IRISH MEDICAL
ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Pre-Budget Submission 2010

The 2010 budget will be one of the most difficult to deliver in Irish history. With resources now scarce and their distribution being challenged on every level, prioritisation of budget allocation will require incredible analysis, reflection, understanding, rationalisation, compassion and foresight.

Every year the Irish Medical Organisation (IMO) asks for investment in health, this year – we ask not only for investment but for protection. Funding for our health care services must be protected. Everyone acknowledges that funding cuts made in the 1980s are the fundamental cause of the hospital services crisis both in acute care and Accident and Emergency. Investment during the boom times failed to keep up with public demand and expectations. Ireland's healthcare system remains substantially under-funded.

The vulnerable people in our society must be protected and funding must be allocated where it's needed most. The IMO challenges the government to prioritise our now scarce resources so that the children, older people, those with disability and the poor are cherished by the State and not abandoned.

We also have to protect and promote health services that are efficient and effective. Funding should be ring-fenced for healthy life-style promotion and the prevention of chronic disease. Resources should no longer be wasted on the hospital co-location project which will fail to address healthcare needs and simply reinforce Ireland's two-tier health system.

Health Services for Children with Disabilities

Under the Disability Act 2005, children under 5 years old are entitled to an independent assessment of health and educational needs. Following the assessment, the HSE is obliged to provide a statement of the services that will be provided.

Children with disabilities need a wide range of services that extend across the board from specific health interventions to community and hospital-based therapies to preschool and school education. At the end of 2008 over 3,500 applications for a needs assessment had been received,[1] yet substantial deficits in health services for children with disabilities continue:

- only 40% of assessments in the first half of 2008 had been completed, with only 20% completed within the statutory timeframe;[2]
- continued shortfall in Occupational Therapy, Speech and Language Therapy and Physiotherapy Services[3] leading to waiting times of up to 36 months for some services;
- unmet demand for respite services in 2008, including 995 summer camp day places and 325 holiday respite placements.[4]

In the emergency budget April 2009 the Government decided to defer the implementation of the remaining provisions of the Education for Persons with Special Education Needs (EPSEN) Act 2004 and the Disability Act 2005 which would provide a similar needs assessment for education and health and social care services for 5 to 18 year olds in 2010. By this the Government is reneging on its commitments to the most vulnerable children in our society, preventing 2% of under 18 year olds from reaching their potential.

Recommendations

- Multi-annual ring-fenced funding for disability services;
- Gaps and inadequacies in the assessment process must be addressed so that all children have a complete assessment within the statutory timeframe;
- Immediate recruitment of speech and language therapists, occupational therapists and physiotherapists to deliver urgent assessment and treatment to children who have been waiting;
- Increase the provision of respite services to meet demand;
- Full implementation of the Disability Act 2005 and the EPSEN Act 2004.

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[1] Citizens Information Bureau, Relate 2009
[2] Health Service Executive, HSE National Service Plan 2009 : 37
[3] HSE, Report to the Minister for Equality, Disability and Mental Health as provided under Section 13 of the Disability Act 2005, 2008
[4] Health Research Board, National Physical and Sensory Disability Committee Annual Report 2008 : 47

Elderly Care

Access to community and long-term care for the elderly should be based on medical need.

Community Care

Older people consistently state a preference to live their lives in their own homes. The Home Care Package initiative was introduced as a viable alternative to residential care for Ireland's older citizens. However, eligibility criteria vary across HSE administrative areas and inadequate funding is severely affecting the provision of home care package services for older people, leading to long waiting lists and a total absence of services in some parts of the country. [5] Multidisciplinary teams of community health workers, physiotherapists, occupational therapists, psychologists and suitably trained domiciliary care workers are required to enable the delivery of appropriate care to the patient in their own home.

Long-term Care

For a significant minority of older people, about 5% of people over 65 years, care in the community is no longer possible despite family and state support. At this stage, nursing home care is required. The 5% figure conceals the fact that up to half of older people will spend some time in a nursing home care before they die.

Over the past two years, the HSE has reported a significant growth - from 80 per week to 180 per week - in discharge delays from hospital due to patients having higher medical needs such as appropriate rehabilitation, extended care services or supported living in the community. There has also been a substantial increase - from 70 per week to 260 per week - in patients either requiring or requesting access to a public long term care bed -.[6]

Long-Stay Units by Category 31 December 2007[7]

Category	HSE Extended Care Unit	HSE Welfare Home	Voluntary Home / Hospital for Older People	Voluntary Welfare Home	Private Nursing Home	TOTAL
Long Stay Beds:						
Extended/Continuing Care	4,714	1,018	1,137	257	12,402	**19,528**
Psychiatry of Old Age	346	30	8	15	605	**1,004**
Chronic Young Sick	73	1	42	0	117	**233**
Unspecified Long Stay	303	5	92	26	393	**819**
Total Long Stay Beds	**5,436**	**1,054**	**1,279**	**298**	**13,517**	**21,584**
Limited Stay Beds:						
Rehabilitation	234	58	61	0	50	**403**
Convalescence	240	6	23	1	212	**482**
Palliative	75	4	5	0	32	**116**
Respite	597	45	121	16	269	**1,048**
Other Limited Stay	226	17	17	0	131	**391**
Total Limted Stay Beds	**1,372**	**130**	**227**	**17**	**694**	**2,440**

[5] E. Burke-Kennedy Irish Times 29th July 2008, *Funding shortfall hits services for the elderly*
[6] HSE 2009 *HSE Performance Report March 2009* p28
[7] DOHC, Long-Stay Activity Statistics 2007

The table above shows the majority (62.6%) of long-term beds are provided by private nursing homes. Patients may require access to public long term care rather than private care due to financial reasons, or due to the inability of private nursing homes to care for patients with higher medical needs and/or higher dependency levels. The table also highlights the under-provision of public, voluntary and private rehabilitation, convalescent, palliative and respite care facilities.

Assessment of need should be patient-focused and take into account the person's general health, their disability, the physical environment of their home and the support networks that surround them. A regular review process is needed to ensure that services correspond to a patient's changing needs.

Carers

The contribution made by carers of incapacitated people of all ages must be recognised and supported. It is estimated that the country's 161,000 carers save the exchequer approximately €2.5 billion a year.[8] Carers need help to enable them to care for someone as long as they wish and are able to do so, without jeopardising their own health and wellbeing, financial security, educational opportunities or reducing their expectations of a reasonable quality of life.

Recommendations

- The demand for Home Care Packages must be properly assessed and funding provided to adequately meet that demand;
- Immediate recruitment of community health workers, physiotherapists, occupational therapists, psychologists and suitably trained domiciliary care workers;
- Urgent capital investment in public long-term and intermediate care beds is required to meet immediate as well as future demand;
- Following the recommendations of the Leas Cross Report and the HIQA standards on nursing home care, the Minimum Data Set should be rolled out on a national basis to provide a modern responsive and sensitive measure of older people's needs in the community and nursing homes;
- Increase carer's allowances and tax relief for carers of incapacitated people of all ages.

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[8] Care Alliance Ireland 2009 www.carealliance

Lifestyle and Chronic Disease

According to the World Health Organisation (WHO), chronic diseases such as cancer, cardiovascular disease, diabetes, mental health problems and asthma account for 86% of deaths in Europe.[9] Certain lifestyle factors such as poor diet and physical inactivity (causing obesity), alcohol, drug and tobacco consumption are known to increase the risk of chronic disease. At least 80% of heart disease, stroke and type 2 diabetes as well as 40% of cancer could be prevented if certain major risk factors were eliminated.[10]

Despite this, trends in obesity and alcohol and drug consumption continue to rise, though smoking rates have stabilised.

- 24% of men and 26% of women are obese[11] increasing their risk of type 2 diabetes, heart disease and stroke, cancer of the endometrium, colon and breast, and mental health disorders. A further 45% of men and 33% of women are overweight.[12]
- Annual alcohol consumption per adult is 13.3 litres of pure alcohol, third highest in Europe[13] and 28% of people report binge drinking[14] at least once a week.[15] Alcohol is associated with more than 60 acute and chronic health disorders ranging from accidents and assaults to mental health problems, cardiovascular disease, liver cirrhosis and cancer of the upper aero-digestive tract, colorectum and breast.[16]
- Lifetime use of illegal drugs among adults is 24%. Lifetime use of cocaine is 5%[17] and, when mixed with alcohol, increases the risk of heart attack 24 times.[18] Injecting heroin, leads to the spread of HIV and Hepatitis B and C.[19]
- 29% of adults currently smoke[20] increasing their risk of lung cancer, heart disease and stroke.

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[9] World Health Organisation (WHO), 2005 *The Impact of Chronic Disease in Europe downloaded from* http://www.who.int/chp/chronic_disease_report/media/euro.pdf
[10] DOHC, 2008 *Tackling Chronic Disease…p7* & WHO, 2005 *The Impact of Chronic Disease in Europe…*
[11] Morgan K, McGee H, Watson D, Perry I, Barry M, Shelley E, Harrington J, Molcho M, Layte R, Tully N, van Lente E, Ward M, Lutomski J , Conroy R, Brugha R 2008, *SLÁN 2007: Survey of Lifestyle, Attitudes & Nutrition in Ireland.* Main Report. Dublin: Department of Health and Children *…p101*
[12] Morgan et al 2008, *SLÁN 2007…p101*
[13] Hope A. 2007, *Alcohol Consumption In Ireland 1986-2006*, HSE – Alcohol Implementation Group…p5
[14] Consuming 6 or more standard alcoholic drinks on one occasion
[15] Morgan et al 2008, *SLÁN 2007…p81*
[16] Mongan D, Reynolds S, Fanagan S and Long J 2007, *Health-related consequences of problem alcohol use. Overview 6* Dublin: Health Research Board pp45-46
[17] National Advisory Committee on Drugs (NACD) & Drug and Alcohol Information and Research Unit (DAIRU) 2008, *Drug use in Ireland and Northern Ireland – First results from the 2006/2007 Drug Prevalence Survey..p1*
[18] HSE 2008 *Mixing cocaine and alcohol increases heart attack risk by 24 times* downloaded from http://www.drugs.ie/news/583/
[19] Drugscope 2008 *Drug Dangers* downloaded from http://www.drugscope.org.uk/resources/mediaguide/drugdangers.htm
[20] Morgan et al 2008, *SLÁN 2007…p74*

While chronic illness usually occurs in older people, lifestyle choices are established in childhood and adolescence. In Ireland, high rates among young people for all risk factors prevail.

- 14.4% of 13 year old boys and 12.6% of 15 year old girls are overweight or obese.[21]
- 53% of children (10 to 17 years old) report ever having had an alcoholic drink and over a third of 15 to 17 year olds report being drunk in the last month.[22]
- In 2006/7 last year and last month use of illegal drugs was highest for those aged 15-24 years, 15% and 6% respectively.[23]
- 16% of 12-17 year olds smoke.[24]

Members of the Irish Medical Organisation (IMO) are calling for the elaboration and implementation of an over-riding lifestyle policy for the prevention of chronic disease which facilitates and promotes healthy lifestyle choices among the general population.

Recommendations

- Resources should be provided for the expansion of primary health care services with particular emphasis on lifestyle and chronic disease issues.
- Levies on tobacco and alcohol should be ear-marked for health initiatives.
- The IMO recommends increasing the price of a packet of 20 cigarettes by €1.
- The IMO also recommends introducing a sliding scale of alcohol taxes with the lowest tax on low alcohol beer and the highest tax on spirits. Specifically we recommend a 20% increase on Spirits, 10% increase on Wines and 5% increase on Beers over ABV of 4%.

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[21] DOHC 2005, *Obesity: The Policy Challenges. The Report of the National Task Force on Obesity …p27*
[22] S. Nic Gabhainn, C. Kelly and M. Molcho 2007, *The Irish Health Behaviour in School-aged Children (HBSC) Study 2006* Health Promotion Research Centre, National University of Ireland, Galway and Department of Health and Children *…pp23-26*
[23] NACD & DAIRU 2008, *Drug use in Ireland and Northern Ireland...p1*
[24] Office of Tobacco Control 2006, *Children, Youth and Tobacco: Behaviour, Perceptions and Public Attitudes …p11*

Medical Card Eligibility

As they stand, the current income guidelines are inadequate. Earlier this year, the Combat Poverty Agency[25] found that 22% of people (64,000 people, including 14,500 children) living in consistent poverty do not have a medical card and a further 30% of the population at risk of poverty (220,000 people, including 45,000 children) do not have a medical card.

The positive relationship between poverty and ill-health is well-documented. Available evidence shows that those on low incomes or in poverty have relatively high mortality rates, higher levels of ill-heath and fewer resources to adopt healthier lifestyles. Research for Combat Poverty shows that people without a medical card are less likely to visit their doctor (with an average of 2.3 visits per annum) than medical card holders (6 visits per annum). [26] A recent study in the *Irish Medical Journal* has shown that the removal of entitlement to free health care under the GMS scheme has prevented patients from seeking medical attention and has caused them financial loss. [27]

While the groups at high risk of poverty include the elderly, the unemployed, people with disabilities as well as single parent families - increasingly employed people on a low income or "the working poor" are living in poverty or are at risk. The 2007 Survey on Income and Living Conditions (SILC) in Ireland found that in 31% of households at risk of poverty and in 25% of households in consistent poverty the principal economic status of the head of the household was 'at work'. [28]

Recommendations

- The income guidelines for Medical Card eligibility should be set at the National Minimum Wage, so that everyone living in consistent poverty and at risk of poverty is covered;
- Preventive and chronic disease management services should be included in the services provided to medical card holders.

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[25] Combat Poverty Agency 2009. Analysis of poverty impact of Budget 2009

[26] Layte R . Nolan A. Nolan B. Poor Prescriptions - Poverty and Access to Community Health Services *Combat Poverty Agency, Dublin* 2007: xxiii

[27] O'Carroll and O'Reilly There's a Hole in the Bucket: An Analysis of the Impact of the Medical card Review Process on patient Entitlement to Free Health Care IMJ 2008 101 (1)

[28] CSO, Survey on Income and Living Conditions (SILC) in Ireland 2007 *Central Statistics Office, Dublin* 2008: 36

Acute Hospital Bed- Capacity and Equity of Access

Ireland still has one of the lowest per capita numbers of hospital beds in the developed world. In 2005, Ireland had 2.8 acute hospital beds per thousand population compared to the OECD average of 3.9 beds per thousand population. [29]

Because of the continued shortage of acute hospital beds, 52% of the population feel compelled to purchase private health insurance principally for quicker access to elective care and also to avail of a wider choice of providers. The result however is a two-tier system where the richer echelons of society who can afford private health care are assessed and treated rapidly while those without wait inordinate lengths for both diagnosis and treatment. GPs still report excessive waiting times for patients for specific appointments (2½ years for a public Orthopaedic non-urgent OPD appointment, 1 – 1 ½ years for Neurology, 1 year for Rheumatology).

The current plan to increase capacity through the co-location of private for-profit hospitals on public hospital sites is unlikely to address either issues of capacity or equity of access. The shortage of acute beds primarily affects public patients awaiting elective surgery and both public and private patients requiring access to specialist treatment and interventions for chronic disease. Private hospitals, in order to make profit, tend to "cherry-pick" patients for low cost elective care, while public hospitals will continue to provide the full range of cost intensive, emergency, complex or chronic care under increasingly restricted budgets.

Proposals to match case-mix between public and co-located hospitals on the same site are neither credible nor practical as this would result in inefficient duplication of expensive equipment and facilities. The co-location project is also likely to result in further inefficient allocation of funds as additional capacity created by private hospitals is likely to be used to treat public patients under the National Purchase Treatment Fund (NTPF), at a higher cost to the tax-payer.

The privatisation of long term care has already failed to deliver increased capacity resulting in some elderly patients spending prolonged periods of time inappropriately in acute hospital beds ill-suited to their social or medical needs, because there are no adequate beds available.

The IMO believe that while there is a place for private medicine in Ireland, it must not be at the expense of public patients. Access to hospital services must be based on medical need and not on ability to pay.

Recommendations

- The IMO calls for an immediate halt to the co-location project, and to replace the proposal for co-located hospitals with units for elective patients and patients with chronic illness.

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[29] OECD Health Data 2008,

Summary of Recommendations

- **Funding for health services must be protected**

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