Institute of Public Health in Ireland (IPH) response to the Oireachtas Committee on the Future of Healthcare

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1. Executive Summary

The Institute of Public Health in Ireland (IPH) welcomes the formation of the Committee and the commitment to achieve cross-party consensus on a ten year strategy for healthcare and health policy in Ireland, and to make recommendations on a changed model of healthcare.

IPH welcomes the recognition in the terms of reference *that to maintain health and well-being and build a better health service, we need to examine some of the operating assumptions on which health service and health policy are based*. This submission will focus principally on order item (g) of the terms of reference which states that *the Committee shall examine and recommend how to progress to a changed model of healthcare that advocates the principles of prevention and early intervention, self-management and primary care services as well as integrated care*.

The World Health Organization's (WHO) Ottawa Charter (1986)[1] states that *Health is created and lived by people in the settings of their everyday life – where they learn, work play and love*. The role of healthcare services in improving overall population health and in reducing health inequalities is certainly important but it is also limited. The national public health policy, *Healthy Ireland* (Department of Health, 2013), emphasises that all government departments and sectors must be mobilised to play their part in creating the conditions for health. IPH considers it imperative to invest in public health and to also work towards the integration of public health and primary care to create healthy, active and socially inclusive communities and reduce the demand for reactive disease-based clinical care services in as much as possible.

IPH recommends that the committee take the opportunity to make health inequalities a central concern within any reformed health system by committing to reducing health inequalities across all functions; from health promotion through to primary and secondary care. This commitment can be operationalised through the inclusion of health inequality dimensions within service planning, performance monitoring, audit and evaluation as well as in systems of resource allocation and commissioning.

IPH urges the committee to agree on a clear and open evaluation framework for any reformed health system that will specify the exact population health and clinical outcomes expected and how those outcomes will be monitored. Further development of population health monitoring systems as well as clinical information systems will be needed to underpin this evaluation framework.

[1] See: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

2. Recommendations

1. Foster cross-government and cross-sector commitments to prioritise public health and health promotion as set out in *Healthy Ireland.*

2. Integrate, develop and invest in public health and primary care.

3. A commitment to tackle the broader determinants of health and equitable healthcare provision.

4. What gets measured, gets funded and gets done – measure what's important and construct funding streams that invest in health.

5. Focus on a model of chronic care based on care need.

3. Main body of the submission

The Institute of Public Health in Ireland

The remit of the Institute of Public Health in Ireland (IPH) is to promote cooperation for public health between Northern Ireland and the Republic of Ireland in the areas of research and information, capacity building and policy advice. Our approach is to support Departments of Health and their agencies in both jurisdictions, and maximise the benefits of all-island cooperation to achieve practical benefits for people in Northern Ireland and the Republic of Ireland.

1. Foster cross-government and cross-sector commitments to prioritise public health and health promotion as set out in Healthy Ireland

> *The economic crisis has led to increased demand and reduced resources for health sectors. The trend for increasing healthcare costs to individuals, the health sector and wider society is significant. Public health can be part of the solution to this challenge* (World Health Organization, 2014)

A review of the effectiveness and cost-effectiveness of disease prevention and health promotion approaches undertaken by the World Health Organization (WHO, 2014) concluded that prevention is highly cost-effective, and that population-level approaches are estimated to cost on average five times less than individual interventions. With this consideration in mind, a fundamental principle of the health system is that all evidence-informed approaches should be mobilised to ensure the population remains healthy and free from preventable chronic or infectious conditions and disability for as long as possible.

The current framework for health reform *Future Health – A Strategic Framework for Health Reform* outlines the development of health system structures to enable people to access care more easily and place health promotion and prevention of ill-health as a core pillar of healthcare reform. It is necessary to recognise that medical care is only one component of healthcare and that formal approaches to develop public health policy and embed health promotion initiatives in the Irish healthcare service is essential to achieving health for the Irish population. This requires a shift away from the traditional model of healthcare provision which maintains public health and health promotion on the periphery of healthcare services and requires concerted efforts to integrate these services into ongoing service delivery. The dual components of the healthcare service are public health and care delivery. Public health prevents a wide range of avoidable conditions and covers all the population at risk. Well-functioning public health services minimise

healthcare spending and produce gains in population health overall. Good health improves productivity resulting in a healthier and wealthier population. Economic growth in and of itself also leads to health gains by reducing the negative effects of the broader determinants of health on sub-groups in the population. Healthcare systems that afford low priority to public health are overburdened with preventable conditions, placing a greater burden on the healthcare system in terms of waiting lists, pressure for hospital beds and an overstretched workforce.

2. Integrate, develop and invest in public health and primary care

It is well known that a sole focus on the management and treatment of conditions will be ineffective in reducing the current and future healthcare burden in Ireland. There is an irrefutable argument for investment in prevention and health promotion from a health economics perspective which has often been cited in Irish and EU policy. Effective health promotion and prevention programmes must be recognised as a core component of a fit-for-purpose and modern health system, rather than an optional extra to the provision of care services. The *Five-Year Forward View* of the NHS (2014) set out the main considerations for the development of the NHS in the context of changes in the UK population and their health concluding that *the future health of millions of children, the sustainability of the NHS and the economic prosperity of Britain all now depend on a radical upgrade of prevention and public health* (NHS England, 2014).

Appropriate investment is required to develop and embed effective public health and health promotion interventions into the Irish healthcare system to achieve optimum population health. The core elements of integrated public health and primary care are: health surveillance; health promotion and the prevention of disease and injury.

Fostering collaboration between primary care, social and community care, mental health services, hospitals, cancer screening, clinical programmes and the Health and Wellbeing Directorate as espoused in *Healthy Ireland* will be essential for delivering on priorities in population health.

We strongly concur with the drive to reorient the model of health services to primary and community care and the need to establish a service where patients are treated on the basis of health need rather than the ability to pay. However, the term ‘need’ should not be confined to a service level definition such as the numbers of patients on waiting lists but should encompass a broad population health perspective. For example, the level of ‘need’ emerging through population based surveys may differ substantially from the numbers seeking services.

The current financing structure of primary and secondary care in Ireland encourages a shift away from primary care towards the more expensive secondary care service, and is said to be *exactly*

the opposite of what way an efficient financing system would work (Brennan et al, 2000). The lack of a comprehensive out-of-hours General Practitioner (GP) service in certain areas means that for many patients, an Emergency Department (ED) visit is the only option. The issue of a high number of inappropriate ED attendances is well documented. Odds of frequent attendance are higher for the unemployed, retired and those in receipt of medical cards, indicating possible unmet need in primary care services among these population sub-groups in Ireland (Smith, 2007). IPH recommends that efforts to address this should incorporate an equitable approach to service provision throughout the healthcare system.

Public health is a long-term investment that requires specific funding streams constructed and expanded to incorporate action on the broader determinants of health as well as the more recognised aspects of public health such as smoking cessation programmes or policies on tobacco control. The social and economic benefits of investing in health, distinct from investment in healthcare, have been well borne out in the literature but have yet to be capitalised upon in health policy.

3. A commitment to tackle the broader determinants of health and equitable healthcare provision

Two considerations arise in relation to health inequalities:

i. Health is not experienced equally by all
ii. Healthcare is not experienced equally by all

The poorer health status of lower income groups in Ireland is well documented, indicating their higher level of healthcare need. There is an ethical and economic imperative to tackle inequalities in health and this has often been put forward as a priority in Irish and European health policies. A focus on the broader determinants of health has the potential to address multiple risk factors for those at high risk of developing healthcare needs. Targeting effective policy and health promotion interventions towards those from more deprived, lower socioeconomic backgrounds will not only lead to a reduction in chronic condition prevalence in these groups but will lead to a greater reduction in prevalence overall, as targeted interventions have the potential to disproportionately impact on overall population prevalence of conditions and lead to greater population health gain.

While the principle of equity is embedded in Irish health policy (Department of Health, 2001; 2012; 2013) it is argued that healthcare in Ireland is not provided on need alone but that personal circumstances and resources often determine the extent to which individuals access treatment, the speed of that access (Wren, 2003; Layte, 2007; Burke, 2009) and the quality of care delivered

(Wren, 2003). It has been stated that the Irish healthcare system is operating on a complicated mix of egalitarian and libertarian principles, resulting in a mix of entitlements provided in a two tier system which is at odds with the stated goals of Irish healthcare policy (Smith, 2009).

There is little systematic data available to assess the equitable provision of services to those with a higher level of need in the Irish healthcare system, yet some conclusions can be drawn:

- Service use has been shown to vary substantially according to a range of socio-demographic characteristics including location (Morrissey et al, 2003), distance to hospital services (Smith, 2007), income distribution (Layte, 2007) and healthcare entitlements (Nolan et al, 2007). Those on lower incomes have been shown to have higher use of GP services and prescribing, while use of inpatient and outpatient hospital services appear to be neutral in their distribution across income groups (Layte, 2007). If there is higher healthcare need in lower income groups, this indicates unequal distribution of hospital services in Ireland according to need (Layte et al, 1999; Layte, 2007). This finding is consistent with long-standing international evidence of an inverse care law – the principle that the availability of good medical or social care tends to vary inversely with the needs of the population (Tudor Hart, 1971).
- The two-tier health system in operation in Ireland has been well documented as perpetuating health inequalities, resulting in delayed access to hospital services for public patients even though these patients tend to be older, sicker and poorer than private patients (Tussing and Wren, 2006). There is also long-standing evidence to suggest differential treatment between GMS and non-GMS[2] patients in primary care and acute services. More GMS patients are on hospital waiting lists and hospital care for public patients has been shown to be less effective than that provided to private patients (Wren, 2003). Patients who have neither private health insurance nor GMS may be less inclined to seek medical care in the context of substantial out-of-pocket costs and poorer quality of care in a public system compared to their subsidised privately insured counterparts and medical card holders.
- Previous research also points to inequity in the geographical distribution of Irish healthcare services with areas of disadvantage both within urban and rural regions under-served by GPs (Sinclair et al, 1997). However policy incentives in the intervening years to attract GPs to establish practices in more deprived areas appear to have made gains (Teljeur et al, 2010).

[2] General Medical Services.

Subsequent to the recommendations of the *Five Year Forward View* of the NHS in the UK, the Health and Social Care Act 2012 introduced for the first time legal duties to reduce health inequalities within the specific duties of clinical commissioning groups and NHS England (NHS England, 2014a). However, despite the many commitments made to reducing health inequalities within government policy, no such duties exist in the context of the development of health services in Ireland.

IPH recommends that reducing health inequalities should be formally recognised as a defined high level outcome of any reformed health system. The effects of the health system in reducing or exacerbating inequalities in health should be monitored across health promotion and prevention services as well as in the primary and secondary care system. Inequalities in access, in experience and in outcome should be encompassed within the core quality indicators of health service performance.

The principle of proportionate universalism should be formalised within the allocation of resources across the health system. Equity impact should be carefully considered in coming to a final decision on funding models for healthcare and in monitoring the impact of any changed model.

4. What gets measured, gets funded and gets done – measure what's important and construct funding streams that invest in health.

When healthcare and public health compete for attention and funding in a single system, public health loses out. Public health challenges might easily be identified in research, by the media or by government, such as a measles outbreak or increased chronic condition prevalence but gains made in public health are not always easily captured or readily publicised. Public health gains generally occur at a population level and take time to realise, while healthcare gains are often more immediate and more visible to the public and to political leadership. Systematic data collection efforts in the Irish healthcare system have traditionally focused on episodes of care, care outcomes or specific conditions, distinct from population health outcomes. As a result it is difficult to systematically identify public health priorities at a population level and garner support for public health investment when competing with healthcare funding requirements. Investments in data systems that monitor public health are therefore critical to the recognition of public health challenges and achievements.

The Hospital In-Patient Enquiry (HIPE) Scheme is a health information system designed to collect medical and administrative data at a national level (Economic and Social Research Institute (ESRI), 2012). However, the recording of health status data in this system is limited by

the absence of a unique patient identifier (Health Information and Quality Authority (HIQA), 2009). Furthermore, HIPE does not collect data on additional healthcare episodes including ED, outpatient and primary care visits. Clinical diagnosis obtained outside the acute hospital setting, for example in primary care, is therefore not linked to HIPE data. In short, it is not possible to track a patient's care trajectory, nor ensure all clinical diagnoses have been recorded for an individual patient at a population level. The introduction of a unique patient identifier and data linkage between all areas of the healthcare system would systematically improve data on population health and enable more detailed tracking of health indicators allowing for informed identification of public health priorities. It would also allow for gains and losses in public health to be more accurately monitored.

Moreover, it is not currently possible to adequately measure overall current health system performance in Ireland given the lack of appropriate population level data in Ireland. IPH recommends that the intended effects of health system change should be clearly defined and an allied monitoring and evaluation framework devised using SMART indicators. A programme of investment in a comprehensive health information infrastructure is needed if the impact of any health system reform is to be realistically measured. There has been substantial progress made in the development of health information systems relevant to health service use including Universal Health Identifiers and Electronic Health Records in recent years. However, there are still information gaps in the recording of activity within the primary care system as well as in key population health monitoring systems.

5. Focus on a model of chronic care based on care need

Several important considerations arise when planning for future demographic challenges in the Irish healthcare system:

- While ageing has long been established as a risk factor for a decline in health and the development of chronic, often disabling conditions, especially functional conditions, age *per se*, is not always indicative of poor health as individual older people vary considerably in their health experience.
- Accurate estimates of the health status of older populations are difficult to obtain and may also be subject to some biases. Prevalence estimates for chronic conditions may be biased by a propensity to access healthcare services with a greater opportunity for diagnosis in older individuals compared to their younger counterparts. However this bias may be balanced by age-discrimination practices in clinical care where older patients experience a cumulative increase in delays to access for diagnosis, referrals, and treatment compared to younger patients (Kennelly and Bowling, 2001).

- Despite the proliferation of chronic care programmes and healthcare interventions to address increased prevalence of chronic conditions, little attention has been paid to the complexity of multiple chronic conditions. Despite acknowledgement that there is a disproportionate allocation of resources to a minority of high cost patients, population health interventions and chronic condition management continues to focus on silos of conditions, overlooking the substantial impact of multimorbidity on health outcomes, quality of care and healthcare utilisation and costs (Guthrie et al, 2011). Multimorbidity is a care need that does not easily fit into the current structure of healthcare delivery originally designed to respond to acute and episodic instances of care needs (Fortin et al, 2007).
- Evidence points to a high proportion of people aged under 65 years living with chronic conditions (Taylor et al, 2010; Barnett et al, 2012) whose complex care needs are not being met within the current chronic care model which expects complex patients to be older, more fragile patients. Complex care needs are not only driven by age but are a product of personal and environmental characteristics including demographics such as deprivation, ethnicity, social capital or support and mental health. Complex care needs also encompass experiences in accessing care and maintaining health such as health literacy.

IPH recommends the development of a chronic care model which focuses on care need distinct from age. Principles of geriatric care could be reoriented to create a more streamlined healthcare experience for all patients suffering from chronic conditions who require an informed, joined up response to their multiple care needs. Integrating care across all aspects of the healthcare sector will be an important first step in providing appropriate care for patients with complex care needs. Self-care management approaches will need to adequately acknowledge this healthcare burden on such patients and ensure that they are appropriately guided through their care pathways.

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