IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Budget Submission 2011

November 2010

Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2

Tel: (01) 6767 273
Fax: (01) 6612 758
Email: imo@imo.ie
Website: www.imo.ie

IRISH MEDICAL
ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Mission Statement

The role of the IMO is to **represent** doctors

in Ireland and to **provide** them with all relevant services.

It is committed to the **development** of a caring,

efficient and effective Health Service.

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO

Budget Submission

2011

November 2010

Irish Medical Organisation
10 Fitzwilliam Place
Dublin 2

Tel: (01) 6767 273
Fax: (01) 6612 758
Email: imo@imo.ie
Website: www.imo.ie

Overview

2011 promises another tough budget as the Exchequer requires a further €4bn in tax revenue and expenditure cuts. Ordinary people are paying heavily out-of-pocket to save the banks - they shouldn't have to pay with their health.

The recession is already impacting on health and healthcare. Suicide and self-harm rates have increased, particularly among young males, yet the budget for mental health services has fallen disproportionately. Since the moratorium on recruitment came into play in 2009, over 700 staff have left the Mental Health Services of which just 65 were replaced,[i] severely compromising quality of care and patient safety.

As levels of disposable income decrease, incidents of chronic disease are likely to increase. Certain lifestyle factors are known to increase the risk of chronic disease. As incomes decline people eat cheaper and less healthy meals, drop sports activities and gym membership, delay visiting their GP and are less likely to afford preventive care. It is estimated that three quarters of healthcare expenditure is allocated to the treatment of chronic diseases, yet the OECD estimates that only 3% of healthcare expenditure is spent on prevention and public health programmes.[ii]

Budget measures, such as the increase in the Drug Payments Scheme threshold and the introduction of a 50 cent charge per prescription item under the GMS and Long Term Illness schemes, lack foresight and are likely to cost the health system more in the long run as patients fail to comply with treatment. IMO doctors have proposed an alternative plan to save €300million off the State's drugs bill through a coherent generic medicines policy.

The Acute Hospital System is in a state of chaos. The HSE is persevering with reform without the necessary Capital Funding and with a budget reduced by €1billion. Because of need, more people not less, are being treated in hospital, budgets are exceeded, waiting lists and waiting times are increasing and Emergency Departments are still dangerously overcrowded.

2011 budget should consider the health of the nation and not just the health of our banking sector. The IMO is appealing to the Government to seriously consider the long-term effect of further budget cuts on health and the health system.

Mental Health Services

The recession is having a profound effect on mental health and mental health services in Ireland. 2009 saw suicide rates increase by 24%[iii] and incidents of self-harm increase by 5%.[iv] with higher rates among young males, yet the budget for mental health services has fallen disproportionately.

Mental health disorders affect one in four people each year[v]. In Ireland 6% of adults are classified as having a major depressive disorder and 3% as having generalised anxiety disorder. [vi] Higher levels of psychological distress, depression and anxiety disorders are found among medical card holders, lower income groups and those who are not in paid employment.[vii] 25% of people (approximately 19,400 people) in receipt of illness benefit in 2009 cited mental health issues as the reason they were unfit for work - depression and anxiety accounting for almost 10,000 claims and stress for a further 4,500.[viii] Mental health problems are estimated to cost the economy over €3bn (in terms of lost output, healthcare and other costs)[ix], yet in 2010 just 5.2%[x] of the health budget was allocated to Mental Health Services, down from 7% in 2008[xi].

---

[i] Independent Monitoring Group A Vision for Change – the Report of the Expert Group on Mental Health Policy. June 2010: 42
[ii] DOHC, Tackling Chronic Disease: A Policy Framework for the Management of Chronic Disease 2008 *: 15*
[iii] CSO, Vital Statistics Fourth Quarter and Yearly Summary 2009
[iv] NSRF National Registry of Deliberate Self Harm Annual Report 2009.
[v] Wittchen HU, Jacobi F. Size and Burden of Mental Disorders in Europe – a critical Review and Appraisal of 27 Studies, *European Neuropsychopharmacology* 2005: 15 :357-376
[vi] Barry, M.M., et al, SLÁN 2007: Survey of Lifestyle, Attitudes and Nutrition in Ireland. Mental Health and Social Well-being Report, DOHC 2009
[vii] Barry, MM et al, 2009
[viii] Minihan M. 25% of Sick Claims Cite Mental Health *The Irish Times* 27 January 2010
[ix] O'Shea E. Kennelly B. The Economics of Mental Health Care in Ireland, *Mental Health Commission* 2008 : 89
[x] HSE National Service Plan 2010
[xi] DOHC Health in Ireland: Key Trends 2009

In 2006, *A Vision for Change* set out policy for Mental Health Care including the closure and sale of psychiatric institutions and the transfer of services to a more appropriate community setting. However four years on, the 2nd Independent Monitoring Group for *A Vision for Change* is "*still not in a position to report accurately on the number of CMHTS that exist in the HSE structure*".[xii] Existing teams are inadequately staffed for the provision of holistic multidisciplinary care. Since the moratorium on recruitment came into play in 2009, over 700 staff have left the Mental Health Services of which just 65 were replaced,[xiii] compromising quality of care.

15 "Victorian-era" institutions remain open despite reports of substandard conditions from the Inspector of Mental Health Services. While the Minister of State with Responsibility for Mental Health has promised the closure of the remaining institutions by 2013, alternative services are unlikely to be in place. The 2010 budget provision of €50million to be invested the mental health capital programme is unlikely to be reached as the sale of assets has only managed to raise €10.3million so far this year. xi In the current economic climate with falling property prices, the sale of psychiatric lands can no longer be relied upon to fund A Vision for Change.

Suicide Prevention

Unemployment is a known risk factor for suicide. In 2009, 527 people died by suicide compared to 424 in 2008. Ireland now has the 4th highest rate of youth suicide in the EU. More people die from suicide than from road traffic accidents yet as Dan Neville, President of the Irish Association of Suicidology has pointed out funding for Suicide prevention is just a fraction of that allocated to Road Safety. [xv]

Carers

Because of their social and economic circumstances carers of people with disabilities or long-term illness are at increased risk of mental health problems. In a survey carried out by The College of Psychiatry and The Carers Association of Ireland over half of carers reported having been diagnosed with a significant mental health problem.[xvi] Of those diagnosed with anxiety disorder 69% said it was caused or made worse by their caring role. There are an estimated 161,000 carers that save the exchequer approximately €2.5 billion a year.[xv] Carers need adequate support and respite to enable them to care for someone as long as they wish and are able to do so, without jeopardising their own health and well-being.

Recommendations

- Increase and ring-fence funding for Mental Health Services in line with the recommendations of *A Vision for Change*
- Lift the HSE's Moratorium on recruitment to allow the establishment of full Multi-disciplinary Community Mental Health Teams
- Increase funding levels for suicide prevention and mental health awareness
- Double the carer's allowance and increase the provision of respite services

Lifestyle and Chronic Disease Prevention

As levels of disposable income decrease, incidents of chronic disease are likely to increase. Certain lifestyle factors are known to increase the risk of chronic disease. As incomes decline people eat cheaper and less healthy meals, drop sports activities and gym membership, delay visiting their GP and are less likely to afford preventive care. Chronic diseases and the underlying lifestyle factors that contribute to them are higher among lower income groups.[xviii] 38% of those at risk of poverty and 47% of those living in consistent poverty report having a chronic illness compared to 23 % of the general population.[xix] Mortality rates from chronic diseases are three times higher in the lowest occupational

[xii] Independent Monitoring Group. 2010 : 39
[xiii] Independent Monitoring Group 2010 : 42
[xiv] HSE Performance Report July 2010
[xv] Sheehan M& Quinlan R, Rise in Suicides as money woes hit, *The Irish Times* 18 July 2010
[xvi] The College of Psychiatry and The Carers Association of Ireland, Carers of Ireland Who cares?
[xvii] Care Alliance Ireland 2009
[xviii] DOHC, 2008:11
[xix] Combat Poverty Agency, Health Policy Statement June 2007: 4

classes than in the highest.[xx] Rates of obesity, tobacco and drug consumption are all higher amongst lower income groups. It is generally accepted that the main barriers to healthy food choices are their affordability and one's level of disposable income.

According to the World Health Organization (WHO), chronic disease accounts for 86% of deaths in Europe.[xxi] In Ireland, cancer and cardiovascular disease are responsible for more than two-thirds of all deaths. It is estimated that three quarters of healthcare expenditure is allocated to the treatment of chronic diseases. Approximately 80% of GP consultations, 66% of emergency admissions and 60% of hospital bed days are related to chronic diseases and their complications.[xxii] With Ireland's ageing population and if current trends continue bed requirements will increase by 50-60% over the next 15 years. According to the WHO, "a small shift in the average population levels of several risk factors can lead to a large reduction of the burden of chronic disease,"[xxiii] yet the OECD estimates that only 3% of healthcare expenditure is spent on prevention and public health programmes.[xxiv]

An investment approach is needed and funding should be ring-fenced for the promotion of healthy lifestyles and prevention of chronic disease. Initiatives include:

Taxes and Price Intervention can be used to promote healthy living and to fund disease prevention programmes. A 10% price increase in tobacco products has been shown to reduce demand by 3-5% in high-income countries.[xxv]

While individuals make their own lifestyle choices, information and awareness campaigns create awareness of the dangers associated with those choices and equip the general population to make informed decisions about their health.

Proven screening procedures exist for a limited number of chronic diseases including elevated risk of cardiovascular disease and breast, cervical and colon cancer. [xxvi]

Chronic disease management requires both integrated care and continuity of care and therefore is best suited to the GP under contract. Chronic disease management services are currently provided by GPs to GMS patients on a *pro-bono* basis. Reductions in payments to GPs are limiting their ability to continue these services.

Recommendations

- Increase and ring-fence funding for lifestyle promotion and chronic disease prevention
- Levies on tobacco and alcohol should be ear-marked for health initiatives
- Increase the price of a packet of 20 cigarettes by €2
- Introduce a sliding scale of alcohol taxes with the lowest tax on low alcohol beer and the highest tax on spirits. Specifically we recommend a 20% increase on Spirits, 10% increase on Wines and 5% increase on Beers over ABV of 4% and no increase on alcohol-free beer and wine
- Guarantee funding for evidence-based preventive care and screening
- Resources should be provided for the expansion of chronic disease management and prevention in primary care.

Generic Medicines Policy

Budget measures, such as the increase in the Drug Payments Scheme threshold and the introduction of a 50 cent charge per prescription item under the GMS and Long Term Illness schemes, lack foresight and are likely to cost the health system more in the long run as patients fail to comply with treatment.

[xx] DOHC, 2008 2008:11
[xxi] World Health Organisation (WHO), The Impact of Chronic Disease in Europe 2005 downloaded from http://www.who.int/chp/chronic_disease_report/media/euro.pdf
[xxii] DOHC 2008, 2008:12
[xxiii] WHO, Preventing chronic diseases: a vital investment : WHO global report 2005:96
[xxiv] DOHC 2008 : 15
[xxv] WHO, Preventing chronic diseases…2005 : 98
[xxvi] WHO, Preventing chronic diseases…2005: 103

Cost-sharing is known to deter both necessary as well as unnecessary use of medication and it is generally accepted that they should not be applied to lower socio-economic groups or individuals with higher medical needs. Evidence shows that *"increased cost sharing is associated with lower drug treatment, worse adherence among existing users and more frequent discontinuation of therapy".*[xxvii] For each 10% increase in co-payments, prescription drug spending decreases by between 2% and 6%, depending on the class of drug and the condition of the patient. Research also shows that *"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".*[xxviii]

While the increase in the monthly threshold for the Drugs Payment Scheme impacts most on individuals on low income who are not protected by a medical card, 1.6 million medical card holders will not be immune - including over 70 year olds, people on a low income and those with long-term illness. While the size of the 50c charge is initially modest, doctors and patients alike, fear that the charge will be increased steadily over time. In addition, there will be a significant administrative cost in collecting the charge.

IMO Doctors believe that savings in the region of €300million can be made through a coherent generic medicines policy that encourages all parties including patients, doctors, payers and pharmacists to promote the use of generics. While the Minister plans to implement Reference Pricing and Generic Substitution by pharmacists, the proposed model is unlikely to achieve the maximum potential savings as it ignores the vital role of physicians in prescribing interchangeable drugs. In Ireland just 44% of drugs issued under the GMS scheme are generics or have a generic alternative while in the UK 83% of prescriptions are issued generically.[xxix] Doctors need support in analysing their existing prescription patterns and identifying roles for generic substitutions.

The IMO recommend that in addition to a System of Reference Pricing for interchangeable drugs the DOHC:

- consider the introduction of mandatory generic prescribing across the whole of the health system, with allowances for physicians to prescribe branded products only when concerned about individual patient safety;
- establish a multi party working group to co-ordinate the achievement of economies through generic prescribing and other measures as follows:
- Examine initiatives at the prescriber level to promote rational cost-effective prescribing;
- Develop prescribing protocols, criteria and defined prescribing periods in respect of high cost drugs;
- Develop prescribing formularies at hospital and primary care level;
- Develop protocols for patients being discharged from the hospital setting;
- Review all reimbursable medicines to ensure that wasteful or inefficient medicines with little proven clinical benefit are excluded from reimbursement;
- Carry out cost-benefit analysis comparing newer (and frequently more costly) medicines with existing less costly alternatives;
- Promote the use of generic names during physician training.
- Support optimum levels of generic prescribing through the provision of prescription software systems, prescription data analysis and professional prescribing advice and support.

The IMO also recommends that initiatives that encourage the entry of safe generic medicines to the market as well as the manufacturing of generics in Ireland should be explored.

Recommendations

- Reverse the decision to introduce co-payments on prescription charges under the GMS and Long Term Illness schemes
- Lower the monthly threshold for the Drugs Payment Scheme
- Implement the IMO's proposal to reduce the State's drug bill by €300m through a coherent generic medicines policy

[xxvii] 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
[xxviii] Goldman et al 2007; 64
[xxix] Barry J. Economies in Drug Usage in the Irish Healthcare Setting, National Centre for Pharmaco-economics (NCPE) 2009

Acute Hospital Beds

The Acute Hospital System is in a state of chaos. The HSE is persevering with reform without the necessary Capital Funding and with a budget reduced by €1billion. 1,000 beds are due to close this year. 762 have been closed so far. [xx]

Based on the findings of the PA Consulting Group's *Acute Bed Capacity Review*, the HSE's *Preferred Health System* suggests that with a better balance between inpatient, day case and community-based care just 8,008 public hospital beds will be required in 2014 compared to 11,660 existing beds in 2007.[xxxi] However the *Preferred Health System* relies on the progress of three major strategies:

- the Hospital Transformation Programme and the reconfiguration of major hospitals into regional centres of excellence accompanied by the downgrading of smaller local hospitals;
- the implementation of the Primary Care Strategy including the creation of more than 500 Primary Care Centres; the continued demand for private health care and an additional 1,000 private hospital beds through the Co location Project.

The Hospital Transformation Programme

The HSE publicly announced that the Hospital Transformation Programme needs increased revenue spend as well as capital investment.

> *"The message really needs to get out that we have to put more money in, not just in revenue but Capital investment too. The reality is that smaller hospitals offer great value for money. They do a lot of work more economically than the bigger centres."*[xxxii]

Services have been transferred to from smaller hospitals to regional centres without equivalent transfer of funds and many are running massively over budget. Galway University Hospital is nearly €15million or 9.8% over budget, Limerick is €12million or 14.4% over budget and Our Lady of Lourdes Drogheda is €7million or 12.5% over budget.

The Primary Care Strategy

The HSE has identified 530 Primary Care Teams and 134 Health and Social Care Networks to be developed by 2011 as part of the Primary Care Strategy 2001. However, lack of incentive has delayed progress. In July 2010, just 275 Primary Care Teams are holding clinical meetings. However, many of these teams are "virtual" teams - the actual number of physical Primary Care Centres in operation is unclear as is the number of Social Care Networks. Financial incentives for the development of Primary Care Centres are lacking. Services are increasingly being transferred from Secondary to Primary care without the equivalent transfer of public resources and capital funding, both public and private, in the current climate is restricted.

The Co-location Project

1,000 beds were to be created in 5 years through the co-location project of private hospitals on public sites, announced by the Minister for Health and Children in 2005. Despite generous tax incentives, not one hospital bed has been provided to date. While four hospitals have planning permission, the first hospital may not be completed till 2013.[xxxiii] The IMO believe the co-location project is not the solution to acute bed capacity as private hospitals, in order to make profit, tend to select patients for low cost elective care while patients requiring cost intensive emergency, complex or chronic care will continue to be treated in public hospitals.

At the same time demand for private health care is falling. Over 40,000 people dropped private health insurance in patient cover between June 2009 and June 2010[xxxiv] and many more are suspected to have downgraded their cover. The National Treatment Purchase Fund (NTPF) will be left to prop up the private hospital sector, purchasing, at high cost, elective care for a small number of patients on the National Waiting List.

[xxx] HSE Performance Report July 2010
[xxxi] HSE Towards an Integrated Health Service or More of the Same 2008
[xxxii] Mitchell S, State of Emergency *Sunday Business Post* 12 September 2010
[xxxiii] HSE Performance Report July 2010
[xxxiv] Health Insurance Authority HIA News August2010 Edition

The situation now is:

- More patients, not less, are being admitted to hospital (approx 7% more than planned) and hospital budgets are all overrun.[xxxv]
- In order to cut-costs many hospitals were forced to close theatres for elective procedures during the summer months including Beaumont, Cork University, Letterkenny General and Waterford Regional Hospitals. [xxxvi]
- The overall number of patients waiting placed on the National Waiting List (waiting >3 months) for elective care increased by 9.6% from 18,038 in July 2009 to 19,770 in July 2010. [xxxvii]
- Average waiting times for outpatient appointments exceed international norms in both major and minor hospitals including Beaumont, Letterkenny, Mullingar, Tullamore and Waterford Regional. The worst waiting times at Galway University Hospital - 303 days on average for an OPD Medicine appointment and 574 days for an OPD Surgery appointment. [xxxviii]
- In September 2010, according to the INMO's trolley watch 6,368 patients were treated on trolleys, compared to 4,581 patients September 2009 and 3,494 in September 2007. [xxxix]The Irish Association of Emergency Medicine (IAEM) found 18 out of 31 Emergency Departments were understaffed.[xl] Emergency Departments have been so dangerously understaffed or overcrowded in both Cork and Galway University Hospitals that they have considered closing the doors. [xli]

Recommendations

- Halt the Hospital Transformation Programme and the Closure of Hospital Beds until adequate alternative services are in place
- Provide tax incentives for the development of Primary Care Centres
- Withdraw tax incentives for private hospitals and replace the Co-Location project with funding for units for elective patients and patients with chronic illness
- Value for money must be sought in state capital projects

[xxxv] HSE Performance Report July 2010
[xxx] Donnellan E, Cuts and Closures all around as HSE runs €133m over budget, *The Irish Times* 14 August 2010
[xxx] HSE Performance reports July 2009 and July 2010
[xxxv] HealthStat July 2010 - average waiting times for OPD Consultant led clinics in excess of international targets (all new routine referrals seen within 90 days)
[xxxix] INMO Trolly Watch September 2010 and 2009
[xl]IAEM, IAEM Survey confirms ongoing severe ED staffing difficulties, IAEM Press release 27 September 2010, www.iaem.ie
[xli] Mitchell S 2010 and Death by a thousand cuts *Sunday Business Post* 18 April 2010

Summary of Recommendations

Mental Health Services

- Increase and ring-fence funding for Mental Health Services in line with the recommendations of *A Vision for Change*
- Lift the HSE's Moratorium on recruitment to allow the establishment of full Multi-disciplinary Community Mental Health Teams
- Increase funding levels for suicide prevention and mental health awareness
- Double the carer's allowance and increase the provision of respite services

Lifestyle and Chronic Disease Prevention

- Increased and ring-fence funding for lifestyle promotion and chronic disease prevention
- Levies on tobacco and alcohol should be ear-marked for health initiatives
- Increase the price of a packet of 20 cigarettes by €2
- Introduce a sliding scale of alcohol taxes with the lowest tax on low alcohol beer and the highest tax on spirits. Specifically we recommend a 20% increase on Spirits, 10% increase on Wines and 5% increase on Beers over ABV of 4% with no increase on alcohol free beer and wine
- Guarantee funding for evidence-based preventive care and screening
- Resources should be provided for the expansion of chronic disease management and prevention in primary care.

Generic Medicines Policy

- Reverse the decision to introduce co-payments on prescription charges under the GMS and Long Term Illness schemes
- Lower the monthly threshold for the Drugs Payment Scheme
- Implement the IMO's proposal to reduce the State's drug bill through a coherent generic medicines policy.

Acute Hospital Beds

- Halt the Hospital Transformation Programme and the Closure of Hospital Beds until adequate alternative services are in place
- Provide tax incentives for the development of Primary Care Centres
- Withdraw tax incentives for private hospitals and replace the Co-Location project with funding for units for elective patients and patients with chronic illness
- Value for money must be sought in state capital projects.