IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Statement to the Oireachtas Joint Committee on Health on Hospital Overcrowding and Delays in Admissions and Outpatient Appointments

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Irish Medical Organisation (IMO) Statement to the Oireachtas Joint Committee on Health on Hospital Overcrowding and Delays in Admissions and Outpatient Appointments.

The IMO would like to thank the Chair and the Committee for the invitation today to discuss the ongoing overcrowding issue in hospitals as well as delays in admissions and outpatient appointments.

For more than a decade the IMO has been highlighting the capacity issues that exist across our health system.

Ireland has a growing and ageing population. For many decades the proportion of the Irish population that was over the age of 65 remained static but this has now begun to change and the pace of that change will accelerate rapidly in the years ahead. In simple terms an additional 20,000 people each year will reach the age of 65 and as life expectancy increases the number of those over 80 will double. Over the last ten years the total population has grown by 300,000 or 7% while our population over 65 has increased by 166,000 or 34%. At the same time the healthcare system has undergone significant budget cuts. Between 2007 and 2014 both staffing levels and the number of inpatient beds fell by 13%. Public health expenditure only began to increase from 2015. The cumulative pressure from demographic change and financial cuts is manifesting itself in unprecedented overcrowding in Emergency Departments and waiting lists for outpatient appointments and for elective procedures.

Bed occupancy rates in Irish Hospitals have risen to an average of 97%, and sit even higher, at an average of 104% in Model 4 hospitals[1] well above internationally recognised safe occupancy rates of 85% for inpatient care and 80% for critical care. The HSE' full capacity protocol, which is designed to act as a safety valve when Emergency Department functioning is compromised, has now become the norm, with reports showing the full capacity protocol was implemented on hundreds of occasions in 2017 in our major hospitals across the country. International evidence shows that high bed occupancy is associated with a number of adverse factors including increased risk of healthcare associated infections such as MRSA, increased mortality, increased probability of an adverse event and risks to staff welfare.

A significant contributor to long waiting lists is inadequate medical staffing levels. Our public health services are facing an unprecedented crisis in recruitment and retention in the medical profession. This is clearly evidenced by the facts that:

a) We have at any given time over 450 vacant consultant posts. Almost 90% of consultants who trained in Ireland but are currently working abroad have indicated they will not return to Ireland due to the discrimination on pay scales. One third of existing consultants are considering taking up a post abroad in the foreseeable future. The Public Appointments Service produced figures in 2017 which confirm that we are unable as a public health service to attract applicants – 1 in 10 consultant posts received no applications and the PAS could not identify a suitable applicant for 22 of the 84 posts.
b) Almost 700 GPs are due to retire in the next few years while at the same time 30% of GP Trainees are intending to emigrate and 70% of recent graduates from the GP training scheme have indicated they will emigrate with almost 20% having already emigrated. GPs who have been established for a number of years are now choosing to leave Ireland. This

[1] Department of Health, *Interim Report and Recommendations by the Taskforce on Staffing and Skill Mix for Nursing*, Dublin, February 2016, p. 27.

means that there are a growing number of GMS lists which are attracting few or no applicants.

c) NCHDs (Doctors in Training) are leaving the system in large numbers across all specialties and alarmingly this is happening after Intern year (the first year of training). Two thirds of NCHDs perceive pay to be the primary reason for emigration and 83% believe the pay disparity at consultant level will impact on their decision as to whether to apply for consultant posts in Ireland. Irish trained doctors at NCHD level are three times more likely to emigrate than their UK counterparts.

We cannot hope to reform or reconfigure our health services unless and until those services are capable of attracting and retaining sufficient numbers of doctors to deliver care to patients and that is not the case at present. This is a patient care issue.

We cannot continue to spend money on short-term measures without significant and sustained investment in our public health services. We urgently need to take measures across our health system if we are to address hospital overcrowding and long waiting lists in a sustainable and evidence-based manner. We have had numerous reports now including Sláintecare, the Health Service Capacity Review and A Future Together – Building a Better GP and Primary Care Service which show that we need to invest in capacity in tandem across the health system with a significant budgetary allocation to allow for service development.

1. **Increase Capacity in the Acute Hospital System**

The Health Service Capacity Review shows that we immediately require approximately 1, 200 additional inpatient beds and 50 adult critical care beds in order to meet safe bed occupancy levels of 85% for inpatient beds and 80% for critical care. Given that the majority of inpatient admissions come through the Emergency Department and the considerable back-log for outpatient appointments and elective procedures the number required is likely to be even higher. We have 1,531 fewer inpatient beds in the hospital system compared to 2007. An immediate assessment of the number of acute beds available is required with the financial and manpower resources made available to upgrade and reinstate beds.

2. **Increase the number of consultants across the hospital system.**

The 30% salary cut to all consultants appointed after October 2012 is the single biggest reason for there being 450 unfilled consultant posts nationally. This was a political decision which has adversely affected patient care. Unless this is addressed as a matter of urgency we will struggle to appoint the number and calibre of individuals we need to provide safe patient care.

We have currently just 1.43 specialists per 1000 population compared to a West European Average of 2.4 per 1000[2]

The *Report of the National Task Force on Medical Staffing 2003*, often referred to as the Hanly Report, set out ratios of consultant to population that would need to be met to provide a consultant-delivered health service whereby consultants and their teams would have a direct involvement in the diagnosis, delivery of care and overall management of patients. This would improve quality of care and patient safety as important clinical decisions would be made faster and at a higher level.[3] However NCHDs continue to outnumber consultants 2:1, we are short approximately 1,400 consultant posts based on current population figures. In addition we have significant recruitment and retention issues with over 450 consultant posts either unfilled or filled on a locum basis at significantly increased cost to the exchequer. While the Hanly Report provided an important guideline to necessary consultant staffing, it is also crucial to engage with clinical programme leads nationwide to gain an understanding of the staffing requirements both in terms of the medical staffing and other healthcare professionals to resource the national clinical programmes.

3. Adequately Resource National Clinical Programmes

A significant number of National Clinical Programmes and models of care such as the Emergency Medicine Programme, the Acute Medicine Programme and the Model of Care for Elective Surgery should be fully implemented and resourced. The Programmes represent the most efficient and effective use of resources.

The Acute Medicine Programme was originally set up to provide an alternative pathway to the acute hospital system allowing GPs to directly refer patients to Acute Medical Units (AMU)s. However again due to lack of capacity and under resourcing of both the Emergency Medicine programme and the Acute Medicine Programme, AMUs are no longer satisfying the original set-up criteria and now simply serve as an extension to the Emergency Department.

Waiting lists for inpatient procedures primarily affect patients awaiting elective procedures. The Model of Care for Elective Surgery, if fully implemented and resourced will improve access, quality and cost by reducing waiting times, abolishing cancellations, optimising day surgery and average length of stay , standardising care, and optimising the use of theatre resources. It makes no sense for the National Treatment Purchase Fund (NTPF) to purchase care from the private sector while simultaneously budgetary constraints are leading to rolling theatre closures and cancellation of theatre procedures in the first place.

4. Address delayed discharges with increased resources for long-term and rehabilitative care for elderly patients

No patient should be in hospital longer than is necessary. The movement of patients from acute care to: rehabilitation services, extended rehabilitation, long term care or supported living in the community should be based on patient need, rather than limited by resources. Failure to transition patients to the most appropriate setting increases costs and reduces efficiency as patients are in the

[2] Organisation for Economic Co-operation and Development, Health Statistics 2018, Health Care Resources, Physicians by Category, (available at: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT).
[3] Report of the National Task Force on Medical Staffing June 2003

wrong place for the type of care that they need. Community Intervention Teams have helped to support early discharges for some patients, but we also need to invest significantly in long-term and short-stay beds for elderly patients as well as intensive home care packages.

5. Investment in General Practice and Chronic Disease Management

With an aging population and growing rates of chronic disease, all evidence points to the need to shift the model of care towards General Practice and a GP-led Primary Care System.

An extensive body of international research which shows that continuity of care and the patient-centred approach that is specific to General Practice is associated with reduced mortality rates[4] particularly in the elderly[5] greater patient satisfaction[6], improved health promotion[7],increased adherence to medication[8] and reduced hospital use[9].

Chronic diseases, including cancer, cardiovascular disease, COPD and diabetes, account for approximately 40% of hospital admissions, and 75% of hospital bed days. [10] Acute services currently undertake an enormous volume of chronic care (at significant expense to the tax payer), that could, if resourced properly, be managed in General Practice.

General Practice will not immediately resolve hospital overcrowding, however, in the long-term, if we invest now in GP-led chronic disease management programmes (for which GPs are trained) along with capacity measures to build up medical and nursing levels within General Practice, we can reduce future growth in demand on the hospital system and patients can be seen and cared for in the most appropriate setting.

However experience from other jurisdictions shows that the development of Primary Care requires significant and sustained investment. In Ireland however the exact opposite has happened with FEMPI cuts reducing income per GMS patient by 38%. Immediate reversal of the FEMPI cuts is needed to restore stability to General Practice before any additional workload can be placed on a system that is already operating at capacity. Indeed this is clearly evidenced by the fact that many practices are now closed to new patients.

We appeal to all members of this Committee to urge Government, in the context of the forthcoming budget, to seriously address the problems in our health system and recognise the damage caused by

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[4] Pereira Gray DJ, Sidaway-Lee K, White E, et al Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality BMJ Open 2018;8:e021161. doi: 10.1136/bmjopen-2017-021161

[5] O.R. Maarsingh *et al.*, 'Continuity of care in primary care and association with survival in older people: a 17-year prospective cohort study', *British Journal of General Practice*, Vol. 66, No. 649, August 2016, e531-539.

[6] Baker R , Streatfield J . What type of general practice do patients prefer? Exploration of practice characteristics influencing patient satisfaction. Br J Gen Pract 1995;45:654–9.

[7] Cabana MD , Jee SH . Does continuity of care improve patient outcomes? J Fam Pract 2004;53:974–80.

[8] Chen CC , Tseng CH , Cheng SH . Continuity of care, medication adherence, and health care outcomes among patients with newly diagnosed type 2 diabetes: a longitudinal analysis. Med Care 2013;51:231–7.

[9] Barker I , Steventon A , Deeny SR . Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data. BMJ 2017;356:

[10] Department of Health 2016, Better Health – Improving Health Care. http://health.gov.ie/wpcontent/uploads/2016/05/Better-Health-Improving-Health-Care.pdf

delays for patients in accessing much needed healthcare. We also ask the Committee to recognise the potential for Ireland to deliver a first class health system if sufficient resources are allocated to allow this to happen.