Irish Congress of Trade Unions

Submission to the Oireachtas Committee on the Future of Healthcare

August 2016

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Irish Congress of Trade Unions

1. Executive Summary

1.1 The establishment of the **Oireachtas Committee on the Future of Healthcare** and the attendant focus on formulating a long term vision for a reformed public health service is a positive development.

1.2 The establishment of the Committee presents an opportunity to make a declaration of intent that, over time, we will move to a universal, fully integrated, single tier public health service that guarantees access and quality care, regardless of income.

1.3 The public health service should be funded through a progressive taxation system. At a minimum, the service should be allocated dedicated funding of 10% of GDP per annum, with a further recognition that significant additional capital spending will be required in some years. Over time, the state will cease to subsidise all forms of private health care provision.

1.4 For the vast majority of citizens the first point of contact with the public health service should be a network of public, locally based community health care centres. These Primary Care Centres will provide an expanded range of clinical and diagnostic services and will lead health promotion campaigns in the communities in which they are based.

1.5 The network of public hospitals will continue as a vital cornerstone of the public health service, but the role of the hospital will be re-focused with some services devolved to the Primary Care Centres. Vital to reform of the health service will be a move to a team-based approach to patient care, which is consultant delivered and where all hospital staff are respected and enabled to perform tasks appropriate to their qualification levels and competence.

1.6 The increase in the number of older people living longer is the biggest challenge facing our public health service. It is of such a scale that it will require the state to reverse its current policy of

privatising elder care and re-engage as the principal provider of health care services for older people.

1.7 The incidence of mental health disorders continues to rise and demands a renewed commitment to deliver in full the proposals contained in the *Vision for Change* strategy published in 2006.

1.8 Not for profit organisations currently provide the bulk of health services to people with disabilities. A small number of highly publicised failures have highlighted the need for better oversight and a focus on quality assurance and patient care. A strategy of providing services in community-based settings must be part of an overall approach to the care of people with disabilities.

1.9 The Committee must accept that moving to a universal, fully integrated, single tier public health service presents a number of workforce planning challenges, not least of which is understaffing. In designing the new system, full regard must be had for appropriate remuneration, reward and recognition systems and other conditions of employment, such that the Irish public health system is ultimately viewed as the employer of choice and is capable of attracting and retaining the most talented staff.

2. Introduction

2.1 An essential function of Government is to create the conditions under which all citizens can access high quality public health services.

2.2 The public health service in the Republic of Ireland is staffed by a wide range of highly qualified and dedicated healthcare professionals who strive to achieve excellent outcomes for patients. However a number of funding, structural and organisational difficulties embedded in the system can result in a less than satisfactory experience for some.

2.3 The establishment of this Committee represents a major opportunity to make a declaration of intent on the introduction of a universal, single-tier, public health service, where both access and quality are guaranteed regardless of income. It is imperative that over time the existing two tier health system - with contradictory incentives and ability to pay guaranteeing faster access to diagnostics and interventions - is replaced by a single-tier, equitable and quality service.

2.4 Over the last three decades successive governments have proposed, and implemented, various organisational reforms. However real, transformational, change has not occurred, to the detriment of many who rely upon the public health service. The Committee must acknowledge that a meaningful transformation of Ireland's public health services will require far more than a decade of planning and implementation and as such, its deliberations should not be limited to addressing developments that may be completed within the next ten years.

2.5 In this submission Congress has sought to identify:

- *The guiding principles that should inform any programme of reform;*

- *The measures required across the key pillars of the public health service: primary and community care, public hospitals, care of older people, the mental health service, care of people with disabilities; and*

- *The human resource issues arising from the implementation of a new vision for the public health service.*

2.6 Congress is uniquely placed to provide the Committee with a view on a reformed public health service, given that our affiliated unions represent well over 90% of all employees working in the service. The views expressed in this submission have been developed in consultation with the unions in the sector and the wider trade union movement in Ireland. However the Irish Medical

Organisation (IMO) has independently developed a strategy for the organisation of the health services over the next ten years and beyond, which is the subject of that union's separate submission to the Committee on the Future of Healthcare.

2.7 In our view an essential component of a single tier public health service is that all staff will be directly employed. Critically, any such service must function on a 24/7 basis, where required, and, at a minimum, on a 7/7 basis, in both the primary and secondary care services.

3. Guiding Principles for a Reformed Public Health Service

3.1 In the following paragraphs we set out the principles that should guide the transformation of the public health service.

3.2 In the first instance, there should be an immediate declaration of intent to create a fully integrated, universal, single tier public health service. Clearly, a considerable transition period will be required - probably in excess of a decade - and this should be acknowledged at the outset. It will be vital to secure citizen and stakeholder support for the process and the difficult decisions it may entail. This will require active consultation with those immediately affected *and* a commitment that no service will be discontinued until an alternative service is in place. Likewise, any proposed changes to employment contracts or other contractual arrangements must be the subject of consultation with recognised trade unions, acknowledging that significant red-circling of some current arrangements will be required. Although change will be gradual the transformation envisaged must be clearly set out, along with a timetable for implementation.

3.3 There should be a long-term, multi-annual commitment to provide ring fenced core funding for the public health service at a minimum of 10% of GDP per annum. This funding should be provided through a system of progressive general taxation.

3.4 Building a single tier health service will involve significant capital expenditure to provide the necessary infrastructure. The funding must be allocated, in any given year, in addition to, and separate from, the minimum expenditure of 10% of GDP on current service provision. All health spending must come as a result of realistic budgeting, which can adequately provide for the delivery of planned services and the development of infrastructure.

3.5 As we transition to the desired single tier system, parallel funding will be required as we reconfigure and develop new services, while maintaining existing service provision.

3.6 A further cornerstone of this transformational programme should be a declaration that the state will, over time, cease to fund or to subvent any form of private healthcare provision. This will entail the phased elimination of all tax reliefs for private healthcare insurance and direct subventions, i.e. to existing private nursing homes. This funding should be redirected to specific programmes required for, or linked to, the implementation of the reform programme for the creation of a single-tier service.

3.7 Essential to a reformed public health service must be an appropriate remuneration system. If we are to attract and retain the required number of additional staff, recognising the expansion of services that will be required, the change process must include a significant personnel component. This must recognise that Ireland will be competing with other countries for well qualified health professionals and significant ongoing training and professional development opportunities should be available. Ultimately a transformed public health service must be viewed as an employer of choice.

3.8 Organisational restructuring, planned or under way, will need to be reviewed in order to reflect the structures necessary to deliver the single tier healthcare service. The final organisational structure that emerges must be simple, integrated and readily understood by the general public. This is necessary to ensure efficiency and effectiveness, minimise duplication and, most fundamentally, to

secure the confidence and support of the general public for the transformational programme.

3.9 Congress further calls for improved planning and expenditure on public health initiatives. The current population health strategy - *Healthy Ireland* – can be of considerable importance in lowering future disease burden. However it must be supported with a detailed implementation plan, ring-fenced funding and improved staffing of public health provision.

4. Primary Care: Local Health Services to Meet Local Need

4.1 The delivery of public health care should be designed to ensure that the first, and, for the most part, the continuing point of contact for most citizens will be a community-based, publicly owned and managed primary health care facility.

4.2 A cornerstone of this enhanced system must be universal eligibility for all primary care services, to be provided by directly employed health professionals.

4.3 The range of services offered in these primary care centres is a matter for detailed consideration and may differ based upon urban/rural locations and population density. Staffing should be on the basis of 7/7 opening and centred on a team approach, providing direct access for the public to health professionals together with the provision of cross referral from one health professional to another.

4.4 These Primary Care Centres must offer sufficient diagnostic and support services to ensure that patients can access services at the most appropriate location, thus reducing the burden on acute and secondary services.

4.5 In that context any current or future discussions with regard to expanding or altering existing contracts or arrangements must recognise the potential for significant change and not, in any way,

inhibit or restrict the changes necessary to transform the provision of primary care services.

4.6 As suggested, services should operate to ensure patients receive care at the most appropriate location. However, as patients will still need to attend public hospitals for particular treatments it is important that appropriate technology is utilised to ensure seamless transmission of patient information between the local facilities and public hospitals. This will require separate, ongoing, capital funding.

4.7 In paragraph 2.3 above we referred to once off capital costs that will be incurred as part of the required reforms. It will be necessary to expand the current programme to develop primary care facilities to ensure access to such centres countrywide. The development of community based health facilities is critical to the creation of a universal, single tier public health service.

5. Our Public Hospitals: Acute Care & More

5.1 Devolving some services from public hospitals to community based facilities, provides an opportunity to assess which services will remain with public hospitals and how they will be delivered.

5.2 However in any reform of the role of public hospitals we must ensure that there are sufficient beds in appropriate locations to meet expected demand.

5.3 It is widely accepted that there are insufficient available beds in our public hospitals. This is evidenced by the waiting times experienced in emergency departments and the severe and growing waiting lists for inpatient and/or diagnostic services.

5.4 Research carried out by the OECD shows that in 2006 the number of hospital beds per 1000 of the population stood at 5.3. However by 2012 this had fallen to 2.8. If pubic hospitals are to be capable of responding to the needs of a growing and ageing population

the number of available public beds will have to increase significantly to bring it into line with the OECD average of approximately 5 beds per 1000 of the population.

5.5 It is also accepted that significant change is required in how public hospital services are delivered. Fundamental to this is recognition of the leadership role played by consultants in hospital settings. In order to ensure the effective functioning of a single tier public health service it will require that patient care is delivered by consultants employed and working exclusively for the public health service. It will also require that consultants are rostered over an extended day and on a seven day a week basis. This will require a significant number of additional consultant posts in the core specialisms of medicine, surgery, paediatrics, obstetrics and emergency medicine.

5.6 Moving to a consultant-delivered service in public hospitals - to include a review of the existing ratios between qualified staff and professionals in training - presents an opportunity to create a system of team working where the role played by all working in the hospital is valued and recognised. It also presents an opportunity to assess how vital work is carried out. Most people working in the health service would agree that the quality of patient care could be improved by ensuring that tasks are carried out by the appropriate person in the most efficient way. It is further recognised that many staff in our hospitals are now trained to a level that would allow them to perform an enhanced role in patient care. In the move to a consultant-delivered service the duties currently performed by all those working in this vital part of our health service should be scrutinised and tasks allocated on the basis of achieving the highest possible standard of patient care.

5.7 Congress requests that the Committee note that our affiliates have, particularly in recent years, engaged in very constructive discussions with regard to the reallocation of work, task transfers and the provision of frontline services to patients/client. This must be constantly reviewed during the transformation programme, as

a properly staffed health service, with appropriate ratios of professionals to support staff, greatly enhances the patient/client experience and accelerates the return to full health.

5.8 Congress broadly welcomes the recent establishment of the seven Hospital Groups, including the Children's Hospital, as it has the potential to improve coordination of service delivery. However past experience with regard to reconfiguring acute hospital services is one of failure, with increased overcrowding, loss of public confidence and huge frustration amongst health service staff. Congress, as referred to in paragraph 4.1, continues to believe that the move to an integrated single tier public health service presents an opportunity, on a planned and agreed basis, to transfer some of the procedures performed in hospitals, to more locally based public health facilities.

5.9 A fundamental requirement of any further reconfiguration of acute hospital services, as part of this transition must be to ensure the maintenance of all existing services in their current locations, until the alternative service is established, properly staffed, funded, and, most importantly, enjoys the confidence of the community it serves.

5.10 Where appropriate and proven effective, public hospitals should provide other services critical to the care of patients, necessary for the continuing improvement and development of the public health service. For example, major public hospitals would continue to provide advanced diagnostic tests for patients following referral from partner hospitals and/or locally based primary care centres. Public hospitals should also continue to play a key role in the education and ongoing professional development of those working, or seeking to work, in the public health service. It is also vital that our public hospitals are involved in advanced research and development, thus ensuring ongoing improvements in patient care. When our public hospitals have the capacity to provide world class care and are recognised as leaders in education and research, the public health service is more likely to attract and retain the most talented staff.

6. Care of Older People: The Challenge Facing our Public Health Service.

6.1 While there has been an increase in both the birth rate and the population, the long term trend shows a significant increase in number of older people who will live longer. While obviously welcome, this poses a considerable challenge to our public health service.

6.2 As our population ages, there will be an exponential rise in the incidence of chronic disease and it is imperative that we radically reform the manner in which we deliver healthcare services to those affected. An expanding and ageing population places significant demands on the healthcare system with the incidence of chronic conditions expected to increase by 4% to 5% per annum during the next decade. Many services addressing chronic disease could be better delivered in a community setting and such services must be expanded accordingly.

6.3 Older people who live in their own homes will doubtless benefit from an expanded, locally based network of primary health care facilities. The development of these facilities will reduce their requirement to be admitted to public hospitals and the requirement to travel to avail of services currently provided in public hospitals.

6.4 Older people who do live at home will require support. The home help service currently provides such assistance and the provision of these crucial services is often the reason why older people can continue to live independently. Close to 50,000 people availed of this service in 2015. It is therefore imperative that adequate funding and professional staffing are provided for the continued and improved running of this service.

6.5 For a growing number of older people the reality is they are unable to live independently. Most will require full time residential care. To date official policy has been to privatise this care through

state subsidisation of private nursing home beds run by for profit businesses.

6.6 Congress believes it is vital for the state to declare that, over time, it will become the main direct provider of long term residential care for older people. This will require significant state investment in the development of facilities that will provide single room accommodation in residential settings. It will involve the construction of such facilities and the redevelopment of the existing public, long term bed stock to bring it up to the standards required by HIQA. An extended home help service can address the needs of those who can and wish to remain in their homes despite being unable to live independently.

6.7 As mentioned, the move to a fully integrated single tier public health service will take a number of years to implement. In the transition the private sector will continue to be a provider of care to older people. However, there will be greater certainty and security for older people with the state moving to become the main care provider.

7. Mental Health: Removing the Stigma & Providing Effective Treatment

7.1 In 2006 the then Government published a comprehensive policy on mental health, entitled *A Vision for Change*. The key feature was to be the transfer of services to community settings. However in the ensuing decade there has been slow progress in implementing what constituted a transformational shift in the treatment of mental health disorders.

7.2 The proposal to move to a community setting is still relevant and this service should be fully integrated into the locally based primary health care services, referred to earlier.

7.3 However funding for the treatment of mental health disorders is drawn from the main budget, with no certainty about the availability of resources in the longer term.

7.4 Congress believes that mental health requires a dedicated, multi-annual budget. This would facilitate the integration of this important element of the public health service within the locally based primary care service, with the capacity to plan for the treatment of children and adolescents, along with planning for the treatment of adults presenting with mental health disorders.

7.5 Arising from the provision of this dedicated, multi-annual budget, specific goals and objectives must be set for the rapid development of mental health services. These must include significant investment in capital infrastructure (again through a separate capital budget) the provision of specialist services, universally available, and the employment of additional allied health professionals and nursing staff. Access to acute/ supportive mental health services must be available, on a 24/7 basis, either through the primary health care centres, or dedicated staff within emergency departments in major urban areas.

7.6 An effective means of reducing the incidence of mental health disorders is through preventative programmes that seek to lessen the prevalence of risk factors, including: substance abuse, social isolation, economic disadvantage or family conflict. The dedicated budget for mental health referred to in paragraph 7.4 above, should provide resources for the implementation of such programmes.

8. Disability Services

8.1 The funding of health services for people with disabilities dramatically reduced during the economic crisis and this must be reversed.

8.2 The delivery of these services is primarily carried out by not for profit voluntary organisations working nationally or locally. In the vast majority of cases the services provided are to the highest standard, given the resources made available to them.

8.3 However a small number of highly publicised failures in service provision highlights the necessity to ensure that quality assurance and patient care are at the heart of service delivery to those with disabilities. It must also be acknowledged that the provision of disability services, through numerous small, not for profit agencies has led to a lack of consistency, in terms of service location and access. Congress therefore proposes that the services be delivered, through direct provision and directly employed staff, and in a manner which ensures that access to necessary supports is available regardless of income and location.

8.4 Equally we must continue to relocate services, where appropriate, from existing residential type accommodation to more appropriate community based homes. While this is existing policy it has not been properly funded and, quite frequently, the infrastructure within the community home location is inappropriate for the needs of the client. It must also be recognised that there will be many occasions when the individual continues to enjoy a better quality of life by remaining in their current location, receiving the required level of supports.

8.5 The reform process must ensure that we fully utilise the skills and competencies of all staff working in the area of disability services. As part of the transition to this single tier system we must, without exception, maintain standards and practices and ensure respect for the human rights of the individual with a disability. The provision of such a service will require legislative changes to guarantee the rights of the disabled person, including the provision of all services necessary to optimise their lives, potential and overall well-being.

9. The Ambulance Service

9.1 The National Ambulance Service plays a critical role in connecting the community with hospital and other key health care services.

9.2 Due to changing demographics citizens dependent on community medical services will require support in the home. Citizens will require social support which is already provided by Home Help Services and as such it is imperative that adequate funding and qualified personnel be provided. It is therefore crucial that Government commits to adopting a strategic plan for care of citizens in the community which ensures the highest standards are maintained and that those who provide and manage the service are regulated. It is also vital that the workers in this sector are protected and remunerated in line with their counterparts who provide similar services in institutional settings.

10. Regulation & Standards

10.1 As an integral part of this transformation programme Congress supports strong regulations to govern how all health professionals practice. If the public is to have confidence in those providing care it is essential that very clear regulations remain in place to ensure high standards.

10.2 As we move to a single tier public health system it will be necessary to ensure that a full independent inspectorate is established and properly funded, charged with the task of constantly challenging the health service to be world class in all facets of its operation.

11. Future Workforce Planning

11.1 There are significant workforce planning issues to be considered as part of the transition to a fully integrated single tier public health service.

11.2 It is our view that in the transition period all future recruits to the public health service will be direct employees, working exclusively for the public health service.

11.3 Remuneration, reward and recognition systems and quality continuing professional development systems must be put in place, with the aim of attracting and retaining the most talented staff.

11.4 If the ambition of a fully integrated, single tier public health service is to be realised and if it is to operate across all settings in a timely and responsive manner, it will require significant investment in staff at all levels.

12. Conclusion

12.1 The establishment of the Committee on the Future of Healthcare presents a significant opportunity to develop a new, all-embracing and transformative vision for the future of our health care system.

12.2 It is the view of Congress that the Committee should clearly state that an overarching goal of this process is to move to a universal, fully integrated, single tier public health service that guarantees access and quality care, regardless of income.

12.3 The public health service must be properly resourced through the taxation system to a minimum of 10% of GDP per annum, with a recognition that additional capital funding will also be required over time. This will also see the state cease funding for all forms of private health care.

12.4 A network of Primary Care Centres will act as the first point of contact for many accessing the health service, with the centres providing a range of key services and leading local health promotion campaigns. Service provision in the public hospital network will be refocused to reflect this change, but the network will continue as the cornerstone of the health care system.

12.5 At the heart of a transformed health service will be a consultant delivered, team-based approach to patient care, with all staff carrying out tasks appropriate to their qualifications.

12.6 The biggest challenge facing our public health service is the increase in the number of older people living longer. This will require the state to become the principal provider of health care for older people.

12.7 The growing incidence of mental health disorders demands the full implementation of the proposals contained in the 2006 *Vision for Change* strategy.

12.8 Moving to a universal single tier public health service presents major workforce planning challenges. Any new system must put in place conditions of employment that will make our health system the employer of choice for the most talented staff.

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