IRISH HOSPITAL CONSULTANTS ASSOCIATION

HERITAGE HOUSE
DUNDRUM OFFICE PARK
DUBLIN 14

TELEPHONE: 298 9123
FAX: 298 9395
e-mail: info@ihca.ie
Website: www.ihca.ie

IHCA Pre-Budget Submission on the Health Sector Budget, 2009

1. Introduction

This IHCA Pre-Budget Submission is focused on the needs of the Acute Hospital and Psychiatry Services, because its consultant members have a significant involvement in the provision of these services. The IHCA recognizes other significant health services may need attention.

2. Current Context

While the IHCA recognises that the Government faces difficult decisions in setting the 2009 Budget it would be a mistake for the Government to under provide funding for the Health Sector, because:

- Access to healthcare is a basic right that should not be denied even in tightening National Budget circumstances;

- Political decisions of the 1980's/1990's, which resulted in a 20% reduction in the acute hospital bed capacity, should not be repeated, as it is clear that the reduced capacity is hampering the ability of the Hospital Sector to deliver health services to the population;

- Ireland's demand for health care has increased significantly because of strong population growth, an aging population underpinned by ongoing demographic trends, a steep increase in births and advances in medical technology (Figure 1);

- International comparisons confirm that Irish Health Sector funding is below that of most other EU and OECD countries and it had the second lowest level of expenditure as a percentage of GDP in the EU 15 countries in 2006;

- Insufficient funding has been provided for the HSE in the last two budgets, giving rise to a shortfall of 2% - 3% based on demand and activity levels.

3. International Comparisons

The most recently published OECD comparative data on funding, capacity and other indicators confirm that Ireland's health sector is severely restricted due to a lack of resources. The following key indicators confirm this conclusion:

- Ireland's total expenditure, at 7.5% of GDP in 2006, was the second lowest in the EU 15 and the eighth lowest in 30 OECD countries reported on (Figure 5);

- Total expenditure per capita, at $3,082 (PPP) in Ireland was the seventh lowest in the EU 15, based on 2006 OECD data;

- Ireland's acute care beds, at 2.8 per thousand of population, is the fourth lowest in the EU 15;

- Ireland has one of the shortest average lengths of stay (ALOS) at 6.6 acute care days, the sixth shortest in the EU 15 and the eight shortest in the EU 25 countries for which OECD data was available in 2005; and

- Ireland has the fourth lowest number of practicing physicians per thousand of the population in the EU 25.

4. Budget Provisions, Capacity and Activity Levels in Ireland

4.1 The 2007 and 2008 HSE Budgets have proven to be inadequate because:

(a) Higher levels of demand have arisen than had been provided for in the 2007 & 2008 budgets and their related National Service Plans (NSPs), due to the failure of the Departments of Health and Children and Finance to recognise the increasing demand that has arisen from strong population growth and demographic trends;

(b) Insufficient budget funding of €300 to €350 million has arisen annually in the last two budgets; based on the HSE's own estimates in 2007 and 2008 on an annualised basis[1].

(c) The 2008 Quarter 1(Q1) HSE Data on activity levels (Figures 6 & 8) and waiting times[2] confirm increased levels of activity despite the 2008 Budget being based on the ELS (Existing Levels of Service) in 2007, but after the HSE applied restrictions from September onwards:

(i) Inpatient discharges were running at 1.6% above the year to date (YTD) target in the NSP and 0.5% above the same period in 2007;

(ii) Day case discharges were running at 5.9% above the NSP YTD and 7.5% above the same period in 2007:

(iii) Outpatient attendances were running at 13.6% above the NSP YTD target and some 4.2% above the year to date figure for 2007;

(iv) Emergency department presentations were 1% above the NSP YTD target and 3.3% above the same period in 2007; while ED attendances in Q1, 2008, were 1.7% above the same period in 2007;

(v) Emergency department admissions were 0.5% above the NSP YTD target and 1.2% below the same period in 2007;

(vi) Births at 17,775 were 13% above the same period in 2007 (Figure 4);

(vii) The NTPF waiting list data confirms that in excess of 20,000 patients were on a waiting list for inpatient treatments (which is equivalent to 3.5% of the 2008 annual NSP target and 14% of the 2008 Q1 inpatient total) and in excess of 24,000 were on a waiting list for day case treatments (4% of the annual NSP target and 15.5% of the Q1 day case treatments), (Figure 7);

These increased levels of activity in acute hospitals confirm that the 2008 National Service Plan has under provided for the population's demand for Health Services.

[1] HSE Pre budget discussions in Autumn 2007 with the Department of Finance on the 2007 Budget and the HSE's interim Performance Monitoring Report on the 2008 Budget – May 2008, dated July 10th 2008 (page 20).

[2] Appendix 2: Quarter 1, NHO Activity, Hospital Report, pages 53-62

In order to stay within budgets, which were not adequate and despite the higher activity levels in Quarter 1, the HSE introduced cuts in hospital staff and activity levels[3].

4.2 The capacity of the public health sector, especially in the acute hospital sector, is insufficient to provide a quality health service due to:

(a) The removal of about 3,000 beds from acute hospitals in the 1980's and 1990's;

(b) The failure of the Government to replace these beds in the last decade, despite a significant increase in population and a sharply increased birth rate and an increasingly aging population;

(c) This has resulted in a capacity shortfall, which is leading to long waiting lists (an estimated 20,000 waiting more than 3 months), and the persistent and increasing use of trolleys to cater for patients in accident and emergency (an estimated 200 people on trolleys each day in July 2008);

(d) Failure to invest adequately in step-down beds is resulting in an estimated 200,000 acute hospital bed days being lost, as medically fit patients cannot be discharged due to a lack of facilities.

4.3 **There is a pressing need for the HSE budget to fully provide for the impact of population, demographic and other trends on the demand for medical services, which continue to face the sector.**

The HSE's own assessment of the CSO's April 2008 population and labour force projections is as follows[4] :

a) "It is clear that the population will continue to grow for the foreseeable future and at every age group. This will require the HSE to continue to expand its service base right across the health spectrum. The CSO projects population growth of between 1.3% and 8.3% by 2011, depending on the assumptions relating to migration and fertility.

b) "There will be substantial growth both in real and percentage terms in the older population especially the very old population." The CSO data

[3] HSE Circular, 16/2008, June 3rd. 2008
[4] Performance Monitoring Report – May 2008, pages 6-9

predicts a 16% increase in the over 65 year old group by the year 2011 and a 25% increase in the over 85 year old group by 2011, (Figures 2&3). These significant increases will result in proportionally greater increases in activity levels in acute hospitals.

c) "One of the key drivers putting pressure on the HSE in recent years is the growth in the number of births. While the growth previously seen is not expected to continue into the future, nevertheless births will continue to occur at a high rate. The CSO expects births to level off under 70,000 births per year under moderate migration levels". Births have increased from around 65,000 in 2006 to 72,300 in the 12 months to April 2008. (Figure 6)

4.4 Medical Advancements

Medical treatments continue to improve life expectancy and the number of times patients receive the benefit of medical treatments in hospitals such as:

(a) Technological advancements have resulted in improved diagnostic tests, which, in some cases, increase the volume of tests that may be required to treat patients;

(b) New services have been developed, improving patient care and outcomes in cancer, palliative medicine, epidemiology, etc.;

(c) These advancements combined with an aging population lead to redo operations and an increased number of visits to hospitals

4.5 The Government has failed to implement the "Vision for Change" report on mental health policy, which was launched in 2006. This is on a background of many years of diminishing budgets for the psychiatric service in terms of overall budget in percentage terms;

This failure to implement 'Vision for Change' has resulted in:

(a) Children suffering from mental health problems being admitted to adult psychiatry units due to a lack of beds for children and adolescents;

(b) Failure to provide multidisciplinary teams as recommended by Vision for Change to develop each of the recognised specialities in psychiatry; General Adult Psychiatry, Psychiatry of Old Age, Psychiatry of Learning Disability and Child and Adolescent Psychiatry.

(c) All of this is exacerbated by the siphoning off of the mental health budget to make up for deficits in other areas particularly demand led;

(d) Psychiatry Services have suffered particularly by the suppression of posts in the last quarter of 2007 since many of the posts which had previously been sanctioned for implementing Vision for Change have now been lost to the psychiatric services;

(e) Ireland has a rapidly aging population and in this group mental health problems are common and yet there has been an almost no investment in Psychiatry of Old Age Service in recent years;

(f) Likewise there has been a failure to develop the psychiatric units required for people with learning disability associated with severe mental illness despite the recent forum reports based on Vision for Change to develop these as a matter of urgency. The same problem obtains for children with learning disability and co-existing mental illness;

(g) The proposal to locate the Central Mental Hospital to a prison is widely condemned as it will stigmatise those patients accessing the services of the Central Mental Hospital and is clearly being done for budgetary reasons and without taking cognisance of the needs of the Central Mental Hospital patients or the recommendations of the relatives and staff;

(h) It is widely acknowledged that eating disorder services, particularly specialist eating disorder services for those with the most severe forms of these disorders, are almost non existent within the public services within this country.

The HSE now states that there is no money to implement Vision for Change and at the same time money is being removed from psychiatric services to prop up other areas and the current medical management structures within psychiatry are being dismantled to facilitate this.

4.6 The establishment of the HSE over three years ago and its proposed reorganization and restructuring has failed to deliver an adequately focused and restructured Public Health Service.

This failure is demonstrated by the following problems:

(a) Ad hoc and budget driven reductions in front line employment levels and restrictions on replacement of front line staff in 2007 and 2008;

(b) There has been a significant increase in the numbers employed in management and administration roles, which outstrips the increases in the medical and nursing ranks over the last number of years;

(c) The curtailment of services through restrictions on outpatient services, elective surgery, theatre operating days, etc. This has resulted in:

(i) 7,000 surgery cancellations in the first five months of 2008, in addition to the15,000 operations cancelled in 2007;

(ii) Connolly Hospital services curtailed during the summer months;

(iii) Our Lady's Hospital, Navan, curtailed theatre operations;

(iv) Mercy University Hospital, Cork, curtailed by reducing days for outpatients and theatre operations during July and August;

(v) Curtailment of Pathology services in Mid-Western Regional Hospital, Limerick, during the summer months;

(vi) Three-year waiting lists for initial dermatology referral in Limerick (1,139 waiting over 3 years) and Drogheda.

(vii) Lengthy waiting lists and under provision of services for diabetes patients;

5 IHCA Recommendations

5.1 Budget Requirements

The budget provisions for 2009 must provide full resources to address the following issues unlike the 2007 and 2008 Budget provisions. The HSE 2008 Budget totaled €14,931 million, consisting of €14,337 million on current expenditure and €594 million on capital expenditure. The 2009 Budget must rectify the current and capital expenditure shortfalls and provide for the increasing demand for health services.

Current expenditure provisions in the HSE 2009 Budget need to be increased by an estimated 9% compared with the 2008 Budget to take account of known and likely cost increases facing the Public Health Sector to provide for:

(a) The shortfall in budget funding over the last two years which has been estimated at around €300 million per annum or 2.1% of the HSE 2008 Budget;

(b) The 2009 Budget should take account of actual activity levels in Quarter 1, 2008, (before the introduction of HSE restrictions) and the expected impact of population and demographic trends on 2009 demand levels;

(c) The additional full year cost arising from the two National Wage increases in 2008;
(d) The potential NWA increases in 2009;

(e) Increasing costs will arise from medical and general inflation, which are estimated at 8% to10% and 5% respectively;

(f) Increases in medical card costs;

(g) Increasing medical and other staff requirements, in particular relating to additional consultant staff numbers and costs arising from the 2008 Contract Agreement should be provided for in the 2009 Budget;

Additional current expenditure provisions need to be provided for:

(a) Supplementary Budget increases to provide additional funds for medical card costs if unemployment rates increase further, as was provided for increased School requirements in the Department of Education in recent years. The current management approach of raiding an already under-funded budget is unacceptable, as occurred in 2008;

(b) New services and programmes which are scheduled to be delivered in 2008 and 2009;

(c) The changes envisaged in the 'Vision for Change' which has fallen well behind the timescale for its implementation;

Capital funding needs to be increased to:

(a) Provide for increased capacity in terms of acute hospital beds, equipment and other resources to replace the 3,000 acute hospital beds, which were removed from the hospital sector in the 1980's/1990's;

(b) Fund new hospitals already included in Government policies and strategies in the North East, the new Pediatric Hospital, and other developments;

(c) Increase step-down and long-stay beds at community level, so that medically fit patients can be discharged on a timely basis;

5.2 Other IHCA Recommendations

Adequate funding and other provisions must be put in place within the Public Health Sector to remove blockages, which are limiting the capability and capacity of the service to meet the population's need for Health Services. Budget funding must be sufficient to avoid the annual introduction of restrictions and cut-backs that have occurred in 2007 and 2008. This requires the following:

(a) The Government established Health Forum should meet more frequently to advance a consensus between the stakeholders on restructuring issues. The Health Sector Unions and the HSE share a common goal to deliver the best possible health service to the population. Discussions between the stakeholders should examine the practicality of introducing voluntary redundancy, voluntary early retirement and redeployment schemes for appropriate grades, taking account of efficiency increases that should result from the merger of the Health Boards into the HSE and the introduction of new technologies;

(b) Replacement of front-line staff on a speedier basis than currently applies due to restrictions included in HSE Circulars which are budget driven;

(c) Adaptation of employment ceilings to ensure that particular services, such as the acute hospital sector and mental health services are appropriately staffed to deliver services in response to the known demand and activity levels;

(d) The HSE proposal[5] to reduce staff levels in acute hospitals (NHO) by 5% (2,726 WTE) over the years 2008 and 2009 is not acceptable as it fails to provide sufficient staff levels to deliver the required activity levels in acute hospitals. These proposals need to be discussed with the staff unions and the 2009 Budget must be based on projected activity levels and not on the proposed reduction in staff levels;

(e) Inadequate capacity is restricting the delivery of hospital and psychiatric services. The solution to these problems involves a two-prong approach consisting of increased step down and long-stay beds at community level

[5] HSE Circular 16/2008, June 3rd, 2008

while at the same time increasing the funding in acute hospitals so that they can reduce waiting times and the numbers on waiting lists and increase their activity levels. It is not acceptable for the HSE to propose that the community services would be increased while at the same time the acute hospital funding and staffing levels are to be reduced despite the fact that there are lengthy waiting lists, extensive use of trolleys in ED's and increased demand for acute hospital services;

(f) Patients who have completed their treatment in acute hospitals and are medically fit should be transferred to step down facilities without delay, unlike the current practice which:

(i) Leaves patients in acute hospital beds for longer than necessary, resulting in the loss of around 200,000 acute hospital bed days;

(ii) Curtails the capacity of acute hospitals to deal with patients on waiting lists and reduces activity levels in hospitals;

(g) The two HSE pillars, the National Hospital Office and the Primary Community and Continuing Care Pillars, should be amalgamated to deliver increased efficiencies;

(h) Consultants have agreed a new Contract including a longer working week, a more flexible day and structured weekend inputs on Saturdays, Sundays and Public Holidays. Other HSE staff grades should review their practices in order to facilitate optimization of the changes being provided by consultants;

(i) While the NTPF introduced a method of addressing lengthy waiting lists for particular services in acute hospitals, its continued existence is an acknowledgement by the HSE of its failure to address the fundamental shortcomings in capacities which are resulting in waiting lists in the first place. It is important that the NTPF is not institutionalized and instead the need for it should be removed over time by addressing the capacity constraints in acute hospitals already referred to in this submission;

(j) The HSE should examine the most effective use of resources in relation to the provision of emergency services in small hospitals, which are currently staffed on a 24/7 basis;

(k) The funding of health screening, immunization and education programmes, which improve population health and reduce health budget costs in the medium and longer term. In an era of tighter budgets these

programmes should not be restricted due to short term budgetary constraints;

(l) Excise duty on alcohol and tobacco should be set at appropriate levels to provide disincentives to their excessive use and to encourage a healthier population, which in the longer term will reduce health sector costs;

(m) Provision should be made for increased levels of advice from dieticians throughout the Health Service delivery system;

5.3 Recommendations within the Psychiatric Service

Key mental health developments must be advanced to ensure the implementation of the 'Vision for Change' recommendations:

(a) Provision of acute inpatient psychiatric beds for children including 16 and 17 year olds;

(b) Ring fenced funding for the implementation of Vision for Change;

(c) Mental health teams for adults and children with learning disability and co-existing mental illness;

(d) Development of specialist eating disorder services;

(e) Provision of a comprehensive psychiatry of old age services nationally to include both establishment of services where none exist and adequate resourcing of those that do;

(f) Redevelopment of the Central Mental Hospital on its existing site in keeping with best clinical practice in psychiatry;

(g) The development of intensive care units and secure rehabilitation units nationally;

6. Conclusion

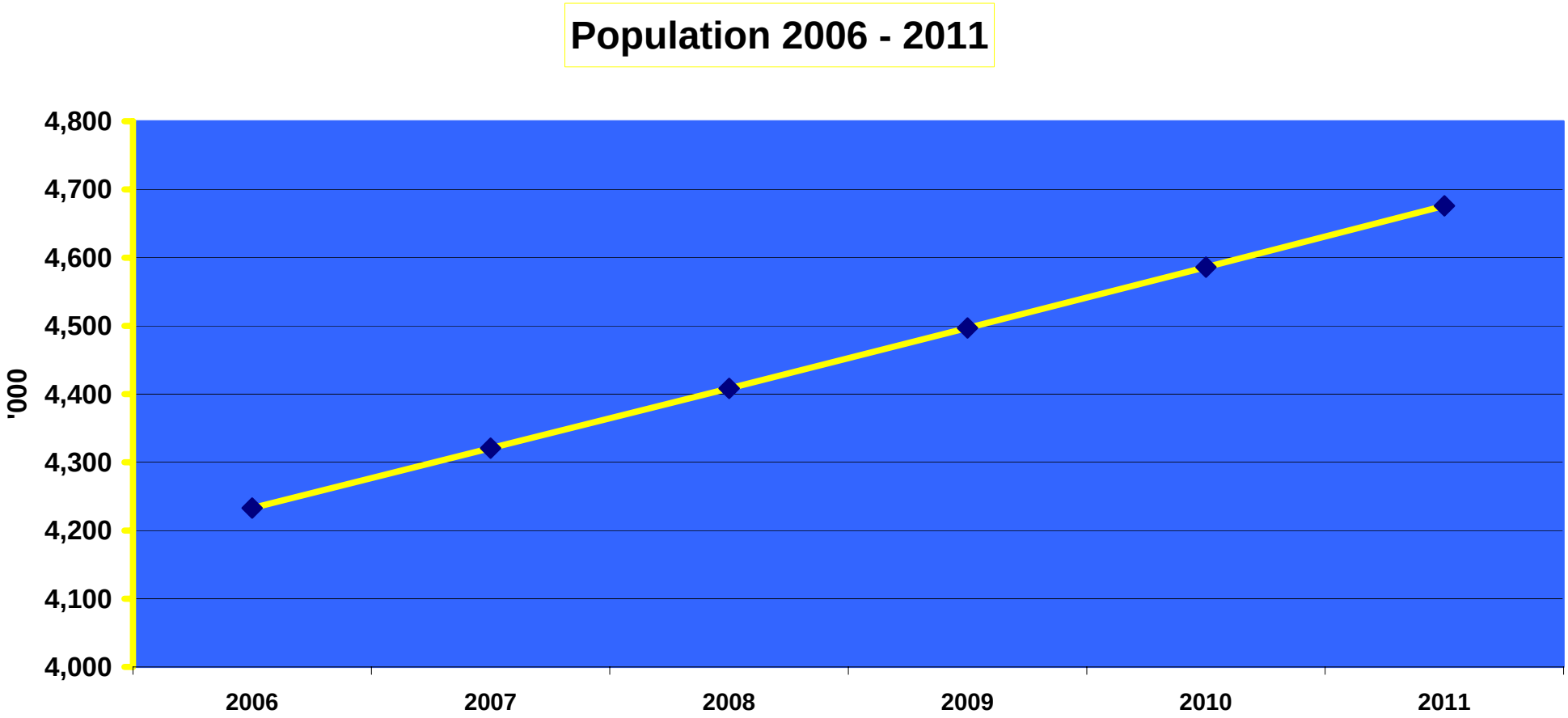
The basic cost drivers arising from activity levels, inflation, national wage increases and known increases in demand led schemes result in a requirement for an estimated 9% increase in the HSE Budget in 2009 compared with the 2008 Budget. In addition, it is expected that population and demographic trends and increased unemployment levels could increase demand further over the existing demand levels.

In conclusion, it is essential that funding for the Public Health Service provides fully for these increases, even in a year of tighter budget circumstances, otherwise the sick and vulnerable will be exposed to unacceptable levels of delays and patient suffering.

IHCA September 3rd. 2008

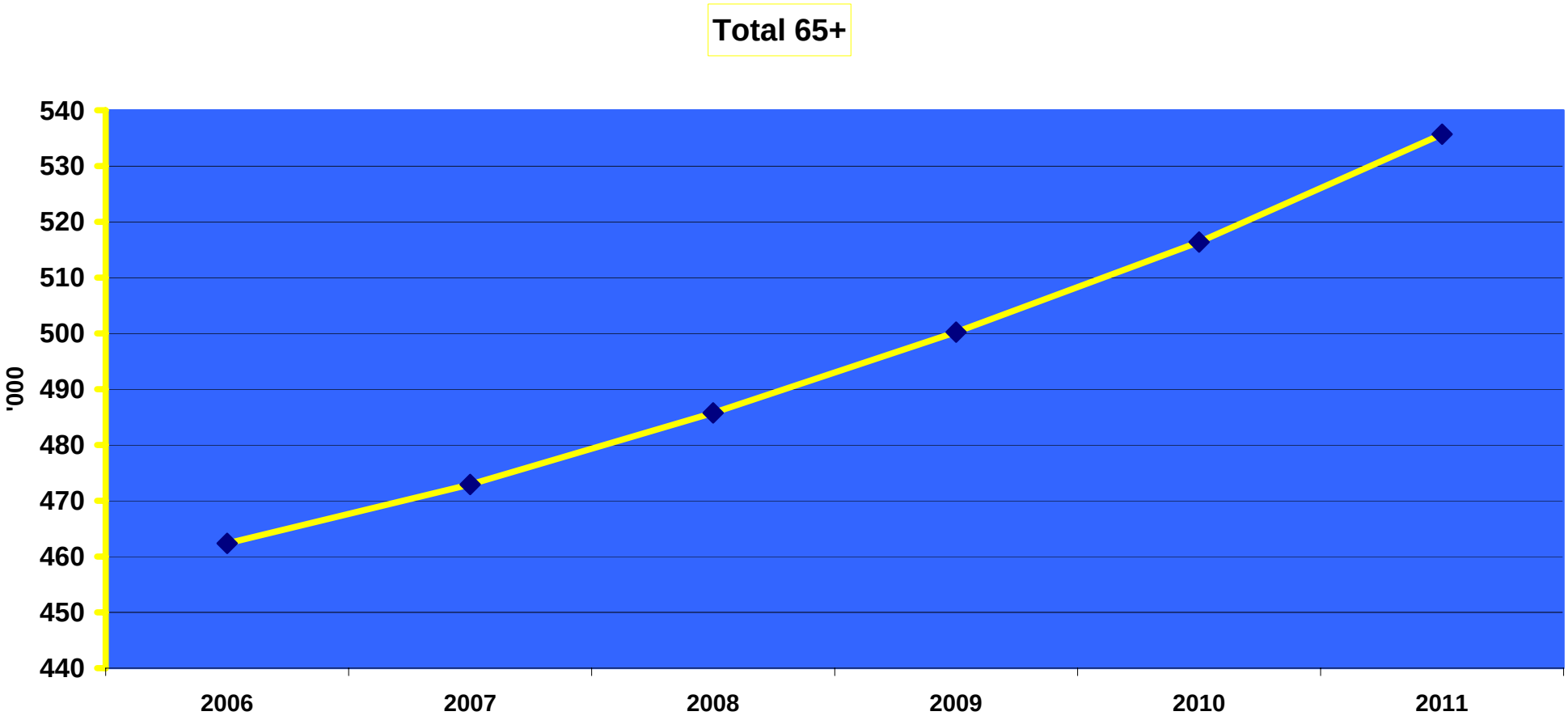
Population Projections

Figure 1



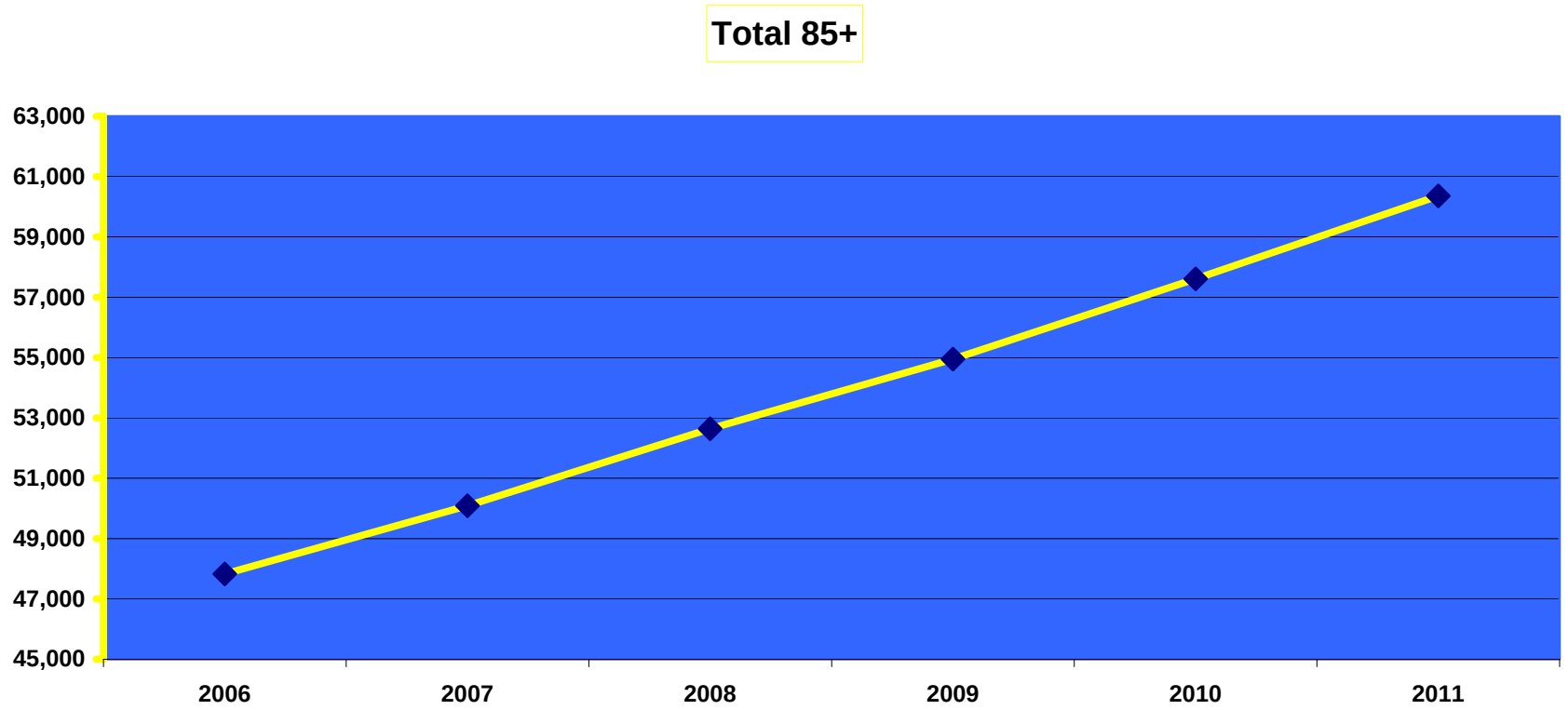
Population Projections

Figure 2



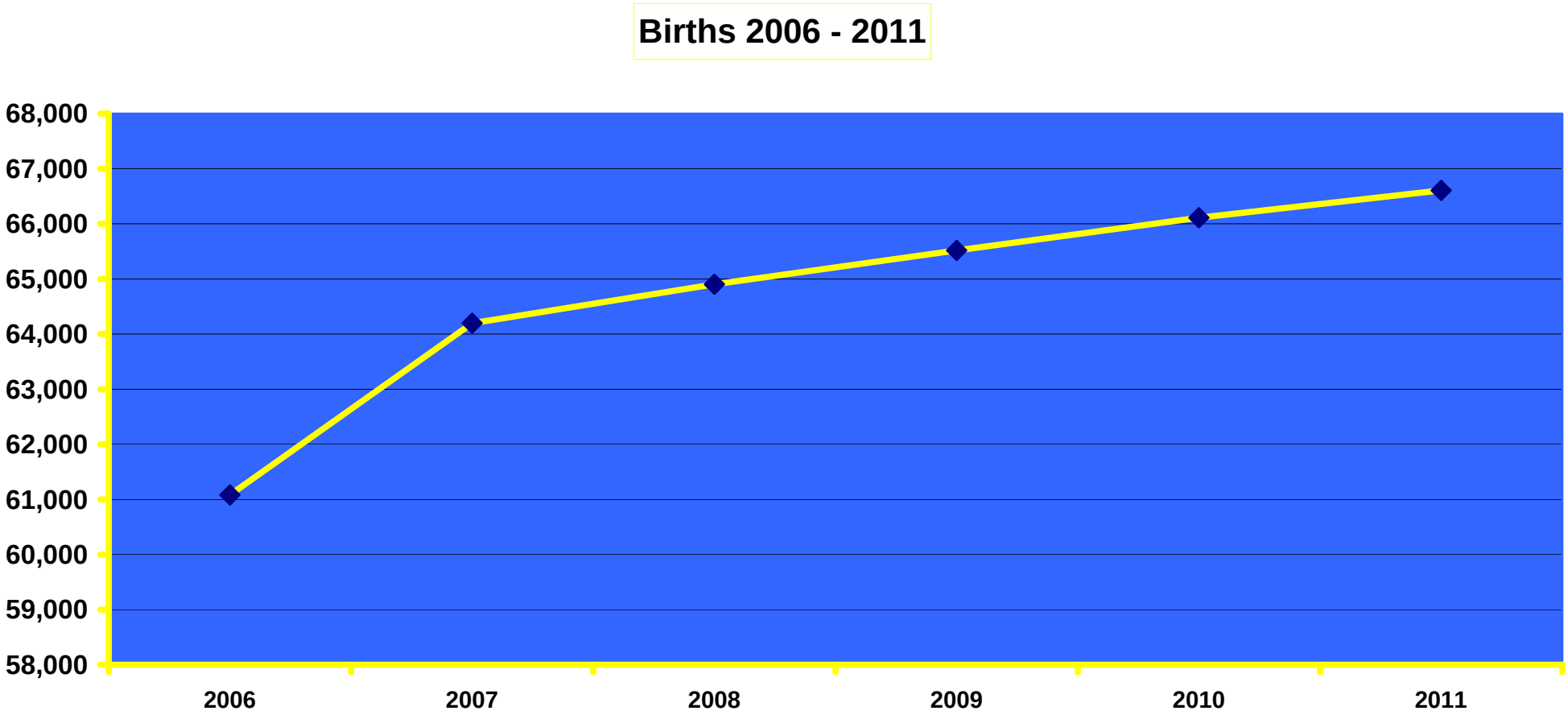
Population Projections

Figure 3



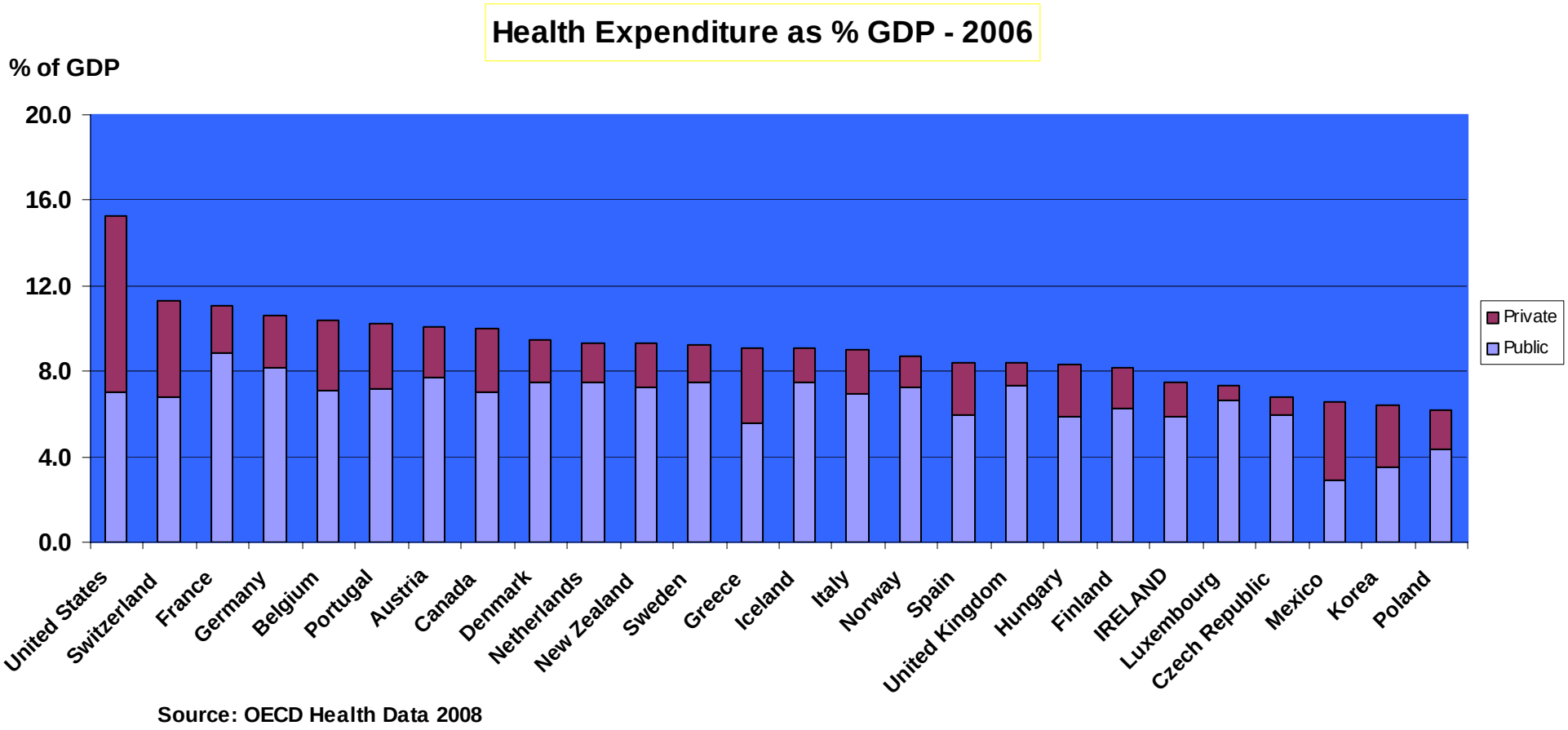
Population Projections

Figure 4



OECD Comparison

Figure 5



Source: OECD Health Data 2008

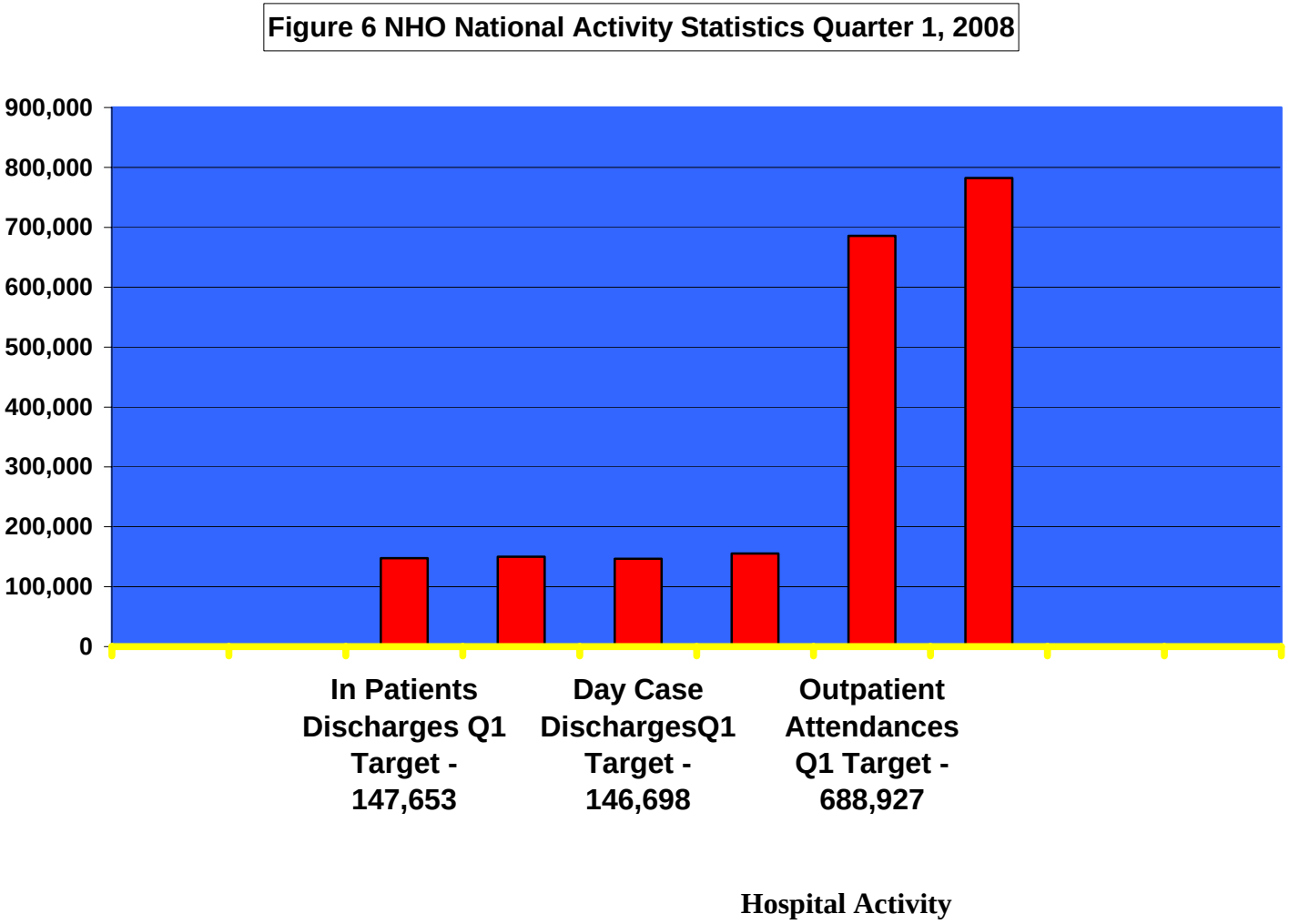


Figure 6 NHO National Activity Statistics Quarter 1, 2008
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
In Patients Discharges Q1 Target - 147,653
Day Case DischargesQ1 Target - 146,698
Outpatient Attendances Q1 Target - 688,927
Hospital Activity

Figure 6

Figure 7 NTPF Waiting List Statistics Quarter 1, 2008

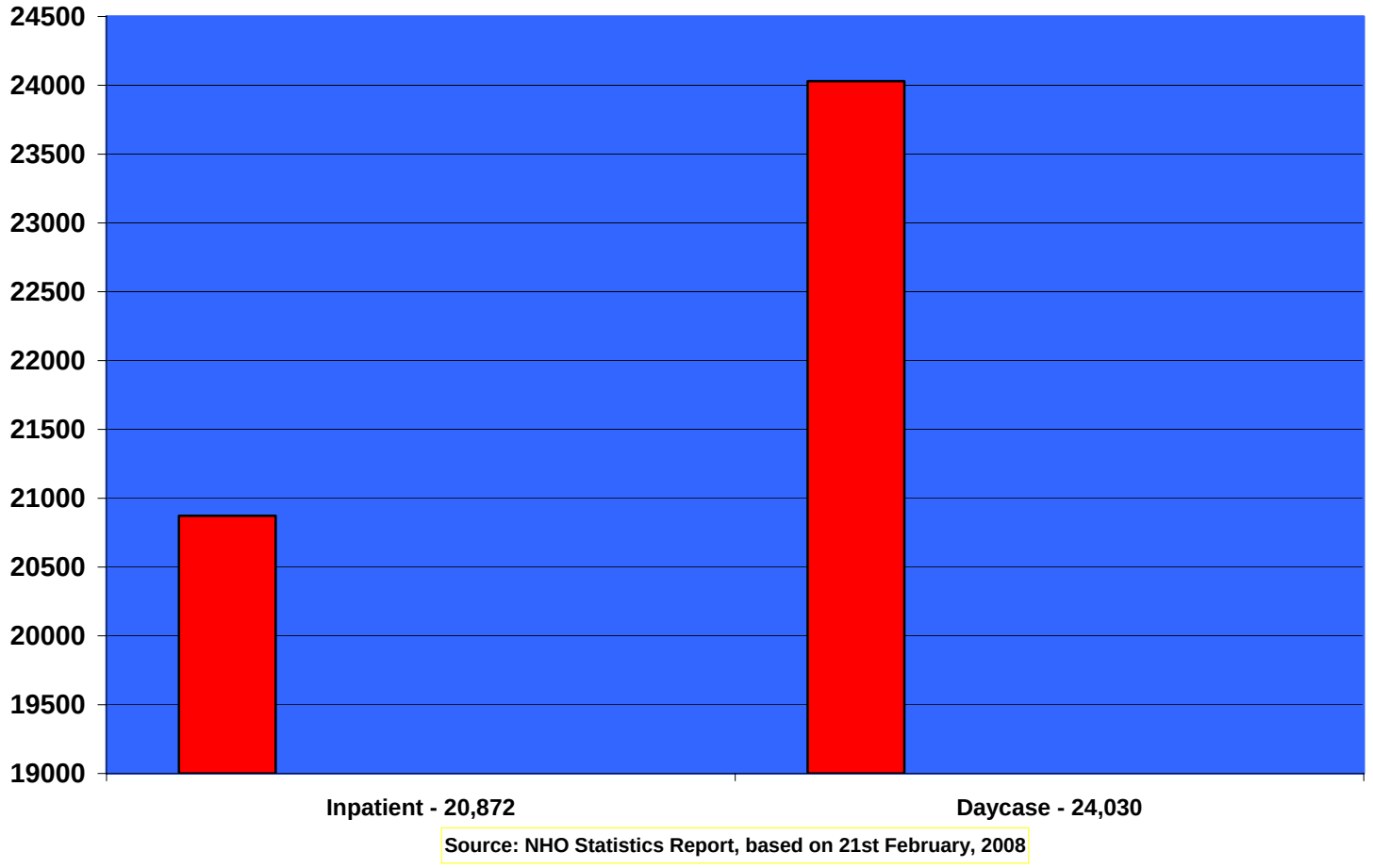


Figure 7

Figure 8 NHO National Activity Statistics Quarter 1, 2008

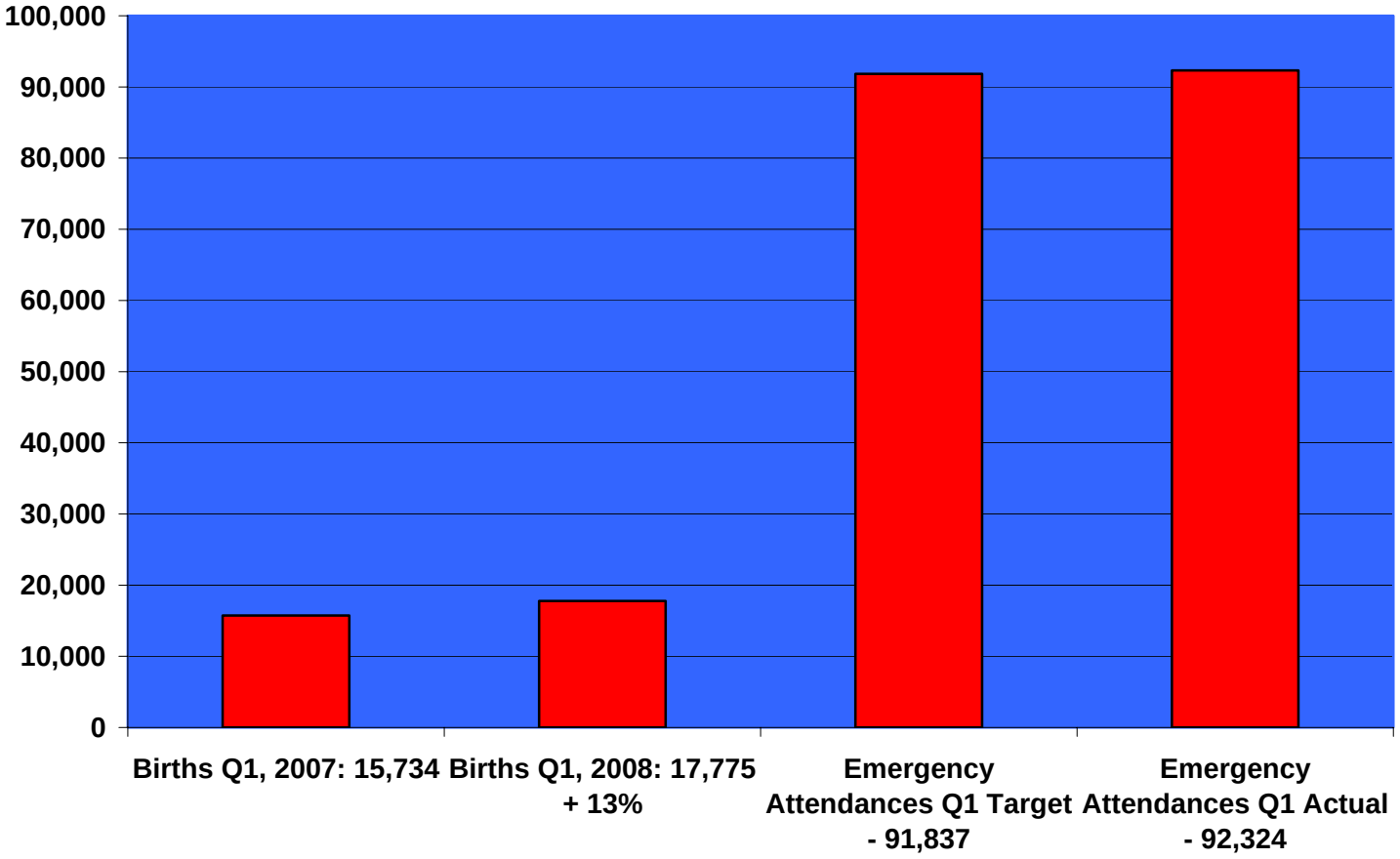


Figure 8