consultant doctors in 2012 must be completely reversed, to restore pay parity among colleagues.
- The negotiation of new Consultant and NCHD contracts to ensure that working conditions in Irish hospitals can compete with other English-speaking countries.

Investment in Acute Bed Capacity

The IMO recommends:

- An immediate replacement of the roughly 1,500 in-patient beds removed from the public hospital system since 2007, with further financial provision made for additional beds, pending the outcome of the Department of Health's bed capacity review.
- Funding for the NTPF should be diverted to support the elective surgery programme
- Resources for improved hospital infrastructure must be provided to bring facilities up to the required standard.
- The health service capacity review must include a comprehensive assessment of bed capacity needs across the health system including acute hospitals, inpatient mental health services as well as rehabilitative and long-term care services.

Improving Efficiency with Information and Communications Technology

The IMO recommends:

- Appropriate funding be provided to ensure that current ICT and eHealth projects undertaken in the Irish health services be completed on time, so that patients may benefit from these initiatives.
- Funding be assigned and ring-fenced to ensure the timely roll-out of Electronic Health Records for all patients nationally, at a cost of between €647m and €875m over a five-year period.

- Resources must also be put in place to ensure that the accuracy and privacy of patients' data are protected from infringement.

Investing in Prevention

The IMO recommends:

- Investment in prevention and public health capacity.
- A price increase of €1.00 per packet of cigarettes, to reduce tobacco consumption.
- The introduction of a tax on sugar-sweetened drinks in 2018, as set out in Budget 2017.
- The urgent introduction of minimum unit pricing on alcohol, to reduce the availability of low-cost alcohol products and the introduction of a levy on the alcohol industry for the treatment of alcohol-related harm.
- That the government provide appropriate resources to ensure the general public are fully informed of the benefits and safety of vaccinations, including the HPV vaccine.
- That resources are provided to extend the HPV vaccination programme to teenage boys.

Pharmaceutical Spending and Access to New Medicines

The IMO recommends:

- The establishment of a working group to examine pharmaceutical expenditure in Ireland and to recommend effective policies to ensure affordability and access to essential medicines in Ireland.
- Initiatives should include but not be limited to the full implementation of the recommendations outlined in the UN Secretary-General's High Level Panel report on Access to Medicines. In particular the IMO calls upon the Government to:
    - make use of the flexibilities in the TRIPS Agreement, such as compulsory licensing, to promote access to health technologies when necessary;
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