



**IRISH HEART
FOUNDATION**
Fighting Heart Disease & Stroke

Irish Heart Foundation

**Submission to Oireachtas Committee on
the Future of Healthcare**

August 2016





About the Irish Heart Foundation

The Irish Heart Foundation is the national charity dedicated to fighting heart disease and stroke. Today in Ireland more people die from heart and stroke-related illnesses than from any other cause of death. Against this background we work to bring hope, relief and a better future to families all over Ireland. We give vital patient support through our Heart & Stroke helpline and we provide high quality public information for all.

We support pioneering medical research, campaign for improved patient care, and promote positive public health strategies. We work in hospitals, schools and workplaces to support, educate and train people to save lives. As a charity we are dependent on the generosity of the public to continue our vital good work. You can fund our work by making a donation, give of your time to volunteer or learn the skills needed to save a life through our courses.

SUBMISSION TO OIREACHTAS COMMITTEE

Future models of healthcare in Ireland

August 2016

Executive summary

The Irish Heart Foundation (IHF) welcomes the establishment of the Oireachtas Committee on the Future of Healthcare to support the Oireachtas adopting a 10-year plan for healthcare. The development of a 10-year plan is an important opportunity to end the two-tier health system and move Ireland towards a health and social care system based on need and not on ability to pay.

The IHF is a founding member of the Health Reform Alliance. Alliance members share a common belief that reform is needed to create a more equitable system. We have developed a consensus on the five principles¹ to underpin reform. The IHF supports the submission made by the Alliance to this consultation. While all patients would be better served by a universal system, which reflected the HRA principles, this submission comments on issues of particular relevance to people with cardiovascular disease (CVD).

As a patient organisation our only interest is in the outcome and experience of patients using the health and social care system. Many CVD patients use medical, rehabilitation and social care services concurrently. Currently, different cost structures for different elements of care lead to complicated patterns of use and unintended interactions between different elements of the system, for example between primary and hospital care.² If the objective is to achieve equitable access determined by need, then complex eligibility criteria must be avoided in the future system.

Summary of issues addressed in this submission

- Chronic disease management, which will be the primary task of the system, requires integration of health and social care.
- It is essential to review the gaps in current chronic disease service provision and develop these services. In particular, develop a network of step-down, social care and community services adequate to meet demand.
- The primary task for reform is to define the system of universal access and define what services will be provided. The financing system is secondary to the objective of delivering universal access but is an important tool to develop integrated services.

Recommendations

- Begin by focussing on the outcome to be achieved - the healthcare system to be delivered by 2026 and the level of universality which the system will deliver. The financing system is secondary to the objective of universality.
- There is a need to fully articulate the vision for healthcare to the public who will be the users and the payees for the system. To achieve public buy-in at an early stage for reform, the Oireachtas should clearly set out the reasons why the final selected model of universality and funding best fits Irish needs and its advantages over alternative approaches.
- Protect the health budget in the short term and return to pre-crisis funding in the medium term.
- Assess the cost of introducing health reform and set aside a reasonable set-up budget.³
- Prioritise integrated care to ensure proper management of chronic diseases, including CVD, as chronic diseases will increasingly be the main focus of the system. The system of chronic disease management must be carefully designed, with reference to patient needs and to a system of financing which will support integrated care.
- Review gaps (including geographical and by population) in current service provision and develop these services. In particular, develop a network of step-down, social care and community services adequate to meet demand. Continue the focus on reducing the waiting lists to access community and acute services. Rehabilitation is an important service for patients following a stroke or a cardiac event and the IHF would welcome universal access to these services, which are currently under-funded or unavailable in many parts of the country.
- Include a strong patient advocacy element in the reform programme to ensure all reforms focus on the quality of care.
- Ensure regulators (HIQA, Patient Safety Agency, etc.) are properly resourced and provide quality standards for the full range of care.
- Use existing and forthcoming research on the Irish health and social care system, particularly the Economic and Social Research Institute's (ESRI) health systems research and Trinity College Dublin's 'Mapping the Pathways to Universal Health Care in Ireland' project.

Cardiovascular disease and the current health system

Recent developments in healthcare treatments and our ageing population mean that healthcare provision now primarily focuses on the management of chronic diseases and particularly on older patients with a combination of chronic diseases. It is essential that the reformed system is built around a proper system of chronic disease management. The IHF is primarily concerned with how the CVD patients we represent, many of whom have multiple care needs, will be served by the reformed system.

Between 1985 and 2000, deaths from CVD in Ireland almost halved, with 44% of the reduction attributed to more effective treatment and a greater impact from improvements in population-level risk factors.⁴ However, the prevalence of CVD risk factors continues to change, including obesity rates. The Institute of Public Health has estimated that due to the ageing population and increases in population overall there will be considerable increases in CVD by 2020.⁵ Further, as life expectancy increases, people are living longer with CVD, requiring community-based care and supports.

The OECD (2015)⁶ has identified a number of significant challenges for countries seeking to reduce CVD: rising levels of CVD risk factors, including obesity; delays in diagnoses of CVD risk factors; lack of adherence to treatment; ageing population leading to more complex health needs; and gaps in timely access to specialised care. All of these challenges are apparent within the Irish system. In Ireland, the Expert Group on Resource Allocation for the Health Sector⁷ outlined the conditions required to establish integrated care for chronic diseases in Ireland, including: formal links [which would likely include formal financing mechanisms] between the primary care system and wider healthcare system; primary care would be seen as a core component of healthcare, rather than as a parallel system to hospital care; primary care would become the centre of chronic disease management, with patients only engaging with hospital for short periods as required; and patients would be incentivised (through free primary care at the point of access) to default to primary care for their health needs. For cardiovascular patients, the *National Cardiovascular Health Policy*⁸ makes a number of recommendations in relation to chronic disease management, including the requirements for primary care, the need for implementation of the ESC Clinical Practice Guidelines, information systems, audit and development of cardiac rehabilitation.

Experience of stroke survivors to illustrate issues experienced by CVD patients in current system

This section briefly outlines how stroke survivors currently fare in accessing essential medical, rehabilitation and ongoing care services. Their experience are likely to be similar to other patients with chronic diseases.

In the acute setting many stroke patients are faced with under-resourced acute stroke services. The 2015 national audit of stroke services⁹ shows that only 29% of stroke patients are admitted to a stroke unit and almost half do not receive any treatment in a unit during their hospital stay. Nearly a quarter of hospitals providing acute care do not meet minimum organisational standards and three of these do not have any of the infrastructure in place required for a stroke unit. In addition, there are staffing deficits of 50% for physiotherapists, 61% for occupational therapists and 31% for speech and language therapists, whilst only 44% of hospitals have any access to a medical social worker and 19% have access to a neuropsychologist.

Rehabilitation after stroke is insufficient for the vast majority of patients, resulting in disability that is unduly severe or prolonged for many people trying to rebuild their lives after stroke. The 2014 Stroke Rehabilitation in Ireland report¹⁰ conducted for the IHF and HSE found poor resourcing of inpatient and community rehabilitation for stroke survivors in Ireland. There is great variability in the availability of therapy staff and the intensity with which therapy is delivered across regions, hospitals and residential and community care settings. The report estimated that over half of all stroke survivors – more than 3,000 people a year – could benefit from Early Supported Discharge (ESD), a six week programme providing therapy in people's own homes rather than hospital. Such programmes represent a basic form of care internationally and would free up 24,000 bed days, resulting in annual net savings of from €2 to €7 million. Implementing ESD would require a substantial increase in the resourcing of community therapists, community nurses and other community care above current levels. However, savings from the reduced cost of acute bed days could fund this increase in resourcing.

When stroke patients leave hospital they are faced by a widespread dearth of vital services to support them to continue their recovery, including community rehab teams, homecare packages, housing adaptations and ongoing care. The *National Survey of Stroke Survivors*¹¹ conducted by the RCSI and IHF showed major deficits in community rehabilitation services to help survivors overcome the physical impact of stroke with just half having access to any speech and language therapy, or occupational therapy and one in three survivors who require physiotherapy getting none at all.

Consultation questions

1. Strategy

What are the key strategies for inclusion in a ten year plan for the health service?

The IHF recommends the Committee initially focuses on the content of the ‘universal single tier service’ to be achieved. The first step must be a clear definition of universality for the Irish system. To achieve a universal system for Ireland the plan should focus on: removing financial barriers to care through use of pooled funds; defining the services which will be financed by the fund and the breadth of coverage of the population; and defining the limits placed on out-of-pocket payments.¹² The funding model is the vehicle through which the universal system will be delivered.

What are the key challenges, in your view, to achieving a ‘universal single tier health service where patients are treated based on health need, rather than ability to pay’?

The key challenge will be to develop a definition of universality for the Irish system. The WHO framework¹³ defines universality in terms of three dimensions – population coverage, service coverage and cost coverage (proportion of costs covered) – and is rooted in the use of pre-paid pooled funds to remove barriers to care at point of access. Reflecting the position of the Health Reform Alliance, we consider that the services covered should include curative, rehabilitative, long-term nursing, ancillary and prevention services as well as medical goods. The services should be free at the point of access, of good quality and measured against agreed quality indicators.

What actions are needed to plan for, and take account of, future demographic pressures (population growth, ageing population), and their impact on the health system?

In order to meet the needs of our ageing population and the number of people living with CVD and other chronic diseases, social care must be integrated with the health system so that people can be treated in the most appropriate setting.

Reform of the health system should put health promotion and prevention of CVD and chronic disease at its core. The 10-year plan should incorporate targets for health status, risk factors, mortality, morbidity and increases in healthy life years.

Commit to addressing health inequities as part of the Committee’s 10-year plan. Currently, there is no reference to reducing health inequities within the Committee’s terms of reference. Reducing health inequities should be a major target of the 10-year plan. Poverty directly effects health, reduces access to healthcare services and makes it harder for people with low incomes to lead healthy lives. As a result, people in the most deprived areas have

the lowest life expectancy (CSO, 2010).¹⁴ In relation to CVD, coronary heart disease is almost 2.5 times more prevalent and stroke 2.2 times more prevalent in the most deprived areas than in the least deprived areas.¹⁵

2. Integrated primary and community care

What steps are needed to move from the current model towards a model based on integrated primary, secondary and community health care?

Following years of policy commitments, primary care services need to be developed and resourced. Eligibility for primary care services should be universal.

The Adelaide Health Foundation's analysis on Integrated Healthcare¹⁶ makes a number of recommendations about how better integration may be achieved between different levels of the health and social care systems. Many of these recommendations particularly relate to the care of chronic diseases.

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

One of the major barriers to chronic disease care in the current system is the separation of the health and social care systems with entirely separate budgetary and decision-making processes. While health need is to some extent met in the public system, social care is primarily viewed as an individual responsibility subject to heavy means-testing. Access to social care systems is mixed with some services being free, some being charged for and some being means-tested. Consequently, vital social care services are increasingly available only to those with the highest needs and lowest incomes, rather than as a universal service supporting the whole population.

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

The fundamental building blocks of a primary care-led single tier system, community and continuing care, have significant gaps in their infrastructure.

In the current system a person's diagnosis often determines the financial support received for their care. For example, if you require rehabilitation after stroke, or social care supports for your dementia, this is not as available as medical care would be for other conditions, even though your need for care is equivalent. This is particularly the case for people whose disease requires social care input - such as home care packages - to stay well.

Further, people are treated differently depending on their insurance/medical card status. Patients going through the public system are often subjected to waiting lists and delays,

while those with greater resources and health insurance get faster treatment often on public hospital sites. As the medical card system has developed it has become a 'passport' required for people to access certain entitlements, including health (e.g. primary care therapists, public health nurse, etc.) and non-health services. A medical card gives access to many services which are unavailable to patients without a medical card, such as public health nurses. These services should be available to all those who have medical and/or income needs. This blockage can be overcome through provision of universal access to healthcare, as is envisaged by the Committee.

Access to social care supports (e.g. home-care packages, home help and meals on wheels) is subject to budget caps. This means that access to social care will depend on the resources that are available locally.

Receiving care in the community is the preference of most people and is also the stated policy of Government. The statutory provision of Fair Deal, in tandem with the 'discretionary' basis of home care supports, has inadvertently prioritised long term residential care over home and community care.

Cuts in funding have further restricted access to health services through the closure of hospital beds, longer waiting lists and reductions in frontline staff. Austerity has also led to significant increases in the charges patients must pay to access health and social care.¹⁷

There is a lack of data on quality measures and patient outcomes, which is vital to ensuring quality of care, monitoring costs and planning for future health needs. Patient registries which operate across all healthcare settings are required to ensure effective service planning and quality care for patients across the healthcare system. Given the volume of CVD patients in the system there is a pressing need for the establishment of either a combined CVD register, or separate registers for acute coronary syndrome, stroke and heart failure. The current stroke register in hospitals receives no dedicated funding and operates in about two-thirds of hospitals in addition to the official duties of overworked stroke care teams. Meanwhile national stroke services have recently been audited for just the second time ever. On both occasions the national audit could not have been undertaken without funding from the IHF.¹⁸

3. Funding model

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

A universal system free at the point of access paid for by all through pooled funds. All those using the system would contribute to costs through taxation or social insurance but would receive care free at the point of access. The ESRI's 2015 review of UHI¹⁹ estimated that 77% of healthcare expenditure came from general taxation in 2013; 9% from insurance and 12% from out-of-pocket payments.

Specifics of the financing, payment methods and service delivery (purchaser and provider) of the model you are advocating

The funding model must be progressive, based on ability to pay and the State, through transfers, must ensure that healthcare is affordable for low income groups.

The IHF would caution against the use or retention of co-payments within the reformed system. Equity in healthcare provision comes from the separation of payment from the receipt of care. Co-payments are a regressive form of financing and are damaging to health because they discourage necessary use by patients. Co-payments put the focus for overuse of care on the patient, rather than on the medical professionals, who should be in a position to properly apportion care according to medical need. Co-payments can also increase the administration costs of a system.

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

Design a system which responds to the health and social care needs of people with chronic disease. People with chronic conditions and older people need access to care, whether that care be for medical services, or care to live in their own home with dignity. In a society where we are increasingly called to care for people with multiple morbidities the differences in entitlement to health and social care services no longer appear appropriate, or fair.

We would advise that the mechanism used to define the services covered in the universal system be careful considered. The development of a 'health basket' is a just one approach which can be taken. Some argue that having a set package from the outset is a limiting approach which may not be responsive to patient's needs. For example, the NHS does not have a formalised 'basket' of care, instead the National Institute for Clinical Excellence (NICE) develops evidence-based practice guidelines to guide NHS service delivery.²⁰ Setting out a defined universal health basket would be a major exercise and would need to be continually updated to consider changing technology and evidence.

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The information provided in this publication was correct and accurate at the time of publication to the best of the Irish Heart Foundation's knowledge.

¹ The five key principles set out by the Health Reform Alliance for reform of our health and social care systems are:

1. The health and social care system treats everyone equally.
2. The health and social care system is focused on the needs of all social groups in society.
3. People have an entitlement to health and social care, free at the point of access.
4. The different elements of the health and social care system work together and are connected.
5. The health and social care system is a universal, publicly funded system.

² Smith, S. (2009) *Equity in Health Care: A view from the Irish health care system*. Dublin: The Adelaide Health Foundation.

³ The lack of set-up funding for health reform to date can be compared with the reported €180 million provided for the establishment of Irish Water (for example, see Irish Independent, 14 January 2016 <http://www.independent.ie/blog/irish-water-total-set-up-costs-will-be-180m-29916070.html>).

⁴ Bennett, K., Kabir, Z., Unal, B., Shelley, E., Critchley, J., Perry, I., Feely, J., Capewell, S. (2006). Explaining the recent decrease in coronary heart disease mortality rates in Ireland, 1985–2000. *Journal of Epidemiology and Community Health*, Vol 60, pp322-327. <http://jech.bmj.com/content/60/4/322.abstract>

⁵ For example see, Institute of Public Health (2012) 'Chronic Heart Disease Briefing'. http://www.publichealth.ie/sites/default/files/documents/files/CHD_Briefing_26_Jun_2012.pdf

⁶ OECD (2015) *Cardiovascular Disease and Diabetes: Policies for Better Health and Quality of Care*. Paris: OECD Health Policy Studies, Publishing. DOI: <http://dx.doi.org/10.1787/9789264233010-en>

⁷ Department of Health and Children and ESRI (2010) *Report of the Expert Group on Resource Allocation and Financing in the Health Sector*.

http://health.gov.ie/wpcontent/uploads/2014/03/resource_allocation_report_hiRes.pdf

⁸ Department of Health (2010) *Changing Cardiovascular Health - National Cardiovascular Health Policy 2010-19*. http://health.gov.ie/wp-content/uploads/2016/04/changing_cardiovascular_health.pdf

⁹ McElwaine, P., McCormack, J. and Harbison, J. on behalf of the National Stroke Programme Audit Steering Group. *Irish Heart Foundation/HSE National Stroke Audit 2015*. http://www.stroke.ie/media/pub/strokereports/ihf_hse_national_stroke_audit_2015__web_version.pdf

¹⁰ Wren *et al.* (2014) *Towards Earlier Discharge, Better Outcomes, Lower Cost: Stroke Rehabilitation in Ireland*. Dublin: ESRI / Irish Heart Foundation. https://www.esri.ie/publications/latest_publications/view/index.xml?id=4071

¹¹ Horgan, F., M. Walsh, R. Galvin, C. Macey and C. Loughnane (2014). *National Survey of Stroke Survivors 2013: Experiences and long-term needs reported by stroke survivors living in the community in Ireland*. Dublin, National Disability Authority/ Irish Heart Foundation.

¹² See WHO re movement to universal health coverage - WHO (2015) *Health System Financing - the path to universal coverage*. http://apps.who.int/iris/bitstream/10665/44371/1/9789241564021_eng.pdf

¹³ World Health Organisation - universal coverage - three dimensions. http://www.who.int/health_financing/strategy/dimensions/en/ (Accessed 23 August 2016).

¹⁴ Life expectancy is correlated with a person's social class, the affluence of the area in which they live and educational attainment. People with disabilities and carers also die younger, as do single persons and those who are widowed and divorced.

¹⁵ Balanda, K. *et al.* (2010). *Making Chronic Conditions Count: Hypertension, Stroke, Coronary Heart Disease and Diabetes*. Dublin: Institute of Public Health in Ireland.

¹⁶ Darker, C. (2014) 'Integrated healthcare in Ireland – a critical analysis and a way forward'. Dublin: Adelaide Health Foundation. <http://www.adelaide.ie/files/Integrated%20Healthcare%20in%20Ireland.pdf>

¹⁷ Thomas, S., *et al.* (2014) 'The Irish health-care system and austerity: sharing the pain'. *The Lancet*, 383 (3), 1545-6.

¹⁸ Irish Heart Foundation (2008) *National Audit of Stroke Care*. Dublin: Irish Heart Foundation https://www.irishheart.ie/media/pub/strokereports/ihf_stroke_audit_final.pdf and McElwaine, P.,

McCormack, J. and Harbison, J. on behalf of the National Stroke Programme Audit Steering Group. *Irish Heart Foundation/HSE National Stroke Audit 2015*.

¹⁹ Wren, M.A., Connolly, S. and Cunningham, N. (2015) *An Examination of the Potential Costs of Universal Health Insurance in Ireland*. Dublin: ESRI. <https://www.esri.ie/pubs/RS45.pdf>

²⁰ See National Institute for Clinical Excellence <https://www.nice.org.uk/about/what-we-do> and <https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/types-of-guideline>. In Ireland, the National Centre for Pharmoeconomics plays a role in terms of determining which drugs are cost effective. Further, the National Clinical Effectiveness Committee is developing national clinical guidelines for healthcare in Ireland. <http://health.gov.ie/patient-safety/ncec/> and <http://health.gov.ie/patient-safety/ncec/national-clinical-guidelines-2/>. HIQA also develops guidelines for certain service types <https://www.hiqa.ie/standards/healthcare>.