IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

2020 VISION FOR HEALTH

IMO Budget Submission 2016

The Reality of our Health Services Today

- **Over the period 2009 to 2014, €4 billion was taken out of the HSE budget. Each year the HSE has required supplementary funding and indications are 2015 will be no exception;**
- **Staffing levels in the HSE have fallen by 12.9% or 14,418 Whole Time Equivalents since 2007;**
- **The number of acute hospital beds has fallen by 13% or 1,631 acute beds since 2007;**
- **Hospitals are operating at an average of 92.6% capacity, well above the recommended 85% capacity and just above the identified tipping point of 92.5% where mortality rates are affected;**
- **Excluding the Under-6 contract, GPs are treating an additional half a million medical card patients with €160m less;**
- **There is no infrastructure to support multi-disciplinary team working in Primary Care and waiting lists apply for all allied health professionals;**
- **The elderly population over 70 years has increased by 20% since 2006 while spending on elderly care services has fallen by 22%. The additional €20m allocated to elderly care represents a mere 2% increase;**
- **Just 6% of the HSE budget is spent on mental health compared to 8.25% recommended in A Vision for Change;**
- **Ireland has one of the highest rates of childhood obesity in Europe and by 2030 the WHO predicts the majority of Irish adults will be overweight or obese;**
- **Ireland ranks 4th in the OECD in terms of alcohol consumption;**
- **The Irish health services are not an employer of choice for Irish trained Doctors - One in five of all emigrants are health and social care professionals**

IMO Budget Submission 2016

Introduction

2020 Vision for Health, launched at the AGM of the Irish Medical Organisation (IMO) in April this year, laid out the IMO vision for the Irish healthcare system over the next five years. This year's Budget Submission lays out the ground work in 2016 for achieving that vision.

The IMO's 2020 Vision for Health is of a **universal health care system NOT universal health insurance** where all citizens in Ireland have equal access to adequate quality healthcare at an affordable price and where access in based on medical need and not on ability to pay. This requires addressing the capacity issues in our health care system and careful **financial, capacity and manpower planning** so that services reflect the needs of an ageing population and are resourced to levels that assure **patient safety and quality of care.**

2020 Vision calls for **mental health to be put on a par with physical health**. Mental health disorders affect one in four adults in Ireland yet just 6% of the HSE budget is spent on mental health services and both financial and manpower resources are unevenly distributed across services. The IMO Position Paper on Addiction and Dependency, launched earlier this year, also identified significant gaps in addiction services across the country and has called for funding through a levy on the alcohol and gambling industry as well as from the proceeds from the Criminal Assets Bureau.

The IMO 2020 Vision calls on the Government to commit to the goals of **Healthy Ireland** and to adopt a **Health in all Polices** approach to increase the overall health of the population and reduce inequalities in health. All policy decisions affecting health, including budgetary decisions, should be evidence-based and subject to a health impact assessment

Healthcare is not a commodity and traditional market principles cannot apply to healthcare services. However simple economic principles can be applied to the cost of prescription drugs and unhealthy food products, alcohol and tobacco. It makes no sense that the Government willingly increases the out-of-pocket cost of prescription drugs deterring consumption but is unwilling to increase the costs of unhealthy foods and alcohol which lead to illness in the first place.

Finally the IMO 2020 Vision calls on the Government to foster and **protect the doctor patient relationship** and ensure that all policy decisions are made in real consultation with the healthcare profession.

The IMO 2020 Vision for Health is of a Universal Healthcare system that aims to secure access to adequate, quality healthcare for all when they need it and at an affordable cost.

Universal Health Insurance is NOT Universal Healthcare. A universal healthcare system is a system that ensures all people have access to necessary preventive, curative, rehabilitative and long-term care based on medical need and not on ability to pay.

Universal health insurance is a funding model that will introduce a market model of healthcare where the profit interests of private health insurers and corporate healthcare providers will take priority over patient care.

Minister Varadkar recently announced that he was looking at alternatives to universal health insurance and that he had asked researchers "to look at costing different degrees of cover for UHI, such as confining it to hospital care only and not including drugs or primary care".[1] However any funding model which relies on mandatory private health insurance is fundamentally flawed and cannot deliver on affordability, equity of access, choice, timely access to care or quality of care and value for money.

Under a market model, healthcare becomes a commodity to be bought and sold for profit. Costs become impossible to control as private providers and insurers vie for healthier clients to increase turnover and market share on more profitable care while leaving more complex, cost-intensive and chronic care to the public and voluntary sector. Market-based systems also necessitate a whole level of regulatory, administrative and marketing costs that are not required in other funding systems and which drain resources from the provision of patient care.

Few countries rely on private health insurance to fund public healthcare. It is no coincidence that countries which rely on private health insurance to fund their healthcare systems, such as the USA, Switzerland and the Netherlands rank first, third and fourth in terms of per capita spending in the OECD.[2]

In order to contain costs the Government and/or private health insurers will be obliged to reduce the minimum basket of care, introduce a mandatory deductible or impose other limiting terms such as restrictions on the healthcare providers patients may use or the number of visits they can make. All these measures enshrine inequity of access and restrict patient choice.

The ESRI (Economic and Social Research Institute) and the HIA (Health Insurance Authority) are currently undertaking a major costing exercise to examine the cost implications of changing to a multi-payer model of universal health insurance as proposed in the White Paper. The analysis is also to examine the effects of alternative systems of financing. The IMO is calling for the urgent publication of the ESRI/HIA costing exercise on UHI and for an open discussion on the most appropriate model of funding universal healthcare before the next election.

[1] Wall M. Leo Varadkar may change universal health insurance plan, Irish Times 17 Jun 2015
[2] Organisation for Economic Co-operation and Development (OECD), *Health at a Glance 2013* Paris, 2013;

Universal GP Care

GP care is the cornerstone of any universal healthcare system and is associated with better health outcomes, equity of access, more appropriate utilisation of services, long-term cost effectiveness and increased patient satisfaction[3] [4] [5]. Ireland's healthcare system is unique in Western Europe in that it is the only country where excluding the new contract for under 6 year olds, just 40% of the population have access to GP care without fees while the majority of citizens 60% pay the full cost of GP care.

Out-of-pocket payments for healthcare are known to deter both necessary and unnecessary use of healthcare services. Patients who have to pay the full cost of GP care may be deterred from seeking medical care, increasing the risk of delayed detection of medical problems. Out-of-pocket payments are also highly inequitable as they apply only to sick people at the point of use and impact disproportionately on those who need it most - lower income groups, patients with long-term illness and the elderly.

The IMO 2020 Vision for Health supports the Government's plans to expand GP care that is free at the point of access to the whole population. However government spending on general practice is significantly lower than in other Western European countries (2.3% of total expenditure public and private, compared with spending of up to 9% in the UK). The implementation of universal access to GP care requires careful planning and expansion on an incremental basis prioritising those with the greatest need first.

The GMS Medical Card Scheme provides a safety net for patients on lower incomes and those at risk of financial hardship protecting patients from catastrophic healthcare costs. A survey[6] of patients in Ireland and Northern Ireland found that 26.3% of patients in the Republic who paid the full cost access GP care had had a medical problem in the previous year and had not consulted the doctor because of cost. Those in the middle of the income distribution group (those just above the threshold for a medical card) were four times more likely to have been deterred than the most affluent group. Rather than expanding access to GP services on the basis of age cohort, the IMO is calling on the Government to prioritise those who need it most by expanding access to GP care on the basis of income with investment in programmes for the management of chronic disease.

Prescription Charges are a False Economy

Over the last number of years, in order to reduce the State pharmaceutical bill, the Government Ireland has increased the out-of-pocket costs for prescription drugs:

- In 2010, a 50 cent charge per prescription item was introduced for GMS patients which quickly rose to €1.50 per item and now stands at €2.50 per item (capped at €25 per month);

While the prescription charge for medical card holders may have provided increased income to the HSE (approximately 120m annually[7]), prescription charges are a false economy. A recent report from the European Commission Expert Panel on Effective Ways of Investing in Health found little evidence

[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, The Strength of Primary Care in Europe, NIVEL 2012

[6] O'Reilly, D. et al 2006 op cit

[7] Estimated annual savings from 50c charge per prescription item = €27m, and estimated additional savings from €1.50 per prescription item = €51m and estimated increased savings on €2.50 per prescription item =€43m

that user charges lead to more appropriate use or are effective as a cost control measure.[8] Even when charges are low they have been found to deter patients from seeking and complying with both necessary and unnecessary care and treatment, leading to delayed diagnosis and increased hospitalisation.

Studies have shown that increased cost sharing for prescription medication is associated with an 11% increase in the probability of non-adherence in publicly insured populations.[9] Furthermore increased cost-sharing is associated with adverse medical events such as hospitalisations and worsening clinical outcomes over 1-2 years for patients with congestive heart failure, lipid disorders, diabetes and schizophrenia".[10] The IMO 2020 Vision for Health is calling for an immediate reversal of prescription charges for medical card holders.

Two-tier Hospital Care

Significant capacity issues exist throughout the Irish healthcare system resulting in hospital overcrowding and long-waiting times for diagnostic, outpatient and elective care. While the number of people who can afford private health insurance has fallen dramatically since 2008, approximately 45% of the population continue to purchase private health insurance to sidestep waiting lists and to access a wider choice of healthcare providers.

Rather than addressing capacity issues in the public health system, Government policy continues to incentivise the purchase of private health insurance and the two-tier system of access to hospital care where those who can afford private health insurance have faster access while those without wait inordinate lengths of time for diagnostics, outpatient appointments and elective care. Government health policy should stop focusing on propping up the private health insurance industry and concentrate on addressing the capacity issues within our public health system.

The IMO 2020 Vision for Health calls for Universal Healthcare NOT Universal Health Insurance and recommends:

- **the urgent publication of the ESRI/HIA costing exercise on UHI and for an open discussion on the most appropriate model of funding universal healthcare before the next elections;**
- **agreement on a plan for the funding of universal GP care to include chronic disease management programmes and with expansion on the basis of income;**
- **a reversal of prescription charges, which act as an economic disincentive for patients;**
- **the Government to concentrate on addressing the capacity issues in our public health system rather than propping up the private health insurance industry.**

[8] EC EXPH, Definition of a frame of reference in relation to primary care with a special emphasis on financing systems and referral systems, European Commission 2014 downloaded from http://ec.europa.eu/health/expert_panel/opinions/docs/001_definitionprimarycare_en.pdf

[9] Sinnott S-J, Buckley C, O'Riordan D, Bradley C, Whelton H (2013) The Effect of Copayments for Prescriptions on Adherence to Prescription Medicines in Publicly Insured Populations; A Systematic Review and Meta-Analysis. PLoS ONE 8(5): e64914. doi:10.1371/journal.pone.0064914

[10] Goldman DP, Joyce GF, Zheng Y, Prescription Drug Cost Sharing – Associations with Medication and Medical Utilization and Spending and Health, *JAMA* 2007; 298 (1) 61:69

In order to achieve the IMO's 2020 Vision for Health and to ensure that all citizens have equal access to quality care in a timely manner, significant capacity issues in our healthcare system need to be urgently addressed.

Since 2009 our healthcare system has been decimated:

- Over the 6 year period between 2009 and 2014 €4bn (cumulative) was taken out of the HSE budget. The HSE has consistently required supplementary funding including €510m in 2014 and is set to require supplementary funding again in 2015.
- Since their peak in 2007 staffing levels in the HSE have fallen by 14,418 WTEs or 13%.
- In terms of public expenditure as a percentage of GDP, Ireland ranks well below our West European counterparts. Government spending on health in Ireland is equivalent to approximately 6.0% of our GDP, compared to 7.8% in the UK, 8.6% in Germany and 9.0% in France. [11]

At the same time demand on the public health care system has increased:

- Since 2006 the number of people aged 65 and over increased by 25% or approximately 118,700 people;
- since 2008 the number of people with private health insurance fell by 272,000 (11.8%) from 2.3 million in December 2008 to just over 2 million in December 2014;
- since 2008, the number of people who became eligible for a medical card or a GP visit card increased by over half a million.

Capacity has failed to keep up with the demand on our healthcare system. Pressure to keep within budget has led to rolling theatre closures and regular cancellation of elective procedures.

- In February 2015 the number of patients waiting on trollies in our Emergency Departments and on wards reached record levels with an average of 483 patients waiting on trollies in Emergency Departments or on wards;
- At the end of May 2015 there were 414,778 people waiting on an outpatient appointment. 85,130 patients have been waiting over a year for an outpatient appointment while 11,609 are waiting over two years;[12]
- And 67,359 adults and children were waiting on elective procedures of which 9,180 are waiting over 12 months;

The HSE continues to close acute beds without providing sufficient long-term and community-based care. Since 2007, 1,631 acute beds have been taken out of the hospital system and while there is no recent analysis of the number of acute beds currently needed, capacity issues elsewhere in the system compound problems in acute care.

[11] Organisation for Economic Co-operation and Development, Health Resources: Health Spending, [available at https://data.oecd.org/healthres/health-spending.htm (accessed at 2.14pm on 22 May 2015)].
[12] National Treatment Purchase Fund

Long-term and Rehabilitative Care.

According to the HSE, between 15% and 25% of hospital beds are occupied by patients awaiting discharge to long-term or convalescent care. At the end of December 2014 there were 719 patients awaiting discharge of which 573 or 80% were awaiting discharge to long-term nursing care, 85 were awaiting discharge home presumably awaiting a home care package and the remainder 61 were waiting to be discharged to other facilities including the National Rehab Hospital, palliative care or complex issues were involved.

2014 estimates show that 586,600 people or 12.7% of the population is over 65 years of age - an increase of 25% (or 118,700 people) since 2006. By 2021 the number of people over 65 years will increase again by 25% to 734,200. 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 we will require an additional 12,270 long-term care places, 23,670 older people will require formal home care, while demand for all day/daily informal home care by people aged 65+ with disabilities will expand by 23,500. This represents a 60% increase in provision of elderly care services based on 2006 care provision.

In 2015, an additional €25m (representing less than a 2% increase) was allocated to health services for the elderly despite the fact that since 2008, expenditure on elderly care has fallen by 22%. Since 2008 there are 2,186 (9%) fewer long-term beds and the Fair Deal Scheme is not fit for purpose and is fundamentally unfair. While the number of home care packages has increased the overall number of home help hours since 2008 has fallen by 18.5% or 2.3 million hours.

Chronic Disease Management

Chronic disease accounts for a significant proportion of healthcare expenditure. Three quarters of people over 75 have at least one chronic condition and over a third of men over 60 years of age have two or more chronic diseases. Chronic diseases account for two thirds of emergency medical admissions to hospitals and in 2009 the Department of Health estimated that if the current trends continue, hospital bed requirements would increase by 50%-60% over the next 15 years.[13] While General Practice cannot immediately resolve the Emergency Department crisis, Chronic Disease Management in General Practice is associated with a decrease in the likelihood of future hospitalisations as well as decreased premature mortality. With the population over 65 years due to increase by a further 25% by 2021, investment in chronic disease management programmes now will reap long-term savings in the future.

Medical Manpower Planning

The Irish health system is facing a significant medical manpower crisis. In 2003 the Report of the National Task Force on Medical Staffing (Hanly Report) recommended that an additional 3,600 consultants were needed by 2013 in order to move to a team-based consultant provided service and to reverse the ratio of consultants to NCHDs. While there has been some increase in the numbers of consultants employed in the HSE, NCHDs still outnumber consultants 2:1 and significant recruitment and retention issues exist as 1 in 8 consultant posts remain unfilled, exacerbating waiting lists for public patients.

The Graduate Entry Medical Programmes were introduced a number of years ago offering an alternative pathway to a medical career, however young doctors entering the work force now face significant difficulties paying back loans for study under these programmes.

[13] DOHC, Tackling Chronic Disease- A Policy Framework for the Management of Chronic Diseases,

Inadequate numbers of GPs are being trained to meet future workforce requirements, undermining the Government's strategy of incentivising primary care.

- 260 GPs (12% of the GMS workforce) are 64 years or over and are due to retire;
- many newly qualified GPs are emigrating - 1049 Irish trained GPs have taken up principal posts in the UK NHS (these GPs, as well as being GMS principals, were the locums and assistants that allowed flexibility in supply of GP healthcare, facilitating leave or the development of additional services);
- GP services in rural and deprived areas are in need of urgent remedial management with many GMS posts left unfilled;
- there is no infrastructure in place to support multi-disciplinary team working and there are insufficient community and primary care professionals to cope with current demand under the GMS. Waiting lists apply for all allied health and social care services in Primary Care[14] and many of these services are simply not available to patients outside the GMS regardless of their ability to pay.

The IMO 2020 Vision for Health is calling for:

- **a comprehensive assessment and costing of the level of services required across the health system to include:**
  - **a calculation of the number of acute beds required to meet current and future demand;**
  - **an assessment of financial and manpower resources necessary to support the National Emergency Medicine Programme, the National Acute Medicine Programme and the National Programme for Surgery;**
  - **immediate funding to ensure adequate rehabilitation facilities and nursing home beds with a detailed plan to guarantee long-term nursing home and community care for the elderly as an integral part of our healthcare system;**
  - **investment in chronic disease management programmes in General Practice based on current and forecasted morbidity rates and which takes into account high multi-morbidity rates in areas of deprivation.**
- **Integrated manpower planning to ensure adequate levels of healthcare staff to meet current and future requirements including:**
  - **A commitment to the recommendations in the McCraith Report to ensure the recruitment and retention of hospital consultants and NCHDs;**
  - **tax relief on loan repayments for Graduate Entry Medical Students;**
  - **an increase in the number of GP trainee places;**
  - **incentives to ensure encourage GPs into rural and deprived urban areas;**
  - **immediate recruitment of allied health professionals in Primary Care.**

[14] HSE National Performance Assurance Report March 2014

Patient Safety and Quality of Care

Patient safety and quality of care are paramount in the IMO's 2020 Vision for Health.

Healthcare planning must take into account the minimum resourcing levels required to deliver safe, quality services. OECD figures show that in 2012 Irish hospitals were operating at 92.6% patient occupancy rate, a figure well over the established safe occupancy threshold of 85%,[15] and just 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.[16] The recent *Have Your Say* HSE employee engagement survey revealed that 73% of employees (and 76% of medical and dental grades) have come to work despite not feeling well enough to perform their duties; 68% of medical and dental staff regard their stress levels as high (opposed to 56% average); just 13% feel stress levels are low; and 60% of medical and dental grades have seen errors, near misses or incidents that could have hurt patients/clients.[17]

In addition to the profound impact that adverse medical events can have on patients and their families as well as doctors, adverse events cost the State Claims Agency €121million in 2013. The IMO welcomes the Report from the Joint Committee on Health and Children on the Cost of Medical Indemnity Insurance which includes supporting open disclosure, greater use of alternative dispute resolution mechanisms and Tort reform to include pre-action protocols and periodic payment orders as recommended by the IMO when the organisation met with the Committee in February this year. However the single most effective measure the State can undertake is to ensure that our healthcare system is staffed and resourced to safe levels.

In 2012, HIQA published the National Standards for Safer, Better, Healthcare, however since 2012 no additional funds have been provided to support their implementation. While full inspections have yet to take place it is unclear how many healthcare facilities would meet the standards in full. Additional resources are required to ensure that healthcare facilities meet and exceed HIQA standards of care.

The IMO 2020 Vision for Health is calling on the Government to ensure patient safety and quality of care are paramount and to:

- **ensure that all clinical services operate with sufficient minimum financial and manpower resources necessary to provide safe, quality, evidence-based care;**
- **the provision of resources to ensure all healthcare facilities meet and exceed HIQA standards of care.**

[15] Organisation for Economic Co-operation and Development (OECD) , *Health at a Glance 2013*, Paris, 2013;
[16] 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.
[17] Ibid.

In the IMO 2020 Vision for Health mental health is placed on a par with physical health.

Mental health disorders affect one in four people each year.[18] Despite the prevalence of mental health problems and their often chronic and debilitating nature, Irish public health policy as repeatedly failed to divert the required resources to tackling these problems. Just 6% of the health budget this year is allocated to mental healthcare, significantly lower than the 8.24% recommended by the Expert Group on Mental Health Policy in *A Vision for Change - 2006*. This lack of commitment to the protection of funding for mental health was highlighted in 2014 when €15m was cut from the already small figure of €35 million, supposedly ring-fenced for use in the modernisation of sections of the mental health service.

In addition financial and manpower resources are unevenly distributed across mental health services with no relationship between population size or socio-economic need. Last year the Office of the Inspector of Mental Health Services published reports on the service provision within the various catchments nationwide, while also contrasting staffing levels from 2008 to 2013. These reports reveal the seemingly haphazard approach to mental health service provision and staffing in the years since *A Vision for Change* was published. Of the ten catchment areas reviewed, five had fewer psychiatrists than in 2008, six had fewer psychologists than in 2008, and three had no addiction counsellors, in adult services.[19]

Addiction and Dependency Services

For IMO doctors, addiction and dependency remains one of the most challenging public health policy issues:

Alcohol

- more than half of all Irish adults are classified by WHO criteria as harmful drinkers; [20]
- according to the HRB, 6.9% of adults are alcohol dependent with highest rates (14.7%) among 18-24 year olds;[21]
- on average 67 deaths per month are due to alcohol dependency;[22]

Drugs

- over one-quarter of all Irish adults now state that they have used an illegal psychoactive substance recreationally;[23]
- Ireland has the third highest rate of adult drug-induced deaths in the EEA, with 70.5 cases per million annually;[24]

[18] 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.
[19] Office of the Inspector of Mental Health Services, Super Catchment/Local Catchment Area Reports, Mental Health Commission, 2014, [available at http://www.mhcirl.ie/Inspectorate_of_Mental_Health_Services/SC-LAR130314/ (accessed on 23 June 2015 at 2.31pm)].
[20] World Health Organisation, European Status Report on Alcohol and Health 2010, Copenhagen, 2010,
[21] Long, J and Mongan, D, *Alcohol Consumption in Ireland 2013: Analysis of a National Alcohol Diary Survey*, Health Research Board, Dublin, 2014
[22] S. Lyons *et al.*, *Alcohol-related deaths and deaths among people who were alcohol dependent in Ireland, 2004 to 2008*, Health Research Board, Dublin, 2011
[23] National Advisory Committee on Drugs and Public Health Information and Research Branch, *Drug use in Ireland and Northern Ireland: First results from the 2010/11 Drug Prevalence Survey*, Dublin, 2011

- 78% of those who die from poisoning as a result of opioid use are not part of a methadone treatment programme;[25]

Gambling

- there is insufficient research into the prevalence of gambling addiction in Ireland, although research from the UK suggests 1% of the adult population may be experiencing problem gambling while lifetime prevalence may be as high as 5%[26]

The IMO has been raising awareness about addiction and dependency through AGM motions, scientific sessions, position papers and submissions. In November of last year the IMO, in conjunction with the British Medical Association Northern Ireland, hosted an All-Ireland Conference on Mental Health and Addiction, during which delegates had an opportunity to hear from a wide range of speakers including Fr. Peter McVerry, Mr. Oisín McConville and Dr. Cathal Ó Súilliobháin.

In June this year the IMO launched our *Position Paper on Addiction and Dependency Services* which identified a number of gaps in addiction services:

- While the HRB estimates that 6.9% of adults are alcohol dependent, just 0.26% of adults or 8336 adults were in treatment in 2012 with clear disparities between treatment incidence and alcohol consumption across counties;[27]
- Polydrug use is an increasing problem. Between 2003 and 2008 the number of cases where benzodiazepines were reported as a secondary or additional problem substance rose by 59% from 982 cases to 1,562.[28] Despite the serious risks of coma or respiratory failure associated with alcohol and benzodiazepine use, there are no appropriate acute facilities for those with both benzodiazepine and alcohol dependency;
- There are an estimated 21,000 heroin users in Ireland yet fewer than half are accessing treatment. A third of heroin users live outside of Dublin yet there are no Level 2 GPs prescribing methadone west of the Shannon;[29]
- Building on the success of the Pharmacy Needle Exchange in reducing the spread of blood-borne diseases and directing people towards treatment services, an investigation is needed into the potential benefits of using supervised injection sites;
- A third to a half of those treated for substance abuse have an independent co-occurring psychiatric illness. Bar a dual diagnosis clinic at the National Drug Treatment Centre, few developments have been made in the establishment of services for patients with comorbid substance abuse and mental illness, or in the development of agreed protocols in the management of patients with co-existing disorders;

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[24] European Monitoring Centre for Drugs and Drug Addiction, *European Drug Report 2014: Trends and Developments*, *Publications Office of the European Union*, Luxembourg, 2014,
[25] C. Ó Súilliobháin, *Access to Community Based Drug Treatment*, presentation delivered to the Irish Medical Organisation and British Medical Association All-Ireland Conference on Mental Health and Addiction, Dublin, 21 November 2014.
[26] Institute of Public Health in Ireland, *Developing a Population Approach to Gambling: Health Issues – Briefing Paper*, Dublin, December 2010,
[27] Health Research Board, *Treated alcohol use in Ireland: figures for 2012 from the National Drug Treatment Reporting System*, National Health Information Systems, Dublin, 2014
[28] D. Bellerose *et al.*, *Problem Benzodiazepine Use in Ireland: Treatment (2003 to 2008) and deaths (1998 to 2007)*, Health Research Board, Dublin, 2010,
[29] Ó Súilliobháin, *Access to Community Based Drug Treatment*, presentation delivered to the Irish Medical Organisation and British Medical Association All-Ireland Conference on Mental Health and Addiction, Dublin, 21 November 2014.

- There is currently no statutory provision for the treatment of gambling addiction. Financial loss and debt are often a consequence of problem gambling and as such private services are generally prohibitive to patients with a gambling addiction, leaving patients reliant on the voluntary sector.

Where reductions in available funding have given rise to impediments to effective treatment, alternative revenue streams should be sought. Levies should be placed on the alcohol and gambling industries in Ireland to ensure that contributions from these sectors of the economy fund the treatment and rehabilitation of those who have developed clinical dependencies on their products. In much the same way, the proceeds acquired by the Criminal Assets Bureau relating to drug crime should be reinvested in drug treatment programs.

IMO 2020 Vision for Health calls on the Government to place mental health on a par with physical health and recommends that the Government:

- **increase the level of funding of mental health services to 8.24% of the healthcare budget as recommended in A Vision for Change;**
- **appoint a national independent body to determine mental health catchment areas to ensure equality of services in all parts of the country;**
- **urgently develop a strategy for the development of treatment and rehabilitation services for alcohol and drug dependency to include the:**
    - **establishment of acute alcohol and illicit drugs detoxification centres for those who wish to choose detoxification as part of their recovery;**
    - **development of appropriate acute treatment facilities for those with alcohol and benzodiazepine dependency;**
    - **full implementation of the Farrell Report (2010) to allow for the expansion of numbers of patients on the Opioid Treatment Protocol and thus increase access to treatment for heroin dependence throughout the country;**
    - **research to assess the potential benefits and risks of utilising supervised injection sites as a means of reducing drug-related harm and bringing patients into contact with drug treatment;**
    - **development of specialist services in dual-diagnosis, comorbid substance dependency, and mental health illness with appropriate pathways of referral in and out of services and standardised protocols for care;**
    - **provision of State funding for the treatment of gambling addiction;**
    - **placement of levies on the alcohol and gambling industries to fund the treatment and rehabilitation of those who have developed clinical dependencies on their products;**
    - **route proceeds acquired by the Criminal Assets Bureau relating to drug crime to investment in drug treatment programs.**

The IMO 2020 Vision for Health supports Healthy Ireland and a Health-in-All-Policies Approach

Ireland faces significant health challenges as a result of unhealthy lifestyle choices and rising inequality in health.

- In 2010 74% of Irish men were overweight or obese and 26% of men were obese while 57% of Irish women were overweight or obese and 23% were obese. Using a variety of data sources the WHO predict that by 2030, almost all Irish adults are projected to be overweight. For men, 89% are likely to be overweight (which includes obese), and 48% are estimated to be obese by 2030. For women, 85% are likely to be overweight, and 57% obese in 2030;[30]
- With 27% of 5 year olds overweight or obese, Ireland has one of the highest rates of childhood obesity in Europe;
- In 2012, the last year for which reliable statistics are available, Ireland's annual alcohol consumption was measured at 11.6 litres of pure alcohol per person, ranking fourth amongst the OECD member states.[31] Considering that 21% of people abstain from drinking consumption is closer to 14.5 litres of pure alcohol per person;
- In 2012, 22% of adults were smokers while data from 2010 shows that approximately 19% of boys and 22% of girls in the 15-17 years age group report that they are current smokers.[32]

People from poorer socio-economic groups have fewer resources to adopt healthier lifestyles and have relatively high mortality rates and higher levels of ill health.

Health Ireland published by the Government in 2013 lays out a framework for improved health and well-being in Ireland from 2013 to 2025, the goals of which are to:

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

The framework targets a 5% increase in the number of adults with a healthy weight and a 6% increase in the number of children with a health weight by 2019. Targets set out in the framework also aim to reduce the annual consumption of alcohol to 9.2 litres of pure alcohol per capita and to reduce the overall prevalence of smoking by 1% per annum.

While a wide range of measures are needed, simple budgetary measures, while not politically popular, can influence the demand for and consumption of unhealthy products. While criticised for

[30] World Health Organization (WHO) Regional Office for Europe European Congress on Obesity (ECO) in Prague, Czech Republic, 5-6th May 2015
[31] Organisation for Economic Co-operation and Development (2014), *OECD Health Statistics 2014: How does Ireland compare?*, OECD Health Statistics (database). http://www.oecd.org/health/healthdata
[32] Kelly C, Gavin G, Molcho M and Nic Gabhainn S. The Irish Health Behaviour in School-aged Children (HBSC) Study 2010 Health Promotion Research Centre NUIG and DOHC 2012

being progressive in nature, pricing policies have been found to decrease consumption, particularly among young people.

Pricing of Products High in Fat, Sugar and Salt Content

While a wide range of measures are needed to reduce levels of obesity, taxes on foods that are high in sugar, salt and fat can deter consumption of these unhealthy foodstuffs. A UK study predicts that increasing the VAT on junk food to 17.5 % could reduce the incidence of ischaemic heart disease by 1-3%.[33] The Health Impact Assessment conducted by the Institute of Public Health estimates that a 10% tax on sugar sweetened drinks could reduce obesity in Ireland by 1.25%[34] and the Irish Heart Foundation estimate that a 20% tax on sugar sweetened drinks could raise up to €60m[35].

Alcohol Minimum Unit Pricing

Under a minimum pricing structure, the price per unit of alcohol becomes more expensive particularly affecting demand by younger binge drinkers and excessive harmful drinkers who are most likely to purchase cheaper alcohol, thus minimum unit pricing can reduce alcohol-related harm without necessarily penalising moderate drinkers.[36] Analyses from Canada, where minimum pricing has been in place in some provinces for decades, concludes that a 10% rise in average minimum alcohol prices is associated with a reduction of 32% in death wholly due to alcohol, a 9% reduction in chronic and acute alcohol related hospitalisations and a 3.4% reduction in total consumption. A levy should also be placed on the alcohol industry to finance alcohol treatment services and ensure that minimum unit pricing does not increase profits for alcohol producers.

Tobacco Excise Duty

The WHO predicts that a 10% increase in tobacco prices can reduce consumption by 4% in high income countries[37].

Health Impact Assessment

A wide range of factors – such as poverty, inequality, social exclusion, employment, income, education, housing conditions, transport access to health care, lifestyle, stress – all impact significantly on an individual's health and wellbeing. Because good health is socially, economically and environmentally determined, policy choices implemented by all departments, not just the Department of Health, can significantly impact on a person's health. *Healthy Ireland - A Framework for Improved Health and Wellbeing 2013-2025* emphasises the importance of Health Impact Assessments. A Health Impact Assessment is defined as *"a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population".*[38] The IMO believes that all public policy, including budgetary measures, should be subject to a Health Impact Assessment.

[33] Mytton O, Clarke D, and Rayner M. Taxing unhealthy food and drinks to improve health, BMJ 2012;344:e2931 doi: 10.1136/bmj.e2931

[34] Institute of Public Health 2012, Proposed Sugar Sweetened Drinks Tax: Health Impact Assessment Report, Dublin: Institute of Public Health 2012

[35] Irish Heart Foundation Pre Budget Submission 2015

[36] Dyer O. Minimum alcohol pricing delivers health benefits without penalising moderate drinkers, finds analysis BMJ 2013; 346:f2939

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

[38] WHO Europe, European Centre for Health Policy. Health Impact Assessment: main concepts and suggested approach. Gothenburg consensus paper. 1999.

The IMO 2020 Vision for Health calls on the on the Government to commit to the goals of Healthy Ireland - A Framework for Improved Health and Well-being 2013 – 2025 and to ensure a Health-in All-Policies approach. Specifically the IMO recommends:

- **the provision of ring-fenced funding to support the implementation of Healthy Ireland**
- **the introduction of a pricing structure to discourage the consumption of food with high sugar, high fat and high salt content and encourage the consumption of healthier food and drink;**
- **the Government proceed with the Public Health (Alcohol) Bill 2015 which introduces Minimum Unit Pricing and apply a levy to the drinks industry for the treatment of alcohol related harm;**
- **an increase in the price of a packet of cigarettes by at least €1 in 2015;**
- **assurance that policy decisions, including budgetary decisions, are subject to a Health Impact Assessment.**

A Healthcare System that Protects the Doctor-Patient Relationship

The IMO 2020 Vision for Health places the doctor-patient relationship is at the very core of the practice of medicine.

Patients trust their doctors to make decisions that are purely in the patients' interests and exclude commercial, political, or other concerns. A recent poll conducted by Amárach Research, on behalf of the Medical Council of Ireland, found that doctors continue to be the most trusted profession in Ireland.[39] While 91% of adults in Ireland state that they trust their doctor to tell the truth, this figure is decidedly lower in the USA, where just 58% have expressed the same trust.[40] While the components of trust in a given profession are complex and diverse, studies have established that the commercialisation of medicine acts as a barrier to trust and a strong doctor-patient relationship.[41] The USA, where a commercially-driven market model of medicine has been in place many decades, demonstrates the pitfalls of increasing commercial pressures in the field of medicine on trust in the medical profession.

The Government must avoid using short-term financial pressures to further privatise the provision of care, which prioritises commercial concerns, and instead focus on protecting the interests of patients through a publicly funded healthcare system that fosters trust between patients and doctors. Doctors work at the coalface of the health service and every day, make clinical decisions based on scientific evidence and international best practice. Frequently major changes to healthcare policy are guided by economic or political imperatives without any evidence of improvement to quality of care or patient outcomes.

The clinical leadership and knowledge doctors possess can be an instrumental asset in the development healthcare services. The IMO has expertise in its members and dedicated resources to the development of policy, and therefore has a positive contribution to make to health and societal issues. In addition, successful reform of public services is dependent on those who have to implement change. A top down approach to change simply alienates and demoralises public sector employees. Successful reform requires that those who are employed in the public services be fully engaged and given ownership of the reform process. The management of the health service and health policy can be greatly improved through real consultation and engagement with doctors on all health policy matters.

The IMO 2020 Vision for Health is calling for a healthcare system that fosters the doctor-patient relationship and for:

- **the protection of healthcare services and funding from commercial and political interference;**
- **assurance that policy decisions affecting the delivery of healthcare in Ireland are evidence–based and made in partnership with the medical profession.**

[39] Medical Council, Survey of Public Attitudes to Doctors' Professionalism, July 2015
[40] R. J. Blendon, J. M. Benson, and J. O. Hero, 'Public Trust in Physicians — U.S. Medicine in International Perspective', The New England Journal of Medicine, Vol. 371, October 2014, pp. 1570-1572.
[41] A. Banerjee and D. Sanyal, 'Dynamics of doctor–patient relationship: A cross-sectional study on concordance, trust, and patient enablement', Journal of Family and Community Medicine, Vol. 19, Issue 1, April 2012, pp. 12-19.

Summary of Recommendations

Universal Healthcare NOT Universal Health Insurance

The IMO 2020 Vision for Health calls for Universal Healthcare NOT Universal Health Insurance and recommends:

- **the urgent publication of the ESRI/HIA costing exercise on UHI and for an open discussion on the most appropriate model of funding universal healthcare before the next elections;**
- **agreement on a plan for the funding of universal GP care to include chronic disease management programmes and with expansion on the basis of income;**
- **a reversal of prescription charges, which act as an economic disincentive for patients;**
- **the Government to concentrate on addressing the capacity issues in our public health system rather than propping up the private health insurance industry.**

Financial, Capacity and Manpower Planning

The IMO 2020 Vision for Health is calling for:

- **a comprehensive assessment and costing of the level of services required across the health system to include:**
  - **a calculation of the number of acute beds required to meet current and future demand;**
  - **an assessment of financial and manpower resources necessary to support the National Emergency Medicine Programme, the National Acute Medicine Programme and the National Programme for Surgery;**
  - **immediate funding to ensure adequate rehabilitation facilities and nursing home beds with a detailed plan to guarantee long-term nursing home and community care for the elderly as an integral part of our healthcare system;**
  - **investment in chronic disease management programmes in General Practice based on current and forecasted morbidity rates and which takes into account high multi-morbidity rates in areas of deprivation.**
- **Integrated manpower planning to ensure adequate levels of healthcare staff to meet current and future requirements including:**
  - **A commitment to the recommendations in the McCraith Report to ensure the recruitment and retention of hospital consultants and NCHDs;**
  - **tax relief on loan repayments for Graduate Entry Medical Students;**
  - **an increase in the number of GP trainee places;**
  - **incentives to ensure encourage GPs into rural and deprived urban areas;**
  - **immediate recruitment of allied health professionals in Primary Care.**

Patient Safety and Quality of Care

The IMO 2020 Vision for Health is calling on the Government to ensure patient safety and quality of care are paramount and to:

- **ensure that all clinical services operate with sufficient minimum financial and manpower resources necessary to provide safe, quality, evidence-based care;**
- **the provision of resources to ensure all healthcare facilities meet and exceed HIQA standards of care.**

Putting Mental Health on a Par with Physical health

IMO 2020 Vision for Health calls on the Government to place mental health on a par with physical health and recommends that the Government:

- **increase the level of funding of mental health services to 8.24% of the healthcare budget as recommended in A Vision for Change;**
- **appoint a national independent body to determine mental health catchment areas to ensure equality of services in all parts of the country;**
- **urgently develop a strategy for the development of treatment and rehabilitation services for alcohol and drug dependency to include the:**
    - **establishment of acute alcohol and illicit drugs detoxification centres for those who wish to choose detoxification as part of their recovery;**
    - **development of appropriate acute treatment facilities for those with alcohol and benzodiazepine dependency;**
    - **full implementation of the Farrell Report (2010) to allow for the expansion of numbers of patients on the Opioid Treatment Protocol and thus increase access to treatment for heroin dependence throughout the country;**
    - **research to assess the potential benefits and risks of utilising supervised injection sites as a means of reducing drug-related harm and bringing patients into contact with drug treatment;**
    - **development of specialist services in dual-diagnosis, comorbid substance dependency, and mental health illness with appropriate pathways of referral in and out of services and standardised protocols for care;**
    - **provision of State funding for the treatment of gambling addiction;**
    - **placement of levies on the alcohol and gambling industries to fund the treatment and rehabilitation of those who have developed clinical dependencies on their products;**
    - **route proceeds acquired by the Criminal Assets Bureau relating to drug crime to investment in drug treatment programs.**

Healthy Ireland and Health-in-All-Polices

The IMO 2020 Vision for Health calls on the on the Government to commit to the goals of Healthy Ireland - A Framework for Improved Health and Well-being 2013 – 2025 and to ensure a Health-in All-Policies approach. Specifically the IMO recommends:

- **the provision of ring-fenced funding to support the implementation of Healthy Ireland**
- **the introduction of a pricing structure to discourage the consumption of food with high sugar, high fat and high salt content and encourage the consumption of healthier food and drink;**
- **the Government proceed with the Public Health (Alcohol) Bill 2015 which introduces Minimum Unit Pricing and apply a levy to the drinks industry for the treatment of alcohol related harm;**
- **an increase in the price of a packet of cigarettes by at least €1 in 2015;**
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A Healthcare System that Protect the Doctor-Patient Relationship

The IMO 2020 Vision for Health is calling for a healthcare system that fosters the doctor-patient relationship and for:

- **the protection of healthcare services and funding from commercial and political interference;**
- **assurance that policy decisions affecting the delivery of healthcare in Ireland are evidence–based and made in partnership with the medical profession.**