Submission to Oireachtas Committee on the Future of Healthcare

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Executive summary

Age Action, as Ireland's leading advocacy organisation for older people, welcomes the establishment of the Oireachtas Committee on the Future of Healthcare. The development of a 10 year plan is an important opportunity to end the two-tier health system and move Ireland towards a universal integrated health and social care system based on need and not on ability to pay.

As a member of the Health Reform Alliance, Age Action supports the submission made by the Alliance to this consultation. Our own submission comments on issues of particular relevance to older people.

A comprehensive, universal health and social care system, which provides the right care, in the right place, at the right time, is essential for the health and well-being of all, but particularly older people as the main users of our healthcare system.

In this submission we outline priorities for the 10 year plan including the development of comprehensive primary and community care services with integrated pathways to allow people to transition seamlessly between acute, primary and social care.

We also highlight the need to address the factors leading to the long delays in accessing services, and seek to improve the wellbeing of the population by advocating a Health in All Policies approach towards the development of health policy.

To achieve this, we believe that it is important to change the operating assumptions on which our heath services are based; reform the acute care system and how funding is allocated; and address gaps in the skill-mix required to meet future needs.

We suggest a number of actions in planning for the ageing population, including the introduction of a statutory entitlement to home care, to ensure the services required are funded to meet need.

The steps required to move to an integrated care model are outlined and the barriers identified and we comment on the funding model best suited to Ireland.

Recommendations

- Move from current 'deficit model' on which health policy and services are based, to an asset based approach, which focuses on resources and services that promote the self-esteem and coping abilities of individuals and communities at a local level[1]. Within this model, early intervention and self management are prioritised and resourced, delivering care in the community and reducing pressure on hospitals.
- Develop population-based (needs-based) funding to assist with planning and ensure equity. A number of formulae can be used and could include factors such as demographics like age and sex, socio-economic status, population distribution[2].
- Over the next five years, enable a move away from acute care services to primary and social care services through the provision of ring fenced funding for the development of comprehensive services in the community.
- Provide a statutory basis for the allocation of home care. Entitlement will ensures public bodies develop, fund, plan and make available comprehensive services to support independent living.
- Expand the chronic disease management programme to cover more conditions and make the programmes available in every Primary Care Centre.
- Review the current skill-mix within the healthcare system. Raise the status of hands-on caring as a profession to ensure quality and the skills needed for the future.
- To ensure patient flow through acute hospitals and tackle long waiting lists, implement the changes proposed in the various emergency task force reports[3] [4]. Address delayed discharges by providing people with the care and support they need in the appropriate setting, creating an extra 100,000 bed days per year in the major Dublin acute hospitals[5].
- To maintain health and well-being, establish a process to actively engage with all government departments to address the wider determinants of health.
- To progress a model of integrated healthcare:
    - Consult with all stakeholders and create a shared vision of an integrated health and social care system.
    - Set up integrated health and social care teams led by a coordinator in each CHO area.

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[1] http://www.gcph.co.uk/assets/0000/2627/GCPH_Briefing_Paper_CS9web.pdf
[2] http://www.biomedcentral.com/content/pdf/1472-6963-13-470.pdfErin
[3] *health.gov.ie/wp.../Draft-ED-Task-Force-Report-020415-0914-FINAL-COPY.docx*
[4] http://www.lenus.ie/hse/bitstream/10147/43524/1/3468.pdf
[5] ibid

- Implement funding mechanisms that allow flexibility for pooling funding such as money follows the patient from hospital to the community.

1. Introduction

Age Action was established in 1992 as the voice for older people and Ireland's leading advocacy organisation on ageing issues. Our mission is to empower all older people to live full lives as actively engaged citizens and to secure their rights to comprehensive high quality services according to their changing needs.

Older people's quality of life depends on a comprehensive, universal health and social care system, which provides the right care, in the right place, at the right time. We welcome the opportunity to respond to the committee's consultation on the Future of Healthcare.

2. Strategy

2.1 What are the key priorities for inclusion in a ten year plan for health services?

The role of the committee is to plan for 'a universal single tier service'. We believe key priorities for advancing this strategy are

1. The development of a comprehensive, universal primary and community care system where people can access preventative, rehabilitative, medical and social care services in a timely manner based on need and not ability to pay.
2. Our health system is not working efficiently or effectively. Waiting times for potentially lifesaving tests and procedures are lengthy with public patients waiting up to 25 times longer than those paying privately for tests for cancer[6]. A key priority must be to address the factors leading to the long delays for out-patient appointments, diagnostics and in-patient procedures. Delayed discharges contribute to high cancellation rates of scheduled procedures and adversely affect acute hospitals' abilities to provide their services efficiently[7].
3. Develop integrated pathways between the primary, secondary and social care systems to ensure care is coordinated around the person and resources are used to meet the needs of the individual. This will entail putting into place of funding mechanisms that enable the transfer of funds between care sectors and/or ring-fenced funding for integrated pathways.
4. Ensure the 10 year plan incorporates a Health in All Policies approach, where public policies across all sectors take into account the health implications of decisions. This will ensure critical decisions made by government departments will be subjected to health impact assessments, addressing the determinants of health, ensuring improved health outcomes.

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[6] http://www.cancer.ie/sites/default/files/content-attachments/icgp_irish_cancer_society_report_-_access_to_diagnostics_to_detect_cancer.pdf.

[7] http://arrow.dit.ie/cgi/viewcontent.cgi?article=1031&context=buschmanart

2.2 The key challenges to achieving a "universal single tier health service"

a. Changing the operating assumptions on which heath services are based

The current 'deficit' approach, based on problem oriented care, pays little attention to the individual's experience, preferences and knowledge. Instead the focus is on professional knowledge and interventions on behalf of the individual.

This approach is not effective as it 'rations' care to those most in need (e.g. those at risk and emergencies). Treating people further along in their illness, rather than taking preventative or early intervention, is more costly, with implications for the sustainability of this approach.

b. Structural reform of the acute care system

The current acute medical model presupposes that the main task is treatment and cure. However 66 per cent of emergency admissions are exacerbations of chronic disease[8]. Hospital medical specialities are designed around single organ diseases, yet 64.8 per cent of people aged 65 years and over live with multi-morbidity. Patients with multiple long-term conditions are now the norm and this will increase by over 50 per cent in the next 10 years[9]. The challenge is to move away from this high-cost, reactive, acute bed-based care to preventative, proactive and integrated care based close to people's communities, focusing on managing chronic illness and maintaining health and well-being.

c. Funding is allocated based on service users' needs.

Currently, allocation of funding is biased towards acute care, with less funding allocated to primary and social care. For example in 2016, out of a total budget of €12.89 billion, social care services for older people will receive €703 million, less than 6 per cent of the total healthcare budget[10]. Funding is not related to defined populations and their projected needs. Between 2009 and 2015, the healthcare budget fell by over 21 per cent even though the number of people aged 65 and over increased by 9 per cent[11].

[8] http://tilda.tcd.ie/assets/pdf/glossy/Tilda_Master_First_Findings_Report.pdf
[9] Ibid
[10] https://www.hse.ie/eng/services/publications/serviceplans/nsp16.pdf
[11] https://www.hse.ie/eng/services/publications/planningforhealth.pdf

Since 2014, block grant funding of hospitals is being replaced gradually by Activity-Based Funding (ABF) (formerly Money Follows the Patient) with payment now based on episodes[12].This is not conducive to addressing the complex care needs of older people.

The challenge therefore is to implement a pathway mechanism where 'Money Follows the Patient' from the acute hospital to the community to meet need and to facilitate the timely provision of home care packages. Acute hospital beds are among the most expensive resources in the entire healthcare system, costing up to €850 a night[13].

The current HSE target for delayed discharges is 500 people per month. Hence, approximately €425,000 per day of the acute hospital budget is being spent on keeping people in acute care beds. In many instances people are waiting for community supports like Home Care Packages (HCPs). At the end of March 2016, 1,436 people were waiting for HCPs.

d. A workforce with the right skills to meet diverse needs.

The current professional workforce was trained and developed to work around single episodes of treatment in hospital. The greatest demand on services now and in the future is to meet the care and support needs of people with multi-morbidities requiring health and social care. The present skill-mix does not meet these needs. Older people in hospital cannot get assistance with eating; there is difficulty recruiting formal home care staff; home helps cannot shop or prepare a hot meal for a housebound person.

An NHS briefing paper[14]identified the need to realign training budgets and career pathways. Approximately 60 per cent of the NHS training budget is spent on the higher paid health professionals (doctors, nurses and allied health professionals), with no national funding for training less qualified workers such as healthcare assistants, despite the fact that biggest growth in need will be in hands-on, out-of-hospital, and social care[15].

[12] http://health.gov.ie/wp-content/uploads/2015/07/ABF_Implementation_Plan_20_05_2015.pdf.
[13] http://arrow.dit.ie/cgi/viewcontent.cgi?article=1031&context=buschmanart
[14] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/perspectives-nhs-social-care-workforce-jul13.pdf
[15] ibid

2.3 Actions needed to plan for, and take account of, future demographic pressures and their impact on the health system

Over the next 30 years, the number of people aged over 65 is projected to double from 624,183 in 2016 to over 1.4 million in 2046. The very old population (those aged 85 and over) is projected to quadruple from 69,873 in 2016 to 266,900 in 2046[16].

Whilst the vast majority of older people are fit and healthy, approximately 15 per cent have health problems which affect their ability to live full, active, lives in their communities. A further group, approximately 5 per cent, are very frail and dependent[17]. Chronic illnesses like diabetes and cardiovascular diseases affect 8 out of 10 people aged over 65 in Europe. Ninety per cent of our total healthcare costs are spent on 30 per cent of our population with chronic disease[18]. Older age is associated with an increase in multiple long-term conditions and frailty. The percentage of the population aged 85 and over who have a disability is estimated to be 72.3 per cent[19].

People aged 65 and over are major users of the acute hospital care. In 2014, 12.7 per cent of the population consisted of people aged 65 and over, yet 53.3 per cent of total hospital in-patient bed days and approximately 36 per cent of day case and same day bed-days were used by this cohort[20].

The following actions are required to ensure that the health system meets the needs of an older population.

a. Provide a statutory right to home care

With increasing age, demand for long-term care and support will grow. Approximately 10-11 per cent of people aged 65 years and over in Ireland require some form of home care[21]. It is very difficult to access home care and support. Provision of these services is discretionary and there is a lack of transparency in the allocation of hours. Being able to access this vital support is dependent on the resources available at a given time and in a particular area[22].

[16] http://www.cso.ie/en/media/csoie/releasespublications/documents/population/2013/poplabfor2016_2046.pdf
[17] http://www.atlanticphilanthropies.org/app/uploads/2015/09/new-ageing-agenda-report.pdf
[18] https://www.hse.ie/eng/services/publications/planningforhealth.pdf
[19] http://www.cso.ie/en/media/csoie/census/documents/census2011profile8/Profile,8,commentary.pdf
[20] https://www.hse.ie/eng/services/publications/planningforhealth.pdf
[21] https://www.hse.ie/eng/services/publications/planningforhealth.pdf
[22] https://www.ageaction.ie/sites/default/files/aa2c_asi2c_iasw_final_research_report-a4-report_lr_for_web_2.pdf

A statutory entitlement to home care is essential if the service is to attract ring-fenced funding and to meet the needs and preferences of older people. Without certainty in the allocation of homecare, an increasing number of people with low to moderate level of dependency will have no choice but to go into long-term residential care, with a substantial cost to the State, estimated to be €1.234 billion in 2021[23] [24].

b. Provide care that is coordinated around the full range of the person's needs and prioritise prevention and support to maintain independence

A paper from the Kings Fund, 'Making Health and Care Systems fit for an Ageing Population' outlines the many components of care relevant to older people and how the quality, capacity and responsiveness of any one will affect others[25].

The key components include support to live well for those with stable long-term conditions, but also for those with complex co-morbidity, dementia and frailty; rapid support close to home in crisis; good acute care; access to community rehabilitation and enablement after acute illness or injury to maintain independence.

To provide these types of support, multi-disciplinary teams including physical and mental health, social care, public health and the wider public, private and voluntary sectors are required to work together to deliver person-centred care within the community.

The remit of community intervention teams could be expanded to include the provision of Hospital at Home services to people who would otherwise be admitted to acute hospital. There is evidence to show this is effective and there is a high rate of patient satisfactions[26].

Rapid access clinics or 'chair based' geriatric clinics in Primary Care Centres provide effective interventions for those experiencing an exacerbation of a chronic illness or deterioration in health or function[27]. Specialist care units such as stroke units have consistently been shown to save lives

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[23] https://www.hse.ie/eng/services/publications/serviceplans/nsp16.pdf

[24] cost of 25 HCP hours for 3,414 people = 3,414 x €27,300 (€525 per week)= €93.2 million. Cost of NHSS for 3,414 people= 3,414 x €46,176 (NHSS bed per annum)= €157.6 million

[25] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf

[26] http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007491/pdf

[27] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/the-care-of-frail-older-people-with-complex-needs-mar-2012.pdf

and improve outcomes[28] . Geriatric 'in-reach' assessments and consultations for frail older people under other medical and surgical specialties have also been shown to improve clinical effectiveness and efficiency[29].

Managing frailty is a key issue for modern health and social care services. A holistic approach, seeing the whole person in terms of their medical and psychosocial needs, is critical. Early identification of individuals who are frail, providing them with comprehensive geriatric assessment, taking a case management approach in coordinating care, and preventing avoidable disability is essential in managing any deterioration[30].

To prevent admissions to hospitals and nursing homes, and maximise independence follow an acute admission or illness, investment in services such as re-ablement programmes is required[31].

c. Mandatory inclusion of modules addressing ageism and competence in working with older people in all professional education and training.

The vast majority of professionals working in the health and social care field will engage with older people in the context of their work. It is therefore essential that they are competent to help people cope with physical and mental decline and treat their clients with dignity and respect.

3. Integrated Primary and Community Care

3.1 The steps needed to move towards a model based on integrated primary, secondary and community health care.

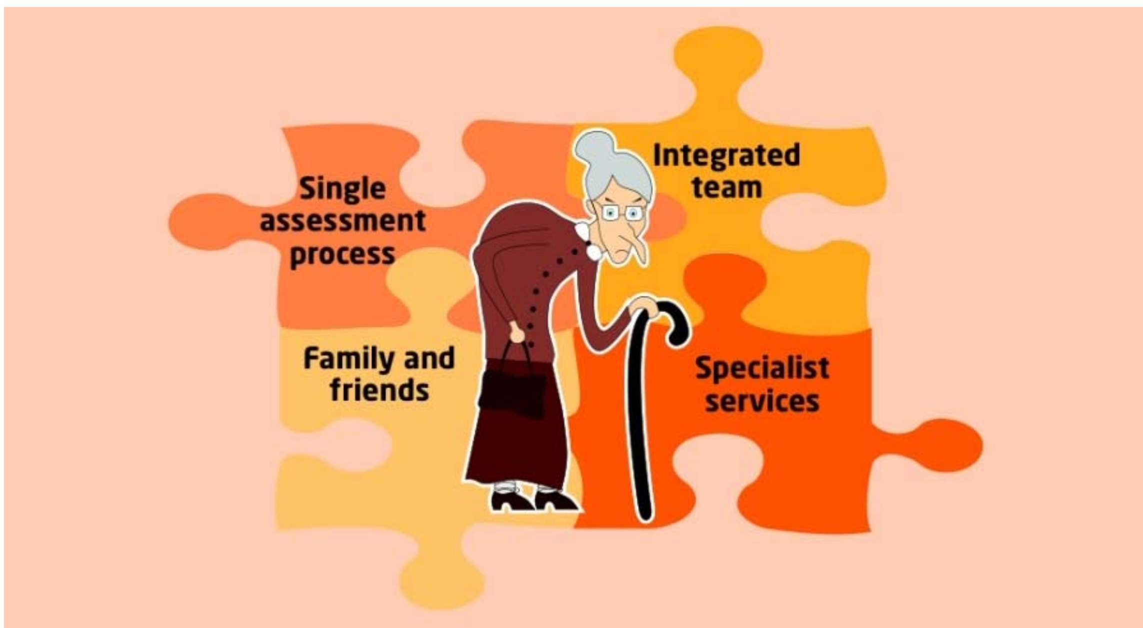
Presently older people experience the health and care system as illustrated by Mrs Smith's experience here[32].

[28]Chan et al, 2013)
[29] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/the-care-of-frail-older-people-with-complex-needs-mar-2012.pdf
[30] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/the-care-of-frail-older-people-with-complex-needs-mar-2012.pdf
[31] http://www.ifa-copenhagen-summit.com/wp-content/uploads/2016/04/Copenhagen-Summit-Final-Report.pdf
[32] http://www.kingsfund.org.uk/sites/files/kf/integrating-health-social-care-torbay-case-study-kings-fund-march-2011.pdf

Mrs Smith's experience of navigating through the health and social care system

Integrated care will improve people's experience and outcomes of care, and deliver greater efficiencies[33].

Outcome for Mrs Smith of an integrated health and social care system



To achieve this integrated model of care requires action at multiple levels and includes:

- Bring on board all stakeholders through participative consultation and create a shared vision for an integrated health system;
- Set up integrated health and social care teams;

[33] http://www.kingsfund.org.uk/sites/files/kf/integrating-health-social-care-torbay-case-study-kings-fund-march-2011.pdf

- Pool health and social budgets. Savings made through eliminating duplicate services such as assessments could facilitate a wider range of services;
- The appointment of a health and social care coordinator proved crucial to the success of an integrated health and social care model in Torbay[34]. The coordinator facilitated good communications, the building of relationships and trust and harnessed contributions from all of the team members;
- Establishing information sharing processes.

3.2 What are the key barriers to achieving this, and how might they be addressed?

- The different value systems that underpin professional disciplines;
- Lack of a joint working approach between secondary services and primary care services;
- The operation of Primary Care teams:
    - The public/private mix within Primary Care Teams. GP engagement with Primary Care Team has costs for the GP, so the level of participation depends on the individual GP. On the other hand, the public nurse and allied professionals are public servants.
    - Inconsistency in the make up of the Primary Care Team e.g. social workers are not part of some teams.
    - Teams are not resourced properly so access to therapies such as physiotherapy and occupational therapy is inadequate, resulting in lengthy waiting times of 12 weeks or more for assessment and therapy[35].
    - The inconsistency in service provision, types of services available and eligibility criteria.
    - Lack of comprehensive primary care services outside normal working hours.
    - Absence of case management approach for people with complex needs.

To address these barriers

- Implement collaborative working practices and shared decision-making ensuring stakeholders work together as a team, in the interest of the patient and the common good, and not in the interest of preserving professional roles and practices.
- Medical and psycho-social needs are accorded equal importance.
- Appointment of a coordinator for each Primary Care Team.

[34]http://www.kingsfund.org.uk/sites/files/kf/integrating-health-social-care-torbay-case-study-kings-fund-march-2011.pdf
[35] HSE National Performance Assurance Report December 2014

- Extend GP practice operating hours within Primary Care Centres to weekends and evenings through a rota system between practices within the centres. Ensuring access to patient history will be important.
- Introduce community case management for people with more complex needs.
- Extend the 'money follows the patient' approach from the hospital to the community.
- Resource Information and Communication Technology and establish information sharing pathways.

3.4 In your experience, what are the key roadblocks you encounter in your particular area of the health service?

Older people are the group most likely to suffer problems with co-ordination of care and transitions between services. An integrated healthcare model is crucial to enable them live independently in the community and to halt premature admission to nursing homes. Key road blocks for older people are:

- Excessively long waits for procedures particularly salient to people aged 65 and over such as minor eye surgery and orthopedic surgery, which have consequences for older people's independence, resulting in premature admission to long-term care.
- The discretionary nature in the allocation of home care, coupled with inconsistency in service delivery across the country acts as a road block to older people remaining in their own homes for longer[36]. Ten days in bed due to a delayed discharged can lead to a significant reduction in leg and hip muscle strength and in aerobic capacity even in healthy older adults[37].

3.5 How would you ensure buy-in from health care professionals to progress towards an integrated health care model?

Through consultation and creating a shared understanding of what an integrated care model will look like and how it can improve service users' experiences. For example, the Torbay integrated health and social care model used a consultation process, starting with frontline staff. Through this consultation process, a vision of what an integrated model of care would look like was created. At the centre of this vision was the story of Mrs Smith, a fictitious user of health and social care services. Building a shared understanding of the changes need and the positive outcome for Mrs Smith ensured but-in from all stakeholders including managers, clinicians, frontline and administration staff.

[36] https://www.ageaction.ie/sites/default/files/aa2c_asi2c_iasw_final_research_report-a4-report_lr_for_web_2.pdf
[37] http://www.ncbi.nlm.nih.gov/pubmed/17456818

3.6 Are there any examples of best practice that the Committee should consider?

The Torbay Model[38] provides a good example of the process undertaken to integrate health and social care for older people. Much of the work of the King's Fund in the UK focuses on models of integrated care to meet the needs of the changing population using case studies[39].

4. Funding Model

4.1 Do you have any views on which health service funding model would be best suited to Ireland?

Age Action believe that a general tax funded health system is the most effective and financially sustainable way to provide universal access to health and social care based on need and not ability to pay[40].

4.2 Please outline the specifics of the financing, payment methods and service delivery (purchaser and provider) of the model you are advocating.

A tax funded system effectively pools health risk across a large contributing population as individuals contribute to the provision of health services through taxes on income, property, capital gains and activities such as alcohol consumption and gambling. Payment is mandatory, and risk is spread as contributions are not related to the individual's likelihood of needing or using health services.

However, financing of the health system is dependent on the efficiency of the taxation model and will depend on the effectiveness of the tax system to raise funds.

4.3 What are the main entitlements that patients will be provided under your funding model?

Universal healthcare should cover preventative, curative, rehabilitation, social and long-term nursing care services along with medical goods.

4.4 Please provide examples of best practice, or estimated costs of such models if available.

Comparative studies have examined models used in different countries for the financing healthcare[41] [42]. Whilst these studies give some insight into the costs, universality in terms of coverage and cost varies.

[38] http://www.kingsfund.org.uk/sites/files/kf/integrating-health-social-care-torbay-case-study-kings-fund-march-2011.pdf
[39] http://www.kingsfund.org.uk/topics/integrated-care/integrated-care-map
[40] https://www.esri.ie/pubs/BP201701.pdf
[41] http://www.who.int/health_financing/taxed_based_financing_dp_04_4.pdf

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[42] http://www.commonwealthfund.org/~/media/files/publications/fund-report/2016/jan/1857_mossialos_intl_profiles_2015_v7.pdf