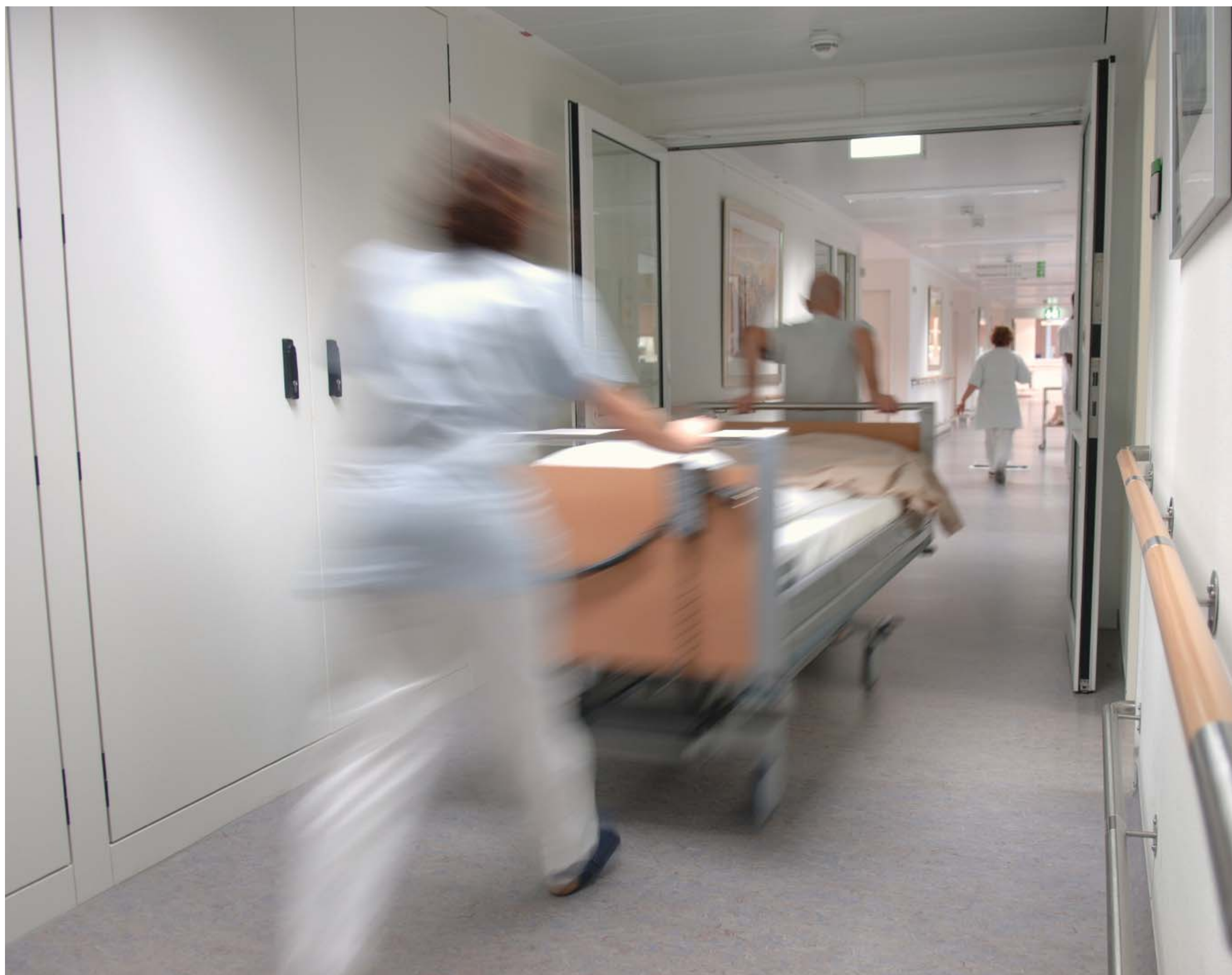
THE PROVISION OF HEALTHCARE in a changing Ireland



AOIFE MORRIS discusses the changes to Ireland's healthcare systems during the boom years, and the implications of economic downturn.

Described by *The Economist* in 1988 as "easily the poorest country in rich north-west Europe", Ireland underwent an unprecedented economic transformation during the 1990s. From a country marred by chronic budget deficits, high levels of unemployment and widespread emigration, it became the European Union's success story. Over a period of only a few years, Ireland emerged as an economic front-runner, with sustained economic growth, and was seemingly 'getting richer' all the time.[1] Ironically, the aetiology of this revolution has ultimately become its downfall; the phenomenon of globalisation. Ireland's geographic position on the periphery of Europe, combined with competitive taxation policies and corporate incentive schemes, made it the ideal base for US companies to bridge the Atlantic and target the European market.[1,2] The influx of large multinational investment placed Ireland at the heart of this new global economy and provided the financial stimulus and momentum for what was, in economic and real terms, a dramatic turning point in Irish interests. However, Ireland's open market economy was, and remains, reliant on global trade and investment, particularly from the US. In 2007, the credit and housing boom in the United States crumbled, triggering a banking and financial market crisis that infected their economy and, by proxy, that of Ireland. The Irish success story received a rude awakening and a sharp reversal in its fortunes. Health expenditure trends in Ireland have naturally followed the national economic position. Strict economising in the earlier part of the 1990s gave way to exponential increases in expenditure between 1996 and 2002.[3] The publication of the 2001 Health Strategy 'Quality and Fairness: A Health System for You' reaffirmed the governing principles of Irish health policy: equity, quality and accountability, with the additional focus of placing the patient at the centre of future reform.[4] This strategy centred on six key areas: strengthening primary care provision; developing the acute hospital system; improving funding; better planning and training for the healthcare workforce; review of the current healthcare structures; and, improving health information systems. This strategy paved the way for a number of reports that changed the landscape of Irish healthcare. For the most part, this change has been quite visible.

Structural and departmental change

The Prospectus Report[5] proposed the Health Service Executive (HSE) as a means of establishing a unitary approach to health service delivery and management. Following the enactment of the Health Act 2004, the HSE was established in 2005 and charged with managing the health service as a single entity. The HSE has control over all executive, managerial and budgetary decisions. Prior to this, the administration and provision of services fell to a number of regional health boards and various government authorities. This system was fragmented and inefficient, with multiple departments lacking clarity of roles and underdeveloped functions. Both the Prospectus and Brennan` reports identified the need for separate operational and policy functions. Following the establishment of the HSE, the Department of Health and Children (DoHC) was restructured. This enabled it to refocus its activities on strategic overview, analysis and evaluation, and to advise the government on health policy. Finally, the Health Information and Quality Authority (HIQA) was established, with the aim of supporting the delivery of high quality services based on evidence-based best practice. Its mandate includes the development of health information, health promotion, the implementation of quality assurance programmes and overseeing health technology assessment.[3]

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While the need for a more streamlined approach to delivering healthcare services was clearly evident, the HSE has been the focus of much dissatisfaction. It has been widely criticised for being too concerned with its own structures and centralised methods of working and for not engaging with those who experience the challenges of running the health service on a daily basis.[6] Where enhanced patient care was a core objective of health strategies, it is felt that such improvement has been only in high profile areas, such as cancer care and the private sector. Other critical issues of hospital overcrowding and community services are being overlooked.[7] The economic context notwithstanding, the HSE's lack of partnership and willingness to harness the experience and expertise that is found at the front line has been detrimental. This was witnessed in the implementation of revised working practices and cost-effectiveness measures. Such unilateral action, particularly where the National Service Plan 2009[8] is concerned, is widely regarded as being unaware of the realities of providing safe and efficient patient care. It has resulted in numerous industrial relations issues, some requiring the involvement of the Labour and High Courts for resolution.

Despite an attempt to clearly delineate the roles and responsibilities of the DoHC and the HSE, there remain grey areas, and of particular concern are budgetary issues. No single agency is accountable for ensuring efficient use of resources,[5] which is critical for managing the health service effectively, especially in the current economic climate. Although this 'managerial vacuum' was identified by the Brennan Report, action based on its recommendations has been nominal and remains controversial.

Recently, however, almost reneging on their stance for the past five years, the HSE has announced that it is to make "significant changes to its organisational structure", reflecting the need to bring decision-making closer to where the service is delivered.[9] This restructuring involves establishing four regional teams and an integrated services directorate accountable to HSE headquarters. Regional teams will be responsible for identifying and setting performance targets, and budgets needed to achieve these will be allocated by the Government. The difficult questions that now need to be answered are whether this will actually be an effective method of resolving current problems or are the issues more complex than simply organisational. Also, it is most important to consider whether this restructuring will be effectively conducted in a budget-neutral fashion.

The Hanly Report

The National Task Force on Medical Staffing was created to introduce the 48-hour working week for non-consultant hospital doctors (NCHDs) by 2009. This was in accordance with the requirements of the European Working Time Directive (EWTD).[3] However, it was also charged with "devising, costing and promoting implementation of a new model of hospital service delivery based on appropriately trained doctors providing patients with the highest quality service, using available resources as equitably, efficiently and effectively as possible".[10]

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The report recommended re-orientation, thereby introducing a "consultant-provided" service as opposed to the existing "consultant-led" system.[10] This would result in a reduction of NCHDs' working hours and attain the goal of complying with the EWTD. This re-orientation would require both the re-organisation of the hospital, and a review of medical education and training, while being sensitive to industrial relations issues. Somewhat unbelievably, the cost of such extensive restructuring was never considered.[3] Unfortunately, implementation of these proposals has been marred by controversy and industrial relations difficulties. It is further complicated by the fact that these recommendations were made at a time of relative economic prosperity. Consultant-provided care necessitates significant changes in existing consultant work practices. These include increased availability, longer working hours, shared consultant management and facilitating efficient treatment with shorter in-patient stays. The negotiation of an acceptable contract for all parties has been lengthy, with an agreement on a revised Common Contract only being accepted in June 2008. In addition, despite many consultants adapting to the new regulations, the HSE has been reluctant to honour its own commitments.[6] These commitments concern both remuneration and identifying issues that continue to hinder optimum implementation of the new contract. While the Minister for Health and Children, Mary Harney TD, has categorically stated that the contract should be, and will be, honoured, this remains to be seen.

As previously mentioned, the "consultant-provided" service was initially proposed to combat the "excessively long working hours" of the majority of NCHDs. It was also considered to be the only solution that would simultaneously address the need "to improve patient care, reform medical education and training, and support the continued provision of safe, high quality, acute hospital care".[10] While this may be a worthwhile endeavour, failure to acknowledge the very different roles of consultants and NCHDS, particularly interns, means that the reality has been very different.

Negotiations for a new NCHD contract reached an abrupt halt following the announcement in November 2008 that NCHDs would bear the brunt of further and immediate cutbacks beyond those already implemented earlier that year. While additional cuts are inevitable in the current economic climate, NCHDs would bear nearly 50% of the HSE's proposed cost-saving measures across the health system.[6] These cuts included curtailment of allowances and training grants, along with significant reductions in payments for overtime and on-call, which represented up to a 40% decrease in potential income.[6] Not only did this conflict with their contractual terms and conditions, it also interfered with the development of their careers in medicine. Reducing the working hours of junior doctors, without increasing their numbers in the hospitals, ultimately impacts the quality of care these junior doctors are capable of providing. This is not only in terms of hours dedicated to patient care and hospital duties but, equally, in training hours necessary to improve clinical knowledge and skill.

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The response from NCHDs was unanimous. A ballot conducted by the Irish Medical Organisation (IMO) in favour of industrial action passed with 99% support. Legal action for breach of contract was taken against the HSE to the High Court in April 2009. A new agreement stipulated that all NCHD terms and conditions of employment were to be honoured and remunerated in full by the HSE with immediate effect. This agreement also provided a platform for negotiations about implementation of the EWTD, during which terms and conditions of existing contracts were not to be altered by the HSE.[11] Members of the IMO voted in favour of the Labour Court's recommendations on the implementation of the EWTD in June 2009.[12] The next phase of discussions took place in September with the aim of reaching an agreement in time to implement a new contract by 2010.The IMO's NCHD committee has reiterated that "all new working arrangements must prioritise patient safety, training for NCHDs, and health and safety issues". Junior doctors, however, remain wary, considering the HSE's attitude towards the value of other healthcare professionals.

Patients

The wide-ranging incomes of citizens, coupled with a multitude of public, private and combined health plans and entitlements, makes it difficult to ensure equitable and fair access to healthcare. During the years of economic growth, Irish citizens benefited from many subsidised schemes. For example, the medical card scheme gave holders access to a range of health services free of charge. In 2001, this scheme was extended to include all those over the age of 70

regardless of financial status. A similar scheme was introduced offering free GP consultations to GP Visit Card holders. Under the Drugs Payment Scheme as of January 2009, non-Medical Card holders and families are only required to pay a maximum of €100 per calendar month for prescription medicines, while the balance is reimbursed by the Government. Attempts were made to reduce waiting lists by introducing the National Treatment Purchase Fund (NTPF) in 2002. Under this programme, any adult waiting one year or more (or any child waiting six months or more) for treatment can have that treatment in a private facility or abroad at the expense of the Fund.[3]

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However, there are serious concerns about the equality of healthcare provision in Ireland and its accessibility for the non-cardholding Irish taxpayer. A survey conducted by the Central Statistics Office in 2008 showed an increase of 9.1% in the previous year in doctors' fees and a similar increase in the cost of other medical services.[13] An independent nationwide survey conducted in 2007 also showed that over half the population (55%) had put off, and over one-third (36%) had delayed, routine medical check-ups because of the cost.[13] Furthermore, research on the utilisation of GP services showed that those with medical cards, despite controlling for a range of socio-economic variables, have an average of 1.6 more visits each year compared to those with similar characteristics and no medical card.[3]

Of more concern is that this research was conducted before the 2008 budget, a budget that increased upfront accident and emergency and outpatient fees, as well as a 10% increase in in-patient admission charges.[14] The budget also called for a review of the eligibility criteria for medical cards and removal of the automatic entitlement at age 70, a move that caused an outspoken public rebuke.

With increasing unemployment and economic deterioration, the physical and mental health of our population is certainly under pressure. While prevention may be the best medicine, the rising cost of healthcare in these difficult economic times will make households less likely to spend money on preventive health, which can seem like an intangible expense.

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