IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Submission to the Oireachtas Committee on the

Future of Healthcare

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Strategy

The Irish Medical Organisation (IMO) is the only body that represents all doctors in Ireland and is committed to a caring efficient and effective health service. **The IMO believes that the primary strategic goal over the next ten years should be to develop a universal healthcare system that aims to secure access to adequate, quality healthcare for all when they need it and at an affordable cost.**

IMO Key Priorities for the Health Service

Building a 21st century universal healthcare system requires:

- Agreement on a strategic plan for the development and resourcing of General Practice. General Practice is the cornerstone of any healthcare system. The continuity of care provided in General Practice is key to improving patient outcomes and cost-effective care;
- Building Capacity in the Public Hospital System. This will require detailed medical manpower planning to assure a consultant-delivered hospital service and an assessment of the acute bed capacity needed;
- Provision for appropriate long-term residential and community care services as well as rehabilitative care services to cater for the needs of an ageing population;
- A new mental health strategy that places mental health on a par with physical health;
- Expansion of Public Health Expertise to ensure that health service planning and prevention measures take into account the best available evidence.

Key challenges to a Universal Health System

Ireland faces three significant challenges to achieving a universal healthcare system, as follows:

I. **Enhancing service provision and manpower capacity across the health system to meet the needs of a growing population and changing demographics.** This requires an assessment of capital investment, manpower planning across all health professionals and the financial resources required to provide a 21st century healthcare service in line with international best-practice.

II. **The recruitment and retention of our highly qualified medical workforce.** As key decision makers doctors are vital healthcare professionals in a 21st century healthcare system assuring the highest quality evidence-based care. Doctors undergo many years of training to become specialists in their field. Only doctors possess the clinical skills and expertise necessary to diagnose illness, recommend treatment and advise patients on the likely prognosis. No other healthcare professional is trained in this way or possesses these skills. With up to 60% of our trainee doctors planning to leave, the recruitment and retention of our medical workforce is the biggest threat to assuring a quality public universal health service.

III. **Financing universal healthcare**. Universal healthcare will require additional capacity and resources. In order to avoid a fiasco like the water charges, open debate is required on both the future vision of our health services and the cost, as well as the most appropriate funding model.

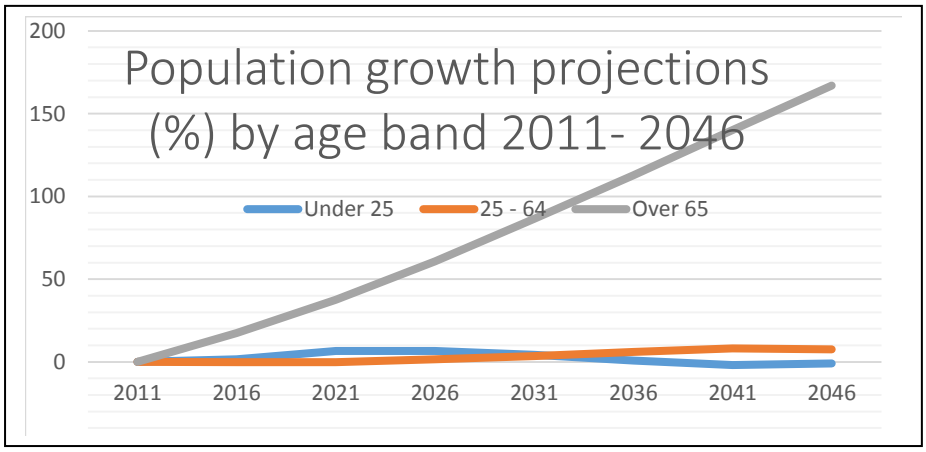
Building Capacity in the Healthcare System

Health services are complex and require detailed long-term planning. In order to achieve the desired goal of a universal healthcare system careful assessment is needed of the capacity, financial and manpower resources needed across the health system.

Ireland's Growing Population and Demographic Change

Ireland's population is both growing and ageing. Based on a number of different scenarios the CSO estimate that Ireland's population will grow from 4.758 million[1] to between 4.85 and 5.3 million by 2026 while the population aged 65 and over will grow from 586,600 people (2014 figures) to between 850,000 and 860,000 by 2026.

[2]



While the majority of people are healthy, an expanding and ageing population places significant demands on the healthcare system with the prevalence of chronic disease expected to increase by 4% - 5% per annum during this period.

Projected Patients with Chronic Disease Aged 65+ (2016 – 2026)

Disease	Prevalence (%)	2016	2021	2026*
Angina	10.1	63,040	73,920	86,930
Hypertension	51.4	320,830	376,180	442,400
Atrial Fibrillation	5.6	34,950	40,980	48,200
Stroke	2.9	18,100	21,220	24,960
Diabetes	10.9	68,040	79,770	93,820
COPD/Lung Disease	5.1	31,830	37,320	43,900
Arthritis	38.9	242,800	284,700	334,810

Health Service Executive, *Planning for Health: Trends and Priorities to Inform Health Service Planning 2016*, p. 37. * 2026 patient projections achieved by applying stated prevalence rates to the aged 65+ population estimate for 2026 of 860,700 supplied in Central Statistics Office, *Population and Labour Force Projections: 2016-2046*, 2013, p. 27. Assessment based on static prevalence.

[1] Census April 2016 www.cso.ie
[2] CSO, Population and Labour Force Projections, 2016-2046 www.cso.ie

Resourcing General Practice

GP care is the cornerstone of any universal healthcare system. Continuity of care and the patient-centred (rather than disease-focused) approach that is specific to General Practice is associated with better health outcomes, equity of access, reduced inequalities in health, more appropriate utilisation of services, long-term cost effectiveness and increased patient satisfaction[3] [4] [5]. Up to 90% of consultations are treated in General Practice without further referral to secondary hospital care.[6]

Extensive research by the late Barbara Starfield[7] found that:

- Increasing the supply of GPs is associated with better health outcomes, lower rates of all-cause mortality, lower post-neonatal mortality rates, higher numbers of people reporting good health and higher life expectancy;
- GP care is associated with more equitable distribution of health in populations.

Investment in General Practice will lead to efficiencies in the medium to long-term. The continuity of care provided by General Practice is associated with lower mortality rates in the elderly,[8] and decreased likelihood of future hospitalization, as well as decreased emergency department use.[9] GP continuity of care is also associated with time saving, less use of laboratory tests, fewer referrals to secondary care and lower health care expenditure.[10]

Health policy discourse that fails to mention the key role of the GP is misleading. International research into General Practice and community care[11] [12], firmly relates to the unique role of the General Practitioner in terms of continuity and coordination of care and the resources provided to support GP care. Countries that 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;
- Provide appropriate economic conditions and distribute resources equitably based on medical need;
- Have strong governance arrangements in place including compulsory registration with a GP and a GP gatekeeping role;
- Provide a comprehensive range of services in General Practice and the community;
- invest in the development of the workforce.

[3] Starfield B. Shi L and Macinko J, Contribution of Primary Care to Health Systems and Health. The Milbank Quarterly, Vol. 83, No. 3, 2005 (pp. 457–502)
[4] Atun R, What are the Advantages and Disadvantages of Restructuring a Health System to be More Focused on Primary Care Services? Copenhagen, WHO Regional Office for Europe, Health Evidence Network report ; January 2004
[5] Kringos DS et al, The Strength of Primary Care in Europe, NIVEL 2012
[6] Gouda P. 2013 Treat or Refer? Factors Affecting GP Decisions Forum August 2013
[7] Starfield B, Shi L and Mackinko J. Contribution of Primary Care to Health Systems and Health, The Millbank Quarterly, 2005: 83:3 457-502
[8] Maarsingh OR et al, 2016 Continuity of care in primary care and association with survival in older people: a 17-year prospective cohort study, British Journal of General Practice Aug 2016
[9] Starfield B, Shi L and Mackinko J. 2005
[10] Mainous III AG. *Continuity of care and trust in one's physician: evidence from primary care in the United States and the United Kingdom.* In: Baker R, editor. 2000 North American Primary Care Research Group Meeting; 2001 January 2001: Fam Med 2001; 2001. p. 22-7.
[11] Starfield B. Primary care: an increasingly important contributor to effectiveness, equity, and efficiency of health services. SESPAS report 2012
[12] Kringos DS et al, The Strength of Primary Care in Europe, NIVEL 2012

General Practice in Ireland has been decimated with the removal of €160 million or approximately 38% of funding through the heavy handed and arbitrary FEMPI mechanism. Ireland is facing a shortage of GPs as our newly trained GPs see emigration as the only viable option.

Proposals to address the shortage of GPs by transferring GP tasks to other healthcare professionals is not in the interest of patients or the state. In addition to interrupting continuity of care, nurse delivered care is associated with a greater use of healthcare resources[13] including higher number of visits[14], longer consultations[15] and higher use of diagnostics[16] while commercial factors have been found to influence pharmacy prescribing above clinical evidence. [17] There is no evidence that patient outcomes are improved by transferring tasks to other healthcare professionals in the community.

Recommendation No. 1

The IMO is calling on the Department of Health and the HSE to agree a strategy with the IMO for the development of General Practice in Ireland over the coming decade. To ensure the maximum benefit for both patients and the health system the Strategy must include:

a) **A commitment to preserving the following positive traits of General Practice:**
   - **Community based, same-day appointment service where appropriate;** expanding free GP care to the entire population will increase GP utilisation.[18] Preserving the same ratio of GPs to population will lead to waiting times of up to a week as experienced in the UK's NHS.[19]
   - **The independent GP contractor model;** which provides patient focused, quality of care and value for money[20] and is the model used in most developed health systems.[21] While corporate models of Primary Care may offer short-term advantages in terms of ready investment capital, in the long-term the corporate model of care leads to fragmentation and poor quality of care.

[13] A. Hemani *et al.*, 'A Comparison of Resource Utilization in Nurse Practitioners and Physicians', *Effective Clinical Practice*, Vol. 2, No. 6, November 1999, pp. 258-265.
[14] E.R. Lenz et al., 'Primary care outcomes in patients treated by nurse practitioners or physicians: two-year follow-up', Medical Care Research and Review, Vol. 61, No. 3, September 2004, pp. 332-351.
[15] C. Seale, E. Anderson, and P. Kinnersley,, 'Comparison of GP and nurse practitioner consultations: an observational study', *British Journal of General Practice*, Vol. 55, No. 521, December 2005, pp. 938-943.
[16] K. Rosenberg, 'NPs and Physician Assistants Order more Imaging Tests than Primary Care Physicians', *American Journal of Nursing*, Vol. 115, No. 3, March 2015, p. 63.
[17] P. P. C. Chiang, 'Do pharmacy staff recommend evidenced-based smoking cessation products? A pseudo patron study', *Journal of Clinical Pharmacy and Therapeutics*, Vol. 31, Issue 3, June 2006, pp. 205–209; P. Rutter and E. Wadesango, 'Does evidence drive pharmacist over-the-counter product recommendations?', *Journal of Evaluation in Clinical Practice*, Vol. 20, Issue 4, August 2014, pp. 425–428.
[18] Brick A, Nolan A, O'Reilly J and Smith S, Resource Allocation Financing and Sustainability in Health Care - Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector, ESRI, Dublin: 2010 Vol II , p507
[19] Campbell D. Patients' waiting times on NHS 'a national disgrace' – GP leader, The Guardian 26 September 2014 (https://www.theguardian.com/society/2014/sep/26/patients-waiting-times-nhs-gps-uk accessed 02 August 2016)
[20] IMO Submission to Department of Health Public on the Scope of Private Health Insurance to incorporate additional Primary Care Services. IMO: January 2015
[21] Ed. E Mossialos and M. Wenzl, London School of Economics and Political Science, R Osborn and D, Sarnak, 2015 International Profiles of Health Care Systems, The Commonwealth Fund. The Commonwealth Fund January 2016

- **The GP Gatekeeper role** which ensures more appropriate use of scarce healthcare resources.

b) A manpower action plan to address the growing shortage of GPs and to include an increase in the number of GP training places - The HSE estimate that by 2025 an additional 1380 GPs are required to ensure the provision of GP services to the under 6 year olds and over 70 year olds – to expand GP care to the entire population an additional 2,055 GPs are required by 2025.[22]

c) In order to halt the exodus of GP trainees, priority must be given to negotiating a new GP contract with the IMO that is properly resourced and fit for purpose for a 21st Century Health Service to include:

- **Terms and conditions that ensure both existing and newly qualified GPs are attracted to a career in the health service.** 17% of newly qualified GPs work abroad[23] with many more planning to emigrate to countries where GP care is more appropriately valued
- **A working environment including an out-of-hours service that provides vital continuity of care and respects the needs of individual GPs**
- **Investment in evidence-based Chronic Disease Management Programmes** (which newly qualified GPs are trained to deliver) **and opt-in enhanced services** (many GPs have training in other specialist areas such as minor surgery or dermatology)
- **Allowances for the employment of practice staff** (including medical, nursing and practice support staff)
- **Additional supports that address the real and specific needs of patients in both rural and deprived areas**
- **Appropriate adoption of new work practices such as telemedicine that are based on international best practice and assure continuity of care**

d) Incentives must be provided for the development of infrastructure including premises, medical equipment, diagnostic equipment, IT (as per the recommendations in the Indecon report) [24]

e) Access to diagnostics and allied health and social care professionals in the community (see integrated care)

f) Access to GP care should be expanded on a phased basis taking into account income and medical need.

[22] HSE HR Directorate National Doctor Training and Planning, Medical Workforce Planning Future Demand for General Practitioners 2015-2025, HSE: Sept 2015

[23] 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

[24] Indecon International Economic Consultants 2015 Analysis of Potential Measures to Encourage the Provision of Primary Care Facilities , Dublin 2015

Expanding Capacity in the Public Hospital System

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. While investment in GP care will reduce the rate of increase in demand on the hospital system it will not immediately resolve waiting lists or the crisis in our Emergency Departments.

Providing a Consultant-Delivered Hospital Service

Waiting lists for specialist outpatient appointments and elective procedures will only be reduced following the introduction of a fully-resourced consultant delivered healthcare service. Hospital consultants undergo up to 15 years of medical education and training to become specialists in their field. The Hanly Report (2003) recommended a consultant delivered hospital service in which consultants have a direct involvement in the diagnosis, delivery of care and overall management of patients. This would improve quality of care and patient safety as important clinical decisions would be made faster and at a higher level.[25]

Research shows that consultant delivered care is associated with:

- marked reductions in all-cause mortality following admission with acute coronary syndromes and a significant reduction in hospital length of stay[26]
- improved patient outcomes and satisfaction and reduced length of stay in emergency care [27] without increases in adverse events or readmissions compared to consultant –led care[28]
- a 96.9% appropriate response rate during the first review of a trauma case.[29]

While there has been a gradual increase in the number of consultants and NCHDs employed in the HSE, NCHDs still outnumber consultants 2:1 [30] and currently 1 in 8 consultant posts remain unfilled. Working conditions in over-crowded hospitals have led to unprecedented recruitment and retention issues. Many of our newly trained doctors are emigrating or planning to emigrate while we in turn are becoming increasingly reliant on foreign trained doctors.

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[25] Report of the National Task Force on Medical Staffing June 2003

[26] (http://www.tandfonline.com/doi/abs/10.3109/17482941.2012.655290)

[27] G.C. Geelhoed and E.A. Geelhoed, 'Positive impact of increased number of emergency consultants', *Archives of Disease in Childhood*, Vol. 93, No. 1, September 2007, pp. 62-64; A.L. White, P.A.R. Armstrong, and S. Thakore, 'Impact of senior clinical review on patient disposition from the emergency department', *Emergency Medicine Journal*, Vol. 27, 2010, pp. 262-265; J. Temple, *Time for Training: A review of the impact of the European Working Time Directive on the quality of training*, NHS Medical Education England, 2010, p. 42.

[28] M. Harvey *et al.*, 'Correlation of physician seniority with increased emergency department efficiency during a resident doctors' strike', *New Zealand Journal of Medicine*, Vol. 121, No. 1272, April 2008, pp. 59-68; G. Robinson *et al.*, 'The New Zealand national junior doctors' strike: implications for the provision of acute hospital medical services', *Clinical Medicine*, Vol. 8, No. 3, June 2008, pp. 272-275; A. Russell *et al.*, 'Consultant-delivered care – what is it worth?', *The Bulletin of the Royal College of Surgeons of England*, Vol. 97, No. 7, July 2015, pp. e22-e25.

[29] G. Finlay *et al.*, *Trauma: Who cares?*, National Confidential Enquiry into Patient Outcome and Death, London, 2007, p. 57.

[30] The latest HSE census report shows that there are currently 2,764 consultants and 5,762 NCHDs employed in the HSE. HSE Census Report May 2016 downloaded from http://www.hse.ie/eng/staff/Resources/Employment_Reports/Census-Report-May-2016.pdf

Recommendation No. 2

The IMO recommends that integrated medical manpower planning takes place at national level which takes into account the number of consultants and specialist training posts required to deliver a Consultant delivered service. Based on the calculations in the Hanly Report an additional 1,657 consultants are required across all specialties to ensure a consultant delivered healthcare service based on current population figures while an additional 1,920 consultants will be needed by 2026.

Hospital Consultants (Recommended vs. Currently Employed)

Speciality	Recommended Ratio of Specialists per Population*	Recommended Number of Specialists per Current Population*	Current Number of Specialists Employed by HSE*	Shortfall from Recommended to Currently Employed Specialists
Anaesthesia	1/8,300	573	358	-215 (-38%)
Emergency Medicine	1/40,000	119	87	-32 (-27%)
Medicine	1/4,700	1,012	692	-320 (-32%)
Obstetrics & Gynaecology	1/20,500	232	132	-100 (-43%)
Paediatrics	1/18,700	254	156	-98 (-39%)
Pathology	1/14,000	340	217	-123 (-36%)
Psychiatry	1/6,600	721	362	-359 (-50%)
Radiology	1/12,700	375	252	-123 (-33%)
Surgery	1/6,200	767	489	-278 (-36%)
Total	**1/1,080**	**4,406**	**2,749**	**-1657 (-38%)**

* *Report of the National Task Force on Medical Staffing*, 2003, pp. 139-158; Current population data (4,757,976) from Central Statistics Office, *Census 2016 Preliminary Results*, July 2016; Current HSE employment figures taken from Health Service Executive, *Health Services Employment: Section 6 Grade Level Detail - Overview by Grade Group: December 2015 to May 2016*, p. 2.

Hospital Consultants (Recommended – Report of the National Task Force on Medical Staffing)

Speciality	Recommended Ratio of Specialists per Population*	Recommended Number of Specialists per Current Population*	Recommended Number of Specialists per 2021 Population*	Recommended Number of Specialists per 2026 Population*
Anaesthesia	1/8,300	573	587	607
Emergency Medicine	1/40,000	119	122	126
Medicine	1/4,700	1,012	1037	1073
Obstetrics & Gynaecology	1/20,500	232	238	246
Paediatrics	1/18,700	254	261	270
Pathology	1/14,000	340	348	360
Psychiatry	1/6,600	721	739	764
Radiology	1/12,700	375	384	397
Surgery	1/6,200	767	786	813
Total	**1/1,080**	**4,406**	**4,514**	**4,669**

* *Report of the National Task Force on Medical Staffing*, 2003, pp. 139-158; Current population data (4,757,976) from Central Statistics Office, *Census 2016 Preliminary Results*, July 2016; 2021 (4,875,100) and 2026 (5,042,100) population projections from *Population and Labour Force Projections: 2016 – 2046*, Central Statistics Office, 2013, using M2F2 models.

Recommendation No. 3

Measures must be taken immediately to improve training pathways, recruitment and retention of our medical workforce including the full implementation of the recommendations made in the report of the Strategic Review of Medical Training and Career Structures ('MacCraith Review') and the negotiation of a new, fit for purpose contracts for both consultants and NCHDs. Arrangements for the training of doctors must be modernised reflecting changes in the practice of medicine and the changing demographics of doctors in training. This requires initiatives to consider the duration of training to bring arrangements in line with international norms. A differentiated model which provides clearer career paths with greater predictability of training arrangements, responsibility, location and working conditions must be developed. Greater flexibility must be achieved to facilitate differentiated arrangements to attract the best and brightest graduates to deliver healthcare in Ireland.

Acute Bed Capacity

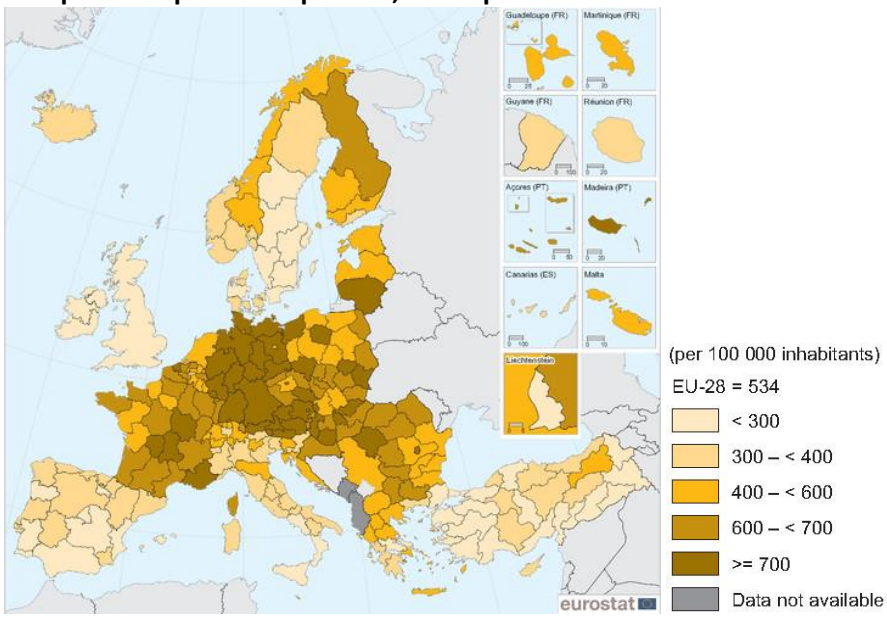
Hospital capacity planning requires assessment of numerous dimensions of healthcare provision, including diagnostic and therapeutic equipment and technology, the manner of delivery, and housing of medical services, and the human and financial resources required for the continuous and adequate delivery of those services. In a number of jurisdictions, hospital bed capacity has been the traditional unit by which care has been planned.[31] Increasingly, states are also using service volume and activity to plan for capacity. This is achieved by detailed recording of services delivered, patient discharges, and other healthcare data, as a means of predicting future demand.

Recommendation No. 4

The IMO recommends a detailed assessment of the number of acute beds needed in the public hospital system to meet current and future demand. The reinstatement of the National Treatment Purchase Fund (NTPF) is not sufficient to alleviate waiting lists nor a sustainable long-term solution. **The private sector does not sufficiently cater for frail or complex patients. When we include both public and private beds the number of acute inpatient and day-case beds falls well below European averages**. 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.

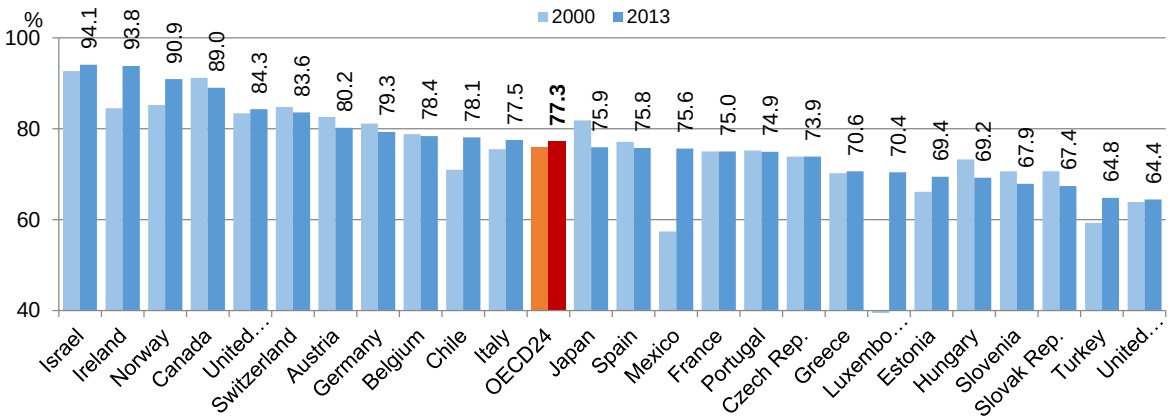
[31] S. Ettelt et al., *Capacity Planning in Healthcare: A Review of the International Experience*, Brussels, European Observatory on Health Systems and Policies, 2008, p. 6.

European Hospital Beds per 100,000 Population



- **The assessment should be based on 85% occupancy rates to ensure patient safety and provide for seasonal increases in demand**[32]**.** OECD figures from 2013 show that Irish public hospitals operate at 93.8% capacity, a figure well over the established safe occupancy threshold of 85%,[33] and 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.[34]

Acute Hospital Occupancy Rates in the OECD



[32] A. Bagust, M. Place, and J.W. Posnett, 'Dynamics of bed use in accommodating emergency admissions: stochastic simulation model', *British Medical Journal*, Vol 319, July 1999, pp. 155–158; R. Jones, 'Hospital bed occupancy demystified', *British Journal of Healthcare Management*, April 2011, dx.doi.org/10.12968/bjhc.2011.17.6.242; F. Madsen, S. Ladelund, and A. Linneberg, 'High Levels Of Bed Occupancy Associated With Increased Inpatient And Thirty-Day Hospital Mortality In Denmark', *Health Affairs*, Vol. 33, No. 7, July 2014, pp. 1236-1244.

[33] Organisation for Economic Co-operation and Development (OECD) , *Health at a Glance 2013*, Paris, 2013;

[34] 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.

- **An immediate and effective plan must be implemented to meet current bed requirements. No further beds should be taken out of the public system until appropriate community and long-term care services are in place.** The plan must include an assessment of available unused capacity in the system. 13% of inpatient beds have been withdrawn since 2009. The plan should also include potential collaboration with Northern Ireland to improve access in border regions and for rare diseases.
- **Capacity planning must include an assessment of Diagnostics, Radiology and Laboratory service requirements in both acute and community care.**

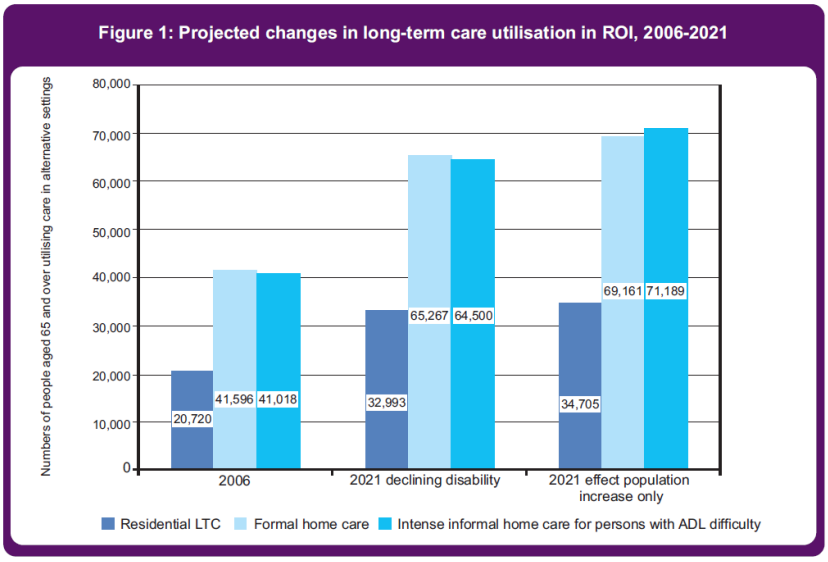
Long-Term and Rehabilitative Care

Older people and people with disabilities have the right to equal access to and equal resourcing of health and social care services, including rehabilitative care services and long-term community and residential care.

Recommendation No.5

Demand for community and long-term care must be properly assessed and adequate resources provided including capital investment, operational funding and manpower.

While only a small percentage of elderly people require long-term care, the ageing population will have a significant impact on the number of long-stay beds required. Wren et al predict that based on 2006 utilisation and some decline in disability rates, by 2020 demand for long-term residential care, formal and informal homecare would increase by almost 60%.



Source: Wren et al, Future Demand for long-term care in Ireland 2012, CARDI Research Brief

Since 2006 the number of long-term beds has fallen, as has the number of people in receipt of home help along with the number of home help hours provided. The number of home care packages provided has trebled although from a low base to approximately 15,000 packages in 2015. The HSE service plan provides for no increase in 2016 of home care packages. The additional €40m announced in June is directed simply at delivering the home care services set out in the HSE National Service Plan 2016.

Placing Mental Health on a Par with Physical Health

Mental health disorders affect one in four adults in Ireland and are the leading cause of disability worldwide[35], but less than 50% of people receive professional help and even less receive appropriate care. [36] In 2006, *A Vision for Change – the Report of the Expert Group on Mental Health*[37] laid out the blueprint for the transfer of mental health services from an institutional to a community-based setting over a period of 7-10 years. However progress has been slow with poor implementation and inadequate and uneven distribution of resources.

Recommendation No. 6

The IMO is calling for a new Mental Health Strategy that puts mental health on a par with physical health which must be accompanied by a detailed implementation plan and an appropriate allocation of resources. Ireland currently spends just 6% of its health budget on mental health compared with 10-11% in the UK, France and Germany [38] and 8.24% recommended in A Vision for Change.

The strategy should include:

- **The appointment a national independent body to determine mental health catchment areas to ensure equality of services in all parts of the country;** Financial and manpower resources are unevenly distributed across mental health services with no relationship between population size or socio-economic need.
- **Urgent investment to address deficits in Child and Adolescent Mental Health Services;** With just 58 child acute psychiatric beds available out of a recommended 98, last year 95 children (26% of child admissions) were inappropriately admitted to adult psychiatric units.[39]
- **Direct access on GP referral to counselling and psychotherapeutic services in the community;** General practitioners (GPs) are often the first point of contact for those suffering from mental illness and 80% of GPs believe that anxiety, depression, and other similar disorders could be managed more effectively in primary care with appropriate resources and supports.[40]

[35] H. Wittchen and F. Jacobi, 'Size and burden of mental disorders in Europe – a critical review and appraisal of 27 studies', *European Neuropsychopharmacology*, Vol. 15, Issue 4, August 2005, pp. 357-376.
[36] Tedstone Doherty D, Moran R, Mental Health and Associated Service Use on the Island of Ireland: HRB Research Series 7 HRB 2009: 13
[37] Department of Health and Children, *A Vision for Change*, Stationery Office, Dublin, 2006, p. 178.
[38] M. Schultz, 'Mental health services in Germany', in N. Brimblecombe and P. Nolan (eds.), *Mental Health Services in Europe – Provision and Practice*, Radcliffe Publishing, London, 2012, pp. 97-120; The NHS Confederation, *Key facts and trends in mental health*, London, November 2009, p. 4; G. Faedo and C. Normand, *Implementation of 'A Vision for Change' for Mental Health Services*, Trinity College Dublin, March 2013, p. 14.
[39] Mental Health Commission, Annual Report 2015 Including Report of the Inspector of Mental Health Services, [accessed http://www.mhcirl.ie/File/2015-Annual-Report-inc-Report-OIMS.pdf 20 June 2016]
[40] A. Jeffers, *Mental Health in Primary Care – What Do Health Professionals Believe Is the Best Model of Care?*, poster presented at the Spring Conference of the College of Psychiatry of Ireland, Cork, 2010.

Expanding Public Health Expertise

Effective health service planning, that provides equal services to all based on need and within the available resources, requires public health medicine expertise and capacity to:

- Assess the health needs of the population in the short, medium and long term using available health data, and an epidemiological approach taking into account population distribution, including age profile and socioeconomic profile
- Develop a comprehensive evidence-base for individual services and wider programmes
- Provide health economic support to the HSE
- Give evidence-based advice to policymakers, including advice on the options available and the benefits and risks of each

Public health doctors have expertise in epidemiology, health economics, health information and planning, health protection and health improvement. They have an essential role in health surveillance, in protecting the public from infectious disease and environmental threats, and ensuring Ireland meets its commitments under national and international health regulations. If properly resourced public health doctors could play a pivotal role in commissioning services, analysing health data, conducting needs assessments, assembling the evidence base for interventions, monitoring services and quality assuring parts of the health service such as screening.

Recommendation No. 7

Immediate action is needed to expand public health capacity and attract medical graduates to this discipline through consultant status and a new fit for purpose contract. Over 40% of specialists in public health medicine were aged over 55 in February 2014. The review of the speciality recommended by the MacCraith Review in June 2014 was scheduled to report by September 2015; the brief was put out to tender in August 2016.

Recommendation No. 8

Health Information and Patient Safety Legislation must ensure the public health planning function has access to appropriate data while at the same time ensuring confidential patient data is protected.

Prevention – Implementing and Resourcing Healthy Ireland

Prevention is the most ethical and cost-effective intervention. Unhealthy lifestyle choices pose significant challenges to population health, while global health threats could undermine all planning. In 2013 the Government published *Healthy Ireland - A Framework for Improved Health and Wellbeing 2013-2025* which lays out the Government's strategy to improve health and well-being in Ireland from 2013 to 2025 the goals of which are to:

- increase the proportion of people who are healthy at all stages of life;
- reduce inequalities in health;
- protect the public from threats to health and wellbeing;
- create an environment where every individual and sector of society can play their part in achieving a healthy Ireland.

Recommendation No. 9

The IMO welcomes the goals of *Healthy Ireland* and calls on the Government to develop a detailed implementation plan supported by ring-fenced funding. Many well-thought out strategies fail

through lack of a detailed implementation plan, resources or a dedicated person with overall responsibility.

- **Health Surveillance Programmes should be enhanced**. Both public health and community health doctors have a key role to play in health surveillance and prevention assuring programmes are delivered to the highest quality evidence-based standards by appropriately qualified health professionals.
- **Immediate priority should be given to:**
    - **Developing a comprehensive multi-disciplinary programme to tackle childhood obesity**
    - **Enactment of the Public Heath Alcohol Bill**
    - **Full implementation of the recommendations for a *Tobacco Free Ireland.***

Integrated Care

An integrated healthcare system can enhance quality of care and patient outcomes and has the potential to improve patient experience and lower costs. Despite some isolated examples and pilots, healthcare in Ireland is both highly fragmented and poorly coordinated.

A commercial competitive healthcare environment where healthcare professionals and corporations compete for scarce resources is not conducive to integrated care. On the other hand key enablers of, integrated care include the effective use of information and communication technology, appropriate standardisation of care through the implementation and appropriate funding of clinical guidelines, and effective management and allocation of resources.

Effective Use of Information and Communication 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 advance of medical knowledge, management of disease and health service planning.

As mentioned above issues relating to patient confidentiality, security and the secondary use of information need to be addressed through Health Information and Patient Safety legislation. 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

Recommendation No. 10

The Government must provide ring fenced funding to support the roll-out of a secure national system of electronic health records. Funding must not be diverted from patient care. New eHealth systems should be piloted to ensure they are fit for purpose, can easily be embedded into existing ICT systems and do not add to the administrative workload.

Appropriate Standardisation of Care through the Implementation and Resourcing of Clinical Guidelines

Care pathways and clinical guidelines contribute to integrated care by standardising care across services and sites, and defining roles and responsibilities of different healthcare professionals within their particular domain of competence.[41] However, there is a danger that, due to resource constraints or the time lag involved in the gathering of evidence and incorporating it into formal quality assured clinical guidelines, that guidelines may not be up to date or result in the optimal clinical outcome. Clinical guidelines are also usually disease focused and thus designed to be applied to population groups with similar morbidity. As a result, they may not factor in co-morbidity or the impact of individual patient characteristics or choices. While guidelines have been developed for GP management of certain chronic conditions, appropriate resources have yet to be provided.

Recommendation No. 11

The development of clinical guidelines must reflect international best practice, must be appropriately resourced and flexible to meet individual patient needs and choices.

[41] Suter E. Oelke N.D. Adair C.E. Armitage G.D. Ten key Principles for Successful health Systems Integration, Healthcare Quarterly 2009 13 Special issue 16-23

Effective Management of Resources

As mentioned above integrated care systems can enhance quality of care and patient outcomes and have the potential to reduce costs. However, Integrated care will not resolve inadequate resourcing of services and new activities cannot be successfully integrated without an increase in resources [42]. While it is expected that integrated care systems can lead to both administrative and clinical cost savings, integration processes may not be achievable without additional initial investment before any savings become apparent. [43]

The HSE is currently developing a large-scale programme of work to integrate health and social care services in the community. However without additional resources the HSE's integrated care programmes will not succeed. Currently waiting lists exist for all community allied health and social care services. In many areas services simply aren't available regardless of ability to pay.

Recommendation No. 12

Integrated health and social care services requires integrated manpower and capacity planning and the provision of appropriate capital and operational resources.

Quality of Care and Efficiency

Recommendation No. 13

In addition to integrated care, there must be an on-going emphasis on improving quality of care and efficiency in the health service through a wide range of measures such as:

- Many specialist faculties are developing and implementing national clinical quality improvement programmes of international acclaim;
- As the elderly are the main users of healthcare services, services can be more age-attuned by creating dementia friendly services;
- Efficiencies in care may be lost without reform of HSE management and administration processes;
- New technologies have the potential to improve care and disrupt work practices. The potential benefits and risks of new technologies should be explored.

[42] World Health Organization, Integrated Health Services – What and Why? – Technical Brief No. 1. WHO Geneva. 2008 Downloaded from http://www.who.int/healthsystems/technical_brief_final.pdf

[43] ibid

Funding Model

Recommendation No. 14

The IMO believe that with significant increases in resources, both capital and operational, and with careful planning the goal of universal healthcare can be delivered under an expanded taxation model or eventually under a system of social health insurance. Whatever changes are introduced to health coverage in Ireland, the process by which change is brought in must include:

- **Informed public debate**
- **Consultation with all relevant stakeholders, including patients and doctors**
- **Detail of the proposed model including cost and funding sources**
- **Analysis of current and future manpower resources needed for implementation**
- **A realistic time table for implementation.**