IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Pre-Budget Submission 2022

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Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2
Tel (01) 676 72 73
Email : imo@imo.ie
Website www.imo.ie

IMO Pre-Budget Submission 2022

Covid 19 has had a profound and enduring effect on health and healthcare, disrupting the provision of care and contributing to major delays in the delivery of health services.

Decades of under-investment left us with insufficient capacity (both in terms of medical manpower, bed capacity and infrastructure) to cope with the additional demands of the pandemic. Our already over-stretched hospital services were ill-prepared to cope with the additional demand, while social distancing and infection control measures saw capacity reduced in some specialities by up to 50%.

We now have an unprecedented backlog of patients waiting for both urgent and non-urgent care while demand for care is continues to grow apace. The recent cyber-attack on the HSE has further compounded delays with many appointments and procedures being postponed or rescheduled.

In 2021 an additional €4billion was added to the health budget, the majority of which was allocated to the pandemic response. While the additional spending is welcome, the Government has yet to tackle the core capacity issues that left our health system so vulnerable in the first place.

Ireland has a growing and ageing population, and the effect of the COVID 19 Pandemic, will be evident long into the future. The Government cannot continue to be blind to the medical manpower crisis and the bed and infrastructure deficits across our health system. Urgent action is needed now to build capacity so that our health system and our economy can remain resilient into the future.

IMO Budget 2022 Recommendations:

1. Invest in Medical Manpower

- **Immediately reverse the discriminatory and universal 30% pay cut imposed on new consultants to the HSE since 2012;**
- **Negotiate with the IMO for a new fit for purpose consultant contract that recognises the value of our newly qualified hospital consultants;**
- **Increase in the number of specialist training posts to meet current and future population needs. This measure will also support compliance with the EWTD;**
- **Modernise specialist training and career pathways in line with the recommendations of the Strategic Review of Medical Training and Career Structure (MacCraith) Reports 2014;**
- **Provide a reasonable and fair pathway for international doctors to access Speciality training;**
- **Introduce tax relief on loan repayments for graduate entry medical students;**
- **Build out a Consultant led Occupational Health service to protect the health of our healthcare workers.**

2. Invest in Acute Bed Capacity and Diagnostic Infrastructure

- **Resource a multi-annual programme of investment in acute bed capacity to include :**
  - **5,000 additional public acute bed capacity including**
  - **investment in stand-alone public hospitals for elective care and**
  - **a doubling of critical care capacity to 550 critical care beds;**
- **Urgently assess and resource diagnostic, radiology and laboratory requirements to ensure timely access to investigations and results for both hospital doctors and GPs in the community.**

3. **Invest in General Practice and the Shift of Care to the Community**
    - **Invest in supports for general practice to employ additional GPs, practice nurses and other support staff;**
    - **Provide incentives for General practice to invest in the development of infrastructure including premises, medical equipment, diagnostic equipment, IT (as per the recommendations in the Indecon report);**
    - **Given the precarious financial position of newly established practices - agree supports to allow these practices remain financially viable and open to patients;**
    - **Invest in a comprehensive Women's' Health Programme in General Practice to include:**
        - **Advice on Contraception**
        - **Access to contraception including Long Acting Reversible Contraceptive (LARC) methods.**
        - **Advice on sexually transmitted infection (STI), screening and testing for STIs**
        - **Advice on fertility and pre-conception**
        - **Advice on menopause**
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4. **Investment in Mental Health Services**

    - **Invest in a clinical programme of care for mental health care in General Practice to be negotiated between the IMO, the Dept of Health, and the HSE;**
    - **Invest in publicly funded counselling and psychotherapy services and supports in the community, accessible on GP referral; - many practices have available rooms, which could facilitate these services and would de-fragment the management of mental health conditions;**
    - **Fully resource community and hospital based mental health care teams in line with the recommendations of *A Vision for Change;***
    - **Urgently assess the number of acute inpatient psychiatric beds required to ensure timely admission of patients presenting with acute psychiatric illness;**

5. **Invest in eHealth and IT Infrastructure**

    - **Invest in secure systems of electronic health records across hospitals and community health centres (systems must be able to communicate and allow embedding of national summary patient records);**
    - **Upgrade IT infrastructure, both hardware and software, to improve cybersecurity to support safe remote-consultations and remote multi-disciplinary team-working;**
    - **Ensure on-going investment and cooperation in the development of eHealth in General Practice in line with the agreement between the IMO, the HSE and the Dept of Health.;**

6. **Invest in Health and Social Care Needs for Older People**
    - **Further resourcing of rehabilitative community care beds and home care supports including intensive home care packages to allow older people remain at home as long as possible;**
    - **Ongoing investment in a holistic approach to care with input from a range of specialties including geriatricians, GPs and public health specialists;**
    - **Invest in a programme of GP care for nursing home patients that reflects the complexity of care required;**

7. **<u>Appropriately Resource Prevention programmes</u>**
    - **Increase Community medical staffing levels to maintain the quality and safety of child health and immunisation programmes, now that schools have reopened;**
    - **Provide appropriate resources for the full re-establishment of life-saving cancer -screening programmes.**

Introduction

Covid 19 has had a profound and enduring effect on health and the delivery of healthcare.

- Since the beginning of the outbreak over quarter of a million (252,808) people in Ireland have contracted the virus, of whom 14,387 have been hospitalised and 1,540 admitted to ICU.[1] The death toll from the Covid 19 - pandemic in Ireland has now reached 5,000 people.[2]
- Prior to Covid 19 our hospitals operated at close to or above 100% capacity. In order to cope with the additional demand, non-urgent appointments were cancelled or delayed, while social distancing and infection control measures saw capacity reduced in some specialities by up to 50%.[3]
- We now have an unprecedented backlog of patients waiting for both urgent and non-urgent care while demand for care is growing exponentially. As of March 2021[4] there were 881,621 patients on NTPF waiting lists, an increase of 13% since February 2020;
- The recent cyber-attack on the HSE has further compounded delays with many appointments and procedures being postponed or rescheduled.
- In 2021 an additional €4billion was added to the health budget, the majority of which was allocated to the pandemic response. However little investment has been made in the core capacity issues within our health system which left our system so vulnerable in the first place.
- The population of Ireland now stands at approximately 4.98 million and is expected to increase to 5.3 million by the end of the decade. At the same time the population over 65 years old is expected to increase by 35% while the population over 85 years old will increase by 53%[5].
- There is insufficient capacity across the system to meet the demands of a growing and ageing population while the impact of Covid is likely to be felt for many years to come.

The Government cannot continue to be blind to the medical manpower crisis and the bed and infrastructure deficits across our health system. Urgent action is needed now to build capacity so that our health system and our economy can remain resilient into the future.

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[1] HPSC, COVID-19 Epidemiology Team, 11/05/2021, Weekly Report on the Epidemiology of COVID-19 in Ireland Week 18, 2021

[2] Department of Health, 01/07/2021

[3] HSE…

[4] NTPF Waiting Lists

[5] CSO in DOH, 2020 Health in Ireland, Hey trends 2019, file:///C:/Users/vanessa/Downloads/45117_6a4f970018d6477bac38f4539f80e927%20(11).pdf

1. Invest in Medical Manpower

The HSE is facing a major medical manpower crisis:

- With just 1.44 consultant specialists per 1,000 population Ireland has the lowest number of hospital specialists in the EU and falls well below the EU average 2.48 per 1,000 population;[6]
- Up to 2,000 (58%) additional consultants are needed to provide consultant delivered care across our acute hospital and psychiatry services to meet the needs of our growing population;[7] [8]
- Out of 3,429 consultant posts in November 2020, More than one fifth 728 were vacant or filled on a temporary locum basis[9];
- Across all specialties, Consultant staffing levels fall far below recommended staffing levels contributing to excessive waiting lists. As of March 2021[10] there were 628,756 people waiting for an outpatient appointment with a hospital consultant of which over a quarter of a million (255,000) patients were waiting longer than a year;
- Specialist training is key to filling future manpower requirements , however there are insufficient training posts to meet either demand or the current shortage of consultants. Each year just over 700 doctors enter basic specialist training, however that number falls to around 500 doctors entering higher specialist training with around 10% of posts unfilled while the HSE estimate that a minimum of 646 additional training posts are required in hospital based specialties over the next 7 years;[11]
- Over the last 5 years almost 3,000 doctors have left the Medical Council Register[12] to take up positions abroad in favour of better employment conditions a work-life balance.

Despite chronic understaffing, doctors and their teams have been resilient throughout the pandemic, continuing to provide care for patients despite high risk of infection and unprecedented levels of burnout and exhaustion . The vast majority of our medical teams had been further affected by covid related absence or redeployment, while at the height of the third wave in January this year, 7 out of 10 doctors were experiencing high risk of burnout.[13]

Urgent action is required to tackle the crisis in recruitment and retention of hospital consultants. Since 2012 consultants employed in the HSE have been subject to a discriminatory and unilateral cut of 30% in addition to the cuts already applied across the public service. It has been widely recognised in the Report of the Public Service Pay Commission and by the HSE that the two-tier consultant pay issue is a major barrier to recruitment;

Poor working conditions, poor work- life balance and career uncertainty have been the key factors driving emigration among trainees and newly qualified specialists. [14] While our health care system

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[6] OECD Health Stats 2019

[7] NDTP, HSE – Demand for medical consultants and specialists to 2028 and the training pipeline to meet demand, 2018

[8] NDTP Medical Workforce Planning for the Specialty of Psychiatry 2020-2030 An Expert Stakeholder Informed Review March 2021

[9] HSE – Breakdown of consultant establishment. 04 November 2020

[10] NTPF Waiting Lists

[11] NDTP, HSE 2018

[12]

[13] IMO Survey of Doctor Mental Health and Wellbeing 2021.

[14] Humphries et al. COVID-19 and doctor emigration: the case of Ireland, Hum Resour Health (2021) 19:29 https://doi.org/10.1186/s12960-021-00573-4

relies on a large number doctors international doctors to fill non-training service posts, but they too move on, disillusioned with working conditions and lack of training opportunities. Unfortunately the experiences of young doctors during the pandemic appear to have "intensified and reinforced rather than radically altered, the dynamics of doctor emigration".[15] In 2014, the Strategic Review of Medical Training and Career Structure (MacCraith) Report[16]s made a number of recommendations to improve the quality of post-graduate training and employment and while progress has been made in some areas further actions is required.

In this year's budget, priority must be given to addressing the medical manpower crisis that our health system is experiencing.

IMO Recommendations:

- **Immediately reverse the discriminatory and universal 30% pay cut imposed on new consultants to the HSE since 2012;**
- **Negotiate with the IMO, the HSE and the Dept of Health of a new fit for purpose consultant contract that recognises the value of our newly qualified hospital consultants;**
- **Increase in the number of specialist training posts to meet current and future population needs. This measure will also support compliance with the EWTD;**
- **Modernise specialist training and career pathways in line with the recommendations of the Strategic Review of Medical Training and Career Structure (MacCraith) Reports 2014;**
- **Provide a reasonable and fair pathway for international doctors to access Speciality training;**
- **Introduce tax relief on loan repayments for graduate entry medical students;**
- **Build out a Consultant led Occupational Health service to protect the health of our healthcare workers.**

2. Invest in acute bed capacity and diagnostic infrastructure

In addition to consultant manpower, capacity deficits in terms of acute beds and diagnostic infrastructure contribute to delays in accessing care.

- At 3.0 hospital beds per 1,000 population, the number of hospital beds in Ireland is significantly lower than the EU average of 5.1[17].
- At 5 beds per 100,000 Ireland has also among the lowest number of critical care beds in the OECD and falls well below the OECD average of 12 ICU beds per 100,000 population.
- Prior to Covid 19 our hospitals operated at close to or above 100% capacity,[18] contributing to significant delays and the boarding of patient in our EDs;
- Covid 19 has added huge additional constraints on hospital bed capacity. In April 2020, inpatient activity fell by 35%, while day case activity fell by 52%, compared with April 2019. While there was a subsequent increase in activity inpatient activity was down 21% and day

[15] Humphries et al. 2021
[16] https://www.gov.ie/en/collection/9ef920-strategic-review-of-medical-training-and-career-structure-maccraith-/
[17] OECD latest figures 2019, May 2021
[18] HSE Service Plan 2021

case activity fell 32% again in January and February 2021 compared with the same period in 2020;[19]

- By the end of March 2021, waiting lists for inpatient and day case procedures had grown by 20% to 79,973 compared with 66, 705 in February 2020;[20]
- Fear of contracting the virus and burdening the health care system has led to a fall in Emergency Department attendances. However, EDs are now experiencing a return to record daily numbers of patients[21]

Budget 2021 promises to bring the total increase in acute beds to 1,146 by the end of 2021 and the number of critical beds to 321, while investment in a further 2,600 beds are planned under the National Development Plan. [22]

Current plans for the expansion of acute bed capacity are based on the minimum requirements of the Health Service Capacity Review 2018,[23] but are dependent on significant reform of the health system including a substantial expansion of GP and community-based services as well community and long-term care services for older people, which have yet to be achieved.

It is widely recognised that the minimum requirements of the Health Service Capacity Review are insufficient to meet population demands.

- The ESRI project minimum bed requirements to be much higher with between 4000 and 6300 beds required across public and private hospitals of which 3200 to 5600 will be required in public hospitals.[24] "*These findings suggest that government plans to increase public hospital capacity over the 10 years by 2600 may not be sufficient to meet demand requirements to 2030, even when models of care changes are accounted for*".
- In 2009 the "Towards Excellence in Critical Care-Prospectus Report" recommended that critical care bed numbers should increase to 579 by 2020.[25]

Diagnostic services have also been significantly affected by Covid:

- NTPF data show that the number of patients waiting for a GI Endoscopy grew by 56% from 22,705 in February 2020 to 35,634 at the end of March 2021. [26]

Delays in accessing diagnostics are particularly evident in our cancer services where

- Just 60% of new patients attending Rapid Access Breast, Lung and Prostate Clinics were seen within the recommended timeframe. [27]

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[19] Crowley, P. and Hughes, A. (2021)
[20] NTPF Active Inpatient /Day case Waiting lists March 2021 compared with February 2020.
[21] IAEM, Press release 17 jun 2021, Ireland's Emergency Departments seeing record numbers of patients while cyberattack impact continues
[22] Government of Ireland, Project Ireland 2040 -National Development Plan 2018—2027
[23] PA Consulting, Health Service Capacity Review. Dept of Health 2018
[24] Keegan C, Brick A, Walsh B, Bergin A, Eighan J, Wren M_A, How many beds? Capacity implications of hospital care demand projections in the Irish hospital system, 2015-2030, t*he International Journal of Health Planning and Management*, 2018, pp. 1-14 https://doi.org/10.1002/hpm.2673
[25] Prospectus, Towards Excellence in Critical Care, Review of Adult Critical Care services in the Republic of Ireland, Final Report, Submitted to the Health Service Executive September 2009
[26] NTPF Active waiting Lists
[27] HSE, *Health Services Performance Profile July - September 2020*

- Figures show that for the first three months this year 450 people per month were not seen within the recommended 4 weeks for an urgent colonoscopy compared to 15 per month pre-covid .[28]

While there is little data available, difficulties in accessing radiology services can create significant bottlenecks in our Emergency Departments while lack of access diagnostic, radiology and laboratory services in the community can lead to greater reliance on hospital services.

To date, no detailed assessment has been carried out of diagnostics, radiology and laboratory service requirements to meet current and future demands while Covid 19 infection prevention and control measures have had a significant impact on capacity.

IMO Recommendations:

- **Resource a multi-annual programme of investment in acute bed capacity to include :**
  - **5,000 additional public acute bed capacity including**
  - **investment in stand-alone public hospitals for elective care and**
  - **a doubling of critical care capacity to 550 critical care beds;**
- **Urgently assess and resource diagnostic, radiology and laboratory requirements to ensure timely access to investigations and results for both hospital doctors and GPs in the community.**

3. Invest in General Practice and the shift of care to the community

General practice has been flexible and quick to adapt to the changes associated with the pandemic. GPs have risen to the additional challenges caused by the virus - General Practice has been the first point of contact for COVID 19 assessments and referrals and has been central to the roll out of the Covid Vaccination programme. All this, while continuing to care for non-Covid patients.

The response by general practice during the pandemic demonstrated how with adequate resourcing, it can help to reduce future pressure on hospital systems. However General Practice is not without it's own capacity constraints:

- There are approximately 3,500 General practitioners in Ireland of which 3,042 hold GMS contracts;
- one fifth of the workforce (approximately 100 GPs per annum) will retire by 2028;
- The most recent analysis of medical workforce requirements [29] from the NDTP estimate that an additional 1,260-1,660 GPs are required by 2028;
- The NDTP estimate that the number of GP trainee places would need to increase by approximately 150% to meet future requirements while the ICGP estimate that the number of training places should be increased to approximately 350;
- An ICGP survey from 2019 found that 35% of current GP trainees were considering emigration while 9.7% of recent graduates are already abroad.[30] Both trainees and recent

[28] Crowley, P. and Hughes, A. (2021),
[29] HSE National Doctors Training & Planning (NDTP) Demand for Medical Consultants and Specialists to 2028 and the Training Pipeline to meet Demand * A Higher level Stakeholder Informed Analysis. HSE, 2020
[30] Collins C et al, 2019, "Finding a Future Path" Career Intentions of GP Trainees and Recent GP Graduates - Report of the 2019 Survey, ICGP https://www.icgp.ie/go/research/reports_statements/DF8CE555-7D66-4346-BBB05CAC93C59689.html

graduates cited quality of life and viability of General Practice as their reasons for emigration.

- For young GPs seeking to establish themselves in a new community, the initial investment costs in premises, equipment, IT systems, insurance etc. and are particularly prohibitive and specific supports are required to support this cohort of GPs.

Investment in General Practice is central to healthcare reform and the shift of care into the community, however over the past decade the FEMPI cuts have decimated General Practice. While the 2019 GP agreement reached between the IMO, the Department of Health and the HSE has brought some stability to General Practice and further resources are needed.

Sourcing locum cover has been a growing issue for GPs during the pandemic , 59% of GPs stated that they were unable to take time off due to difficulties in sourcing locum cover while 66% said had been unable to take sick leave. 62% of GPs show high risk of burnout. [31]

In order to support the shift of care in to the community, GPs require access to diagnostics and a range of therapists in the community, however, infrastructure is poor. The vast majority of the developments in General Practice, require GPs to take the investment upon themselves and their practices to make improvements. In 2015, Indecon[32] carried out an analysis of potential measures to encourage the provision of primary care facilities and recommended a multi-faceted approach including targeted incentives for GPs to invest in premises and equipment.

For young GPs seeking to establish themselves in a new community, the initial investment costs in premises, equipment, IT systems, insurance etc. and are particularly prohibitive and specific supports are required to support this cohort of GPs.

Investment in a Women's health programme in General Practice

We have long known that there is a cohort of women who cannot afford medical expenses associate with contraception care and are at risk of unplanned pregnancy . The Long Acting Reversible Contraceptive (LARC) is known to be the most effective form of contraception and needs to be funded for women who wish to avail of it .

Investment in an appropriate Women's Health Programme also gives the GP the opportunity to screen for sexual health issues and sexual transmitted disease. This area of medicine has gone largely ignored for both men and women and we cannot afford to continue to do so , STIs when diagnosed and treated reduce further spread potential but also reduces the problem with long term sequelae associated with chlamydia, gonorrhoea, HIV, syphilis and viral hepatitis.

Menopause health care is a complex are of care which has been neglected and recent public discourse has shone a light on this. It is a chronic condition which occurs at the time of life where other medical issues become apparent also making for requires lengthy consultations and long term follow up is required. All of these consultations facilitate screening for domestic violence and social stressors and funding them will make massive difference to the health of women and their families.

[31] IMO, Report of the Survey on Doctor Mental Health and Well-being 2020

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

Women should have access to a comprehensive sexual health programme in General Practice that includes:

- Advice on Contraception
- Access to contraception including Long Acting Reversible Contraceptive (LARC) methods.
- Advice on sexually transmitted infection (STI), screening and testing for STIs
- Advice on fertility and pre-conception
- Advice on menopause

IMO Recommendations

- **Invest in supports for General Practice to employ additional GPs, practice nurses and other support staff;**
- **Provide incentives for General practice to invest in the development of infrastructure including premises, medical equipment, diagnostic equipment, IT (as per the recommendations in the Indecon report);**
- **Given the precarious financial position of newly established practices - agree supports to allow these practices remain financially viable and open to patients;**
- **Invest in a comprehensive Women's' Health Programme in General Practice to include:**
    - **Advice on Contraception**
    - **Access to contraception including Long Acting Reversible Contraceptive (LARC) methods.**
    - **Advice on sexually transmitted infection (STI), screening and testing for STIs**
    - **Advice on fertility and pre-conception**
    - **Advice on menopause**

4. Investment in Mental Health Services

There is no doubt that the Covid19 pandemic has had significant psychological effects on the population of Ireland. There are escalating reports of common mental health problems and more marked neuro psychiatric disorders associated with the COVID-19 pandemic and its associated restrictions.

Due to the combined effect of the COVID-19 pandemic and associated restrictions, it is estimated that approximately one person in every five in the general population in Ireland is experiencing a significant increase in psychological distress[33]. Groups who will be particularly vulnerable to the emergence of new mental health difficulties requiring secondary care interventions include: COVID-19 survivors; people bereaved during the pandemic; frontline workers; those with fewer social and economic resources, extremes of the population demographic (both older people and young people aged 15-25); individuals with an intellectual disability and individuals who are pregnant or in the post-partum period. People with established mental illness are also likely to be particularly

[33] Kelly, BD, 2020, Impact of Covid-19 on Mental Health in Ireland: Evidence to Date, Ir Med J; Vol 113; No. 10; P214

vulnerable to relapse, exacerbation of symptoms and impaired functioning as a result of the pandemic.[34]

The mental health burden associated with this pandemic is likely to surpass anything we have previously experienced. However, our mental health services are ill-prepared:

General Practice is generally the first point of contact with the health services for patients suffering with mental illness. International best-practice suggests that 90% of emotional and psychological problems can be adequately managed by GPs in the community[35], without referral to specialist mental health services, however unfortunately the system in Ireland does not support this approach. Currently GPs consult with patients with mental health illness with no formal contract in place other than acute care provision under the current GMS contract while access to psychological therapies, including counselling, cognitive behavioural therapy, psychotherapy and group therapy, in the community is poor.

Those patients with more severe mental illness, such as psychosis and suicidal ideation, will require specialist psychiatric care, however

- A recent report published by HSE mental health division found that staffing levels at the end of 2019 in our Child and Adolescent mental health services were just 57.5% of the recommended levels in recommended in *A Vison for Change*, while staffing levels in Psychiatry of Later Life Teams and General Adult Community Mental Health team were 61% and 77.1% respectively compared to the *AVFC* recommendations.[36]
- Ireland has 33.5 inpatient psychiatric beds per 100,000 population compared to an EU (including UK) average of 68 inpatient psychiatric beds per 100,000 population
- There are 1.2 dedicated acute mental health beds for older people per 100,000, compared with 6 per 100,000 in England and 9.7 in Northern Ireland. (MHC)

In this year's budget it is of paramount importance that the Government invest in mental healthcare both in General Practice and in our Specialist Mental Health Services.

IMO Recommendations:

- **Invest in a clinical programme of care for mental health care in General Practice to be negotiated between the IMO, the Dept of Health, and the HSE;**
- **Invest in publicly funded counselling and psychotherapy services and supports in the community, accessible on GP referral; - many practices have available rooms, which could facilitate these services and would de-fragment the management of mental health conditions;**
- **Fully resource community and hospital based mental health care teams in line with the recommendations of *A Vision for Change;***
- **Urgently assess the number of acute inpatient psychiatric beds required to ensure timely admission of patients presenting with acute psychiatric illness;**

[34] Karen O Connor *et al.* May 2020 Mental health impacts of COVID-19 in Ireland and the need for a secondary care mental health service response Irish Journal of Psychological Medicine 38(2):1-18 DOI:10.1017/ipm.2020.64

[35] Mental Health in Primary Care in Ireland

[36] HSE Mental Health Division Delivering Specialist Mental Health Services 2019 – June 2020

5. Invest in eHealth and IT infrastructure

The Pandemic and the recent cyberattack on the HSE have highlighted the importance of investing in robust, secure eHealth systems and IT infrastructure.

The benefits of investing in eHealth are well-known – The use of Electronic health care records enhance patient safety and quality of care, reduce repetition and errors in diagnostics and treatments and lead to administrative efficiencies. Electronic health records and other eHealth systems are key to developing integrated care, supporting the smooth transfer of patient data between settings. The collection and analysis of patient data also allows for the advance of medical knowledge, management of disease and health service planning.

The pandemic led to an accelerated shift to eHealth including electronic referrals, ePrescribing and electronic access to laboratory and diagnostic results. In addition, remote consultations have been used to protect vulnerable patients and healthcare workers from the risk of infection from COVID-19 by reducing the flow of patients through healthcare facilities.

However the benefits and uptake have not been universal. Many hospitals are still using paper-based electronic records creating delays and risks to the safe delivery of care off-site or at multiple sites, while the failure to upgrade hardware and conference software has impeded inter-professional collaboration and teamwork.

The disruption caused by the HSE cyberattack has further highlighted how dependant healthcare is on robust and secure eHealth systems with disruption from the ransomware attack expected to go on for up to 6 months, with immediate financial costs of €100m.

Investment in secure eHealth systems and infrastructure is crucial for the future delivery of post-covid healthcare and will support a patient centred, digitally integrated healthcare system.

IMO Recommendations:

- **Invest in secure systems of electronic health records across hospitals and community health centres (systems must be able to communicate and allow embedding of national summary patient records);**
- **Upgrade IT infrastructure, both hardware and software, to improve cybersecurity to support safe remote-consultations and remote multi-disciplinary team-working;**
- **Ensure on-going investment and cooperation in the development of eHealth in General Practice in line with the agreement between the IMO, the HSE and the Dept of Health.;**

6. Invest in Health and Social Care Needs of Older People

Although the Covid-19 pandemic is affecting individuals of all ages, Covid-19 has disproportionately affected Irelands older population. People aged 65+ accounted for 24% of all Covid-19 cases, 54% of hospital admissions and over 92% of confirmed Covid-19 related deaths[37] [38].

[37] Latest updates on COVID-19. Department of Health. 2021 [Available from: www.gov.ie/en/news/7e0924-latest-updates-on-covid-19-coronavirus/

[38] Covid 19 Insight Bulletins: Death and Cases, Series 1. Central Statistics Office. 22 May. 2021. https://www.cso.ie/en/releasesandpublications/br/b-cdc/covid- 19deathsandcases/

Older people accommodated in congregated settings, such as nursing homes, were significantly affected. The tragic experience of Covid-19 among nursing home patients highlighted the systemic problems in governance and organisation of care for older people in Ireland.

Ireland has an ageing population and while we are ageing more healthily, there is an increasing prevalence of comorbidities associated with ageing. The restrictions and guidelines associated with the pandemic have led to prolonged cocooning and increased social isolation in the older population. The impacts of isolation, physical inactivity, lack of mental and social contact can have unintended consequences and lead to increased risk of frailty and 'deconditioning'.[39]

The IMO has welcomed the Report of the Covid 19 Nursing Homes Expert Panel[40] and the provision of 5 million additional home care hours, 1,250 community beds, and the expansion of community intervention teams in 2021, reducing delayed transfers of care from an average of 650 pre Covid to 400 since May 2020.[41] However these cannot be one-off provisions and on-going investment in care in the community must be sustained.

In line with the recommendations of the Expert panel on-going investment is required in community specialist teams with input from a range of specialties including Geriatric Medicine, General Practice and Public Health Medicine.

While the majority of older people wish to be and can be cared for in the community, there will still be a small percentage of older people, with more complex needs, that will require nursing home care. To ensure continuity of care, the role of the GP as primary care giver to patients in Nursing Homes should remain in place. The IMO is calling for a programme of care for nursing home patients should be negotiated between the IMO, the Dept of Health, and the HSE that reflects the complexity and workload of care for this cohort of patients.

IMO Recommendations:

- **Further resourcing of rehabilitative community care beds and home care supports including intensive home care packages to allow older people remain at home as long as possible;**
- **Ongoing investment in a holistic approach to care with input from a range of specialties including geriatricians, GPs and public health specialists**
- **Invest in a programme of GP care for nursing home patients that reflects the complexity of care required;**

7. Appropriately Resource Prevention programmes

Investment in prevention is one of the most cost effective ways of reduce demand on our healthcare services and the IMO has welcomed the agreement reached between the IMO, the HSE and the Department of Health to create 84 consultant posts in Public Health Medicine. After 20 years the agreement finally recognises the key role of our Specialists in Public Health Medicine who have been at the forefront controlling the spread of infection in addition to their usual roles health intelligence, health services improvement and oversight of public health programmes. Resources must be provided to support the full implementation of the Crowe Horwath Report on the Role, Training and Career Structures of Public Health Physicians in Ireland.

[39] Crowley, P. and Hughes, A. (2021),
[40] COVID-19 Nursing Homes Expert Panel Examination of Measures to 2021 Report to the Minister for Health, 2020
[41] Crowley, P. and Hughes, A. (2021),

Additional resources are required to support the Healthy Ireland Strategic Action Plan 2021-2025 which is a cross-Government, cross-sectoral plan that sets out a number of key actions to promote health and well-being, address the social determinants of health and improve access to services for our most vulnerable citizens.

Further resources are also required to support preventive programmes including our school immunisation programmes and our cancer screening programmes.

Community Medical Doctors work mainly in areas of Child Health and Immunisation, however the number of doctors employed in community health has fallen over the last ten years despite increased demand due to population growth and implementation of the secondary school HPV, Tdap and MenC vaccination programmes. Since the beginning of the Covid 19 pandemic, Community Medical Doctors have been extremely flexible in redeployment to various other departments for Covid19 related duties, including the Covid 19 vaccination programme, as well as catching up on school Immunisation Programmes. Additional Community Medical Doctors are required to assure the ongoing quality and safety of these programmes.

Paused in March 202O, CervicalCheck and BowelScreen resumed in the summer of 2020 while BreastCheck resumed in October 2020 in line with NPHET guidelines. However, as a result all screening programmes fell far below their annual targets for 2020 and have yet to resume full activity. [42] Our screening programmes can ensure that certain cancers are identified early, with better outcomes for patients and at reduced cost to the health system. However, again Covid 19 has placed significant constraints on capacity to access diagnostic and cancer treatment pathways.

The IMO recommends

- **Resources must be provided to support the full implementation of the Crowe Horwath Report on the Role, Training and Career Structures of Public Health Physicians in Ireland;**
- **Invest in additional resources to support the Healthy Ireland Strategic Action Plan 2021-2025 - a cross-Government, cross-sectoral plan that sets out a number of key actions to promote health and well-being, address the social determinants of health and improve access to services for our most vulnerable citizens.**
- **Increase Community Medical Doctor staffing levels to maintain the quality and safety of child health and immunisation programmes, now that schools have reopened;**
- **Provide appropriate resources for the full re-establishment of life-saving cancer -screening programmes.**

[42] Aontu.ie Peadar Tóbín – Cancer Screening Targets being missed by hundreds of thousands. Figures received from NSS