A Working Paper from the Resilience project in the Centre for Health Policy and Management, School of Medicine, Trinity College Dublin

Measuring, Mapping and Making Sense of Irish Health System Performance in the Recession

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Abstract

A new government came to power in March 2011 with the most radical proposals for health system reform in the history of the Irish state, including improving access to healthcare, free GP care for all by 2015 and the introduction of Universal Health Insurance after 2016. All this was to be achieved amidst the most severe economic crisis experienced by Ireland since the 1930s, resulting in severe cuts to the health budget.

The authors assess how well the system has coped with a downsizing of resources by an analysis of a range of performance indicators. These show a system that managed 'to do more with less' from 2008 to 2012. They also demonstrate a system that was 'doing more with less' by transferring the cost of care onto people and by significant resource cuts.

From 2013, the indicators show a system that has no choice but 'to do less with less'. They indicate diminishing returns from crude cuts, evident in declining hospital cases, increased wait-times, as well as cuts to home care hours and increasing costs of agency staffing. The results suggest a limited window of benefit from austerity beyond which cuts and rationing prevail without structural change.

More information at http://www.medicine.tcd.ie/resilience4health/news/

1. A radical plan for reform

A new Irish government which came into power in 2011 promised a radical overhaul of the Irish health system, committing to free GP care for the whole population by 2015 and the introduction of Universal Health Insurance by 2016, as well as a plethora of other reforms (Government of Ireland, 2011). This government came into office during the biggest economic crisis facing the country since World War Two (Burke, 2013b).

2. Political and economic background

In 2008, Ireland faced up to its economic crisis caused by a combination of international factors and very poor national fiscal and public policy choices (Burke, 2013b). In December 2010, Ireland entered into an international bailout, worth €85 billion (Burke, 2013b). This, combined with a series of austerity budgets led to significant cuts to the public budget, including a 22% cut to the health budget since 2008 (HSE, 2014).

3. Health system background

Ireland has a complex system of public, private and voluntary healthcare providers with an equally multifaceted system of financing, full of perverse incentives (Department of Health and Children, 2010). There is very limited universal access, with most people having to pay to access care. While 40% of the population have medical cards which facilitate access to GP and hospital care without charge, two-tier access to public hospital care means that private patients gain speedier access to both diagnostics and treatment (Burke, 2009, O'Riordan, 2013). Ireland has a very under developed system of primary care and 60% of the population have to pay €40-60 for each visit and up to €144 a month for prescription drugs (Nolan, 2014 forthcoming).

4. Methods

The authors collected indicators of performance of the Irish health system during the economic crisis from 2008 to 2014. These measures relate to the financial and adaptive resilience of the Irish health system (Thomas et al, 2013). These indicators include key metrics over time relating to

(i) healthcare funding and resources,
(ii) the coverage of the population with subsidised care,
(iii) the efficiency of resource use,
(iv) access to timely care.

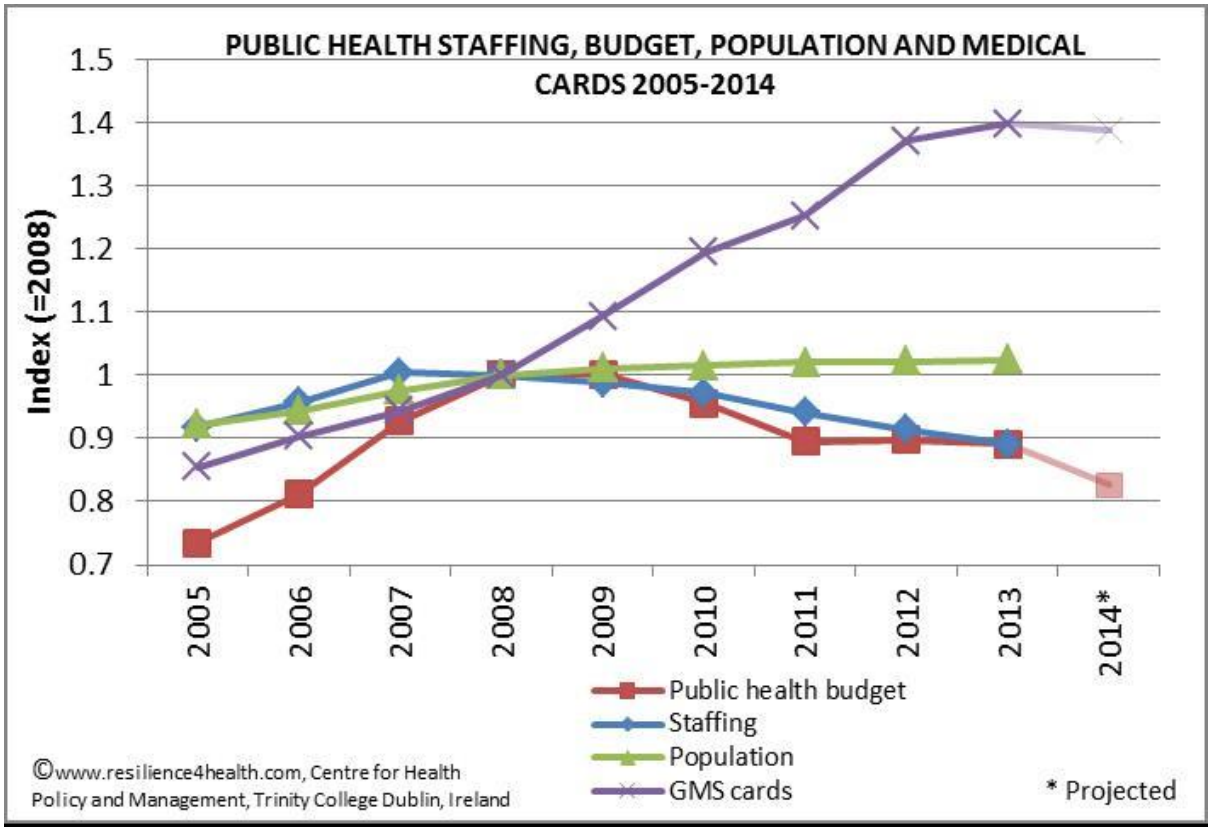
These indicators are used at an OECD level to assess health system performance (OECD, 2013). Ireland has a poor track record in data collection, especially in the health system, and that which exists comes from a wide range of sources including the Department of Finance Revised Estimates, HSE Annual Reports, HSE National Service Plans and waiting list data collected by the HSE (Department of Public Expenditure and Reform, 2014, HSE, 2014, HSE, 2013d, HSE, 2013a, HSE, 2012c, SDU/NTPF, 2013). The data have been gathered in one place for the first time and are presented here.

5. Indicators of the performance of the health system during the economic crisis

Healthcare funding and resources

Approximately €4 billion has been cut from the Irish health system since 2008 and there are over 12,000 fewer Health Service Executive (HSE) staff in December 2013 than there were at the height of public health sector employment in 2007 (HSE, 2013b, HSE, 2014). Simultaneously, Ireland's unemployment rate grew from 4% in 2008 to 12.3% in January 2014 (CSO, 2014). Reflecting lower incomes and higher levels of unemployment by December 2014, there were the highest numbers of people with medical cards in the history of the state (HSE, 2013c, HSE, 2014). These figures combined with a growing, ageing population demonstrate increased demand on a health system which has fewer resources.

Graph 1: Levels of public health staffing, budget, population and numbers with medical cards 2005 to 2014

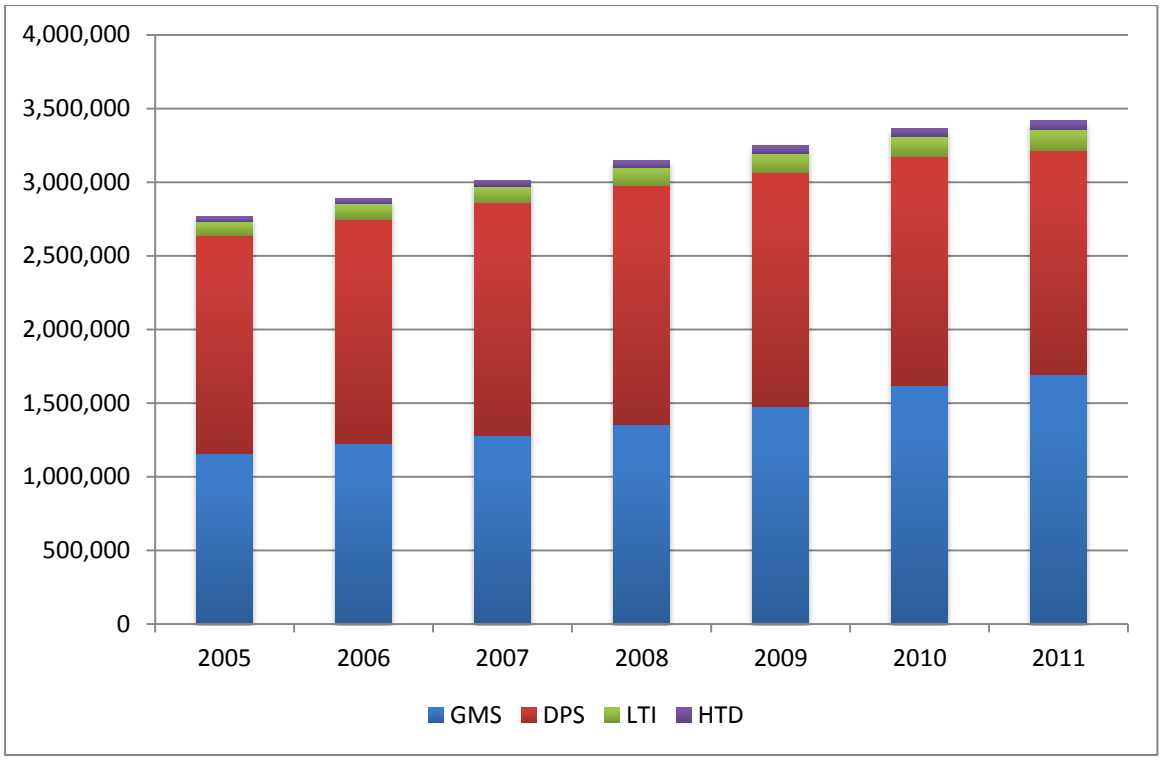


The coverage of the population with subsidised care

Another indicator of demand for the public health system is the numbers using the publicly funded health schemes – the Medical Card (GMS)[1], Drugs Payment (DPS)[2], Long Term Illness (LTI)[3] and High Tech Drug (HTD)[4] schemes. These show (Graph 2) an increase in the overall numbers covered under demand-led schemes which compounds the situation of changing demographics and higher unemployment as outlined above.

[1] The GMS is means tested and allows those who qualify access to GP and hospital care without charge and prescriptions at a low charge.
[2] The DPS reimburses those without medical cards when their prescription drugs cost over a certain amount, in 2014 at €144 per month.
[3] The LTI allows people with certain conditions access to medication and some appliances without charge.
[4] The HDT covers the costs of medicines for people with certain conditions that are usually of a high cost. They are usually prescribed through hospital and dispensed through pharmacists.

Graph 2: Numbers covered by medical cards (GMS), drug payment scheme (DPS), long term illness (LTI) and high tech drug (HTD) 2005-2011[5]

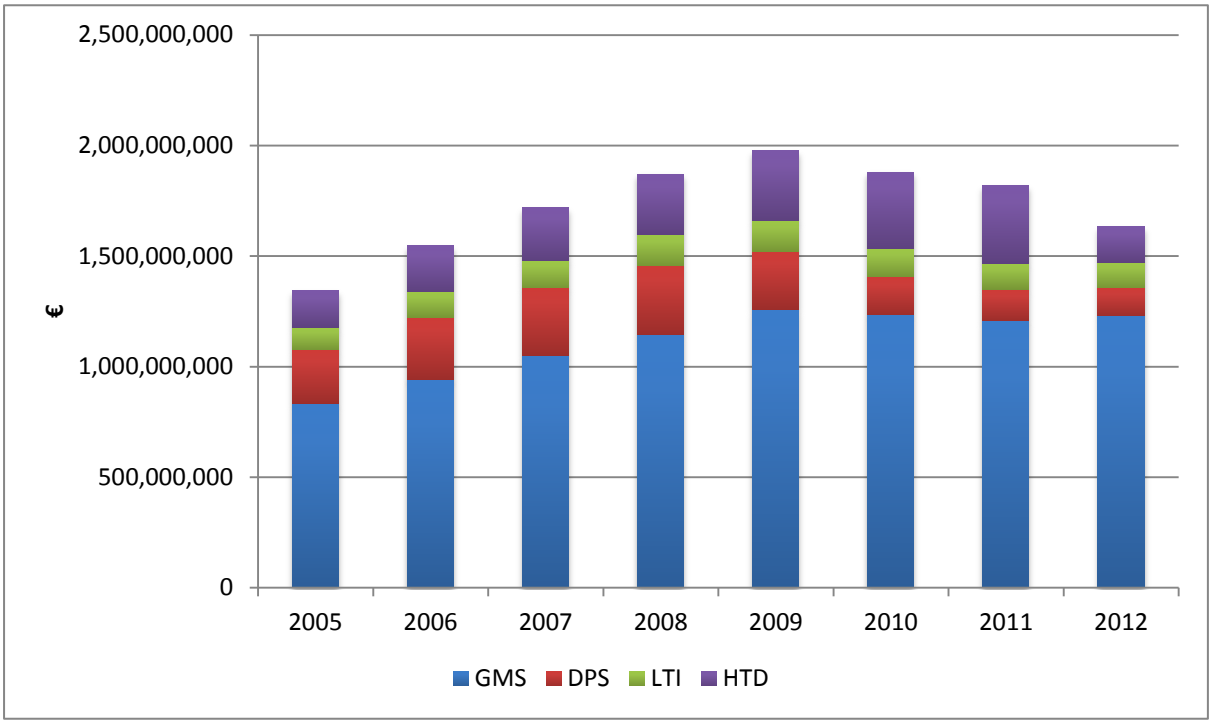


Efficiency of resource use

Graph 3 shows that while the numbers of people covered by all the schemes went up, the cost of the schemes went down. This primarily indicates increased efficiencies during this period which can be explained by better deals done by government with the pharmaceutical industry and a series of cuts in fees paid to GPs, pharmacists and other health professionals under such schemes. Nevertheless, the declining cost for the DPS is driven by declining numbers using the scheme due to hefty increases on the reimbursement threshold, in effect a direct transfer of costs from the State onto patients. In 2008, people were reimbursed for drug costs above €85 per month whereas by 2013, this had risen to €144. In 2008, the State paid out over €311 million in the DPS, by 2012, this had more than halved to €127 million (Nolan, 2014 forthcoming).

[5] Figures are not available after 2011 for numbers covered by the schemes

Graph 3: Cost of each public health scheme 2005 to 2012

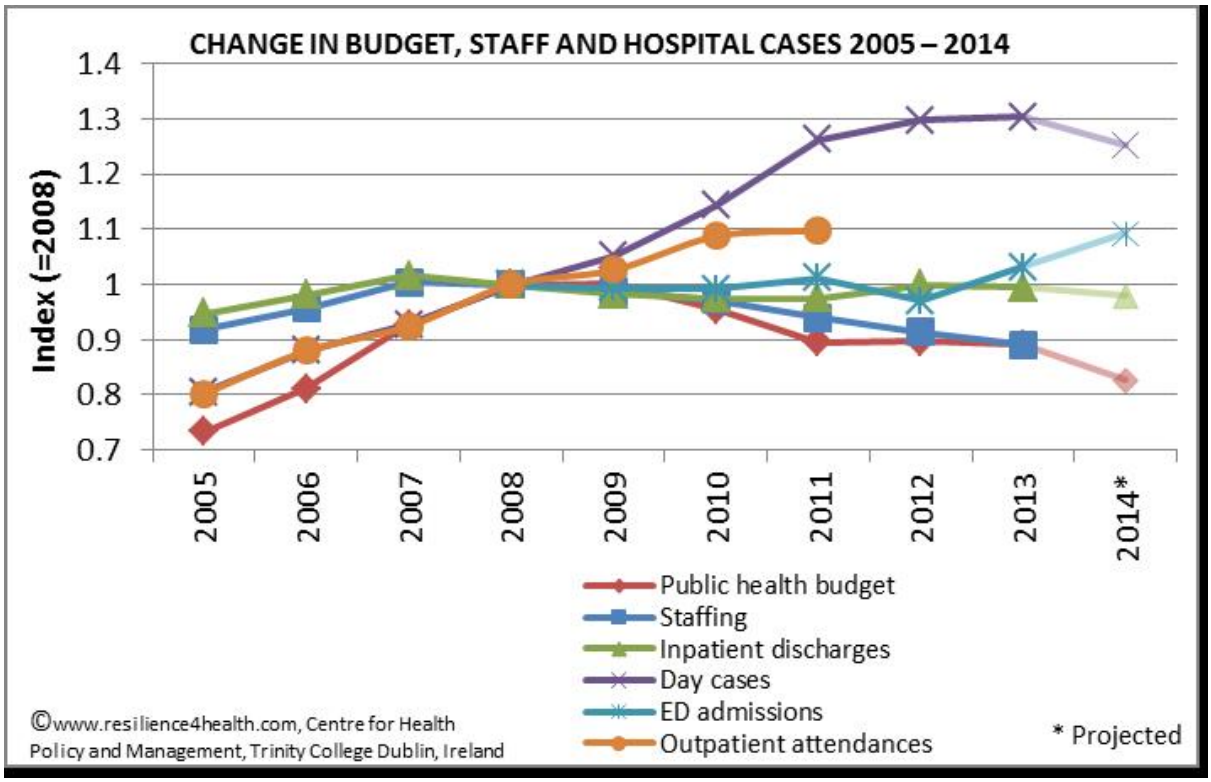


Graph 4 shows that despite the declining budget and staff numbers public hospitals managed to do more with less in the period 2008 to 2012. Evidence of rising numbers of inpatient, day case, outpatient appointments and emergency admissions indicates some 'fat' in the system that was removed (Thomas, 2012). These efficiencies could also be influenced by the clinical care programmes, instigated in 2009 and which began to show benefits from 2010 onwards, and by agreements between health service management and unions which allow for increased flexibility and productivity (HSE, 2014).

Graph 4 also shows a reversal of the trend 'to do more with less'. Towards the end of 2012 and through 2013 and 2014, there was a decrease in inpatient activity and a leveling off of day cases despite increased demand (HSE, 2012a, HSE, 2013b, HSE, 2014). In 2013, there was increased activity in emergency admissions which made up 83% of all admissions to public hospitals, which critically are demand-led and beyond the control of health service management (HSE, 2013b). The only area of hospital activity expected in increase in 2014 are Emergency Admissions (HSE, 2014).

There are very few measures of health system activity in the community, but one area where there is comparable data overtime is home care. The home care service was formalised in 2005 to support people to live independently. While home care hours increased from 2006 to 2008, there has been a steady decline since 2008. In 2013, there were under nine million home care hours provided, compared to over 11 million hours in 2006 (Nolan, 2014 forthcoming).

Graph 4: Percentage change of public health budget, staffing, inpatient, day cases, Emergency Department attendances and outpatient attendances, 2005 to 2013



Access to timely care

Since 2011, the new government made explicit commitments to address the most persistent problems in the Irish health system – very long waiting times in Emergency Departments, for elective treatment and for out-patient appointments with a specialist. Some progress has been made on each of these, for example accurate figures on outpatient wait times were published for the first time in 2012. (HSE, 2012b).

These figures reveal extremely long wait times for an initial appointment with a specialist. In November 2013, there were 384,632 people waiting for public outpatient appointments, of these 846 were waiting over four years, 3,138 were waiting between three and four years, 12,861 were waiting between two and three years, while 39,425 people were waiting between one and two years (SDU/NTPF, 2013). There have been reductions in these wait times since they began collecting them in 2012, however the government failed to meet its ambitious target that no one will wait over one year for this first specialist appointment by December 2013.

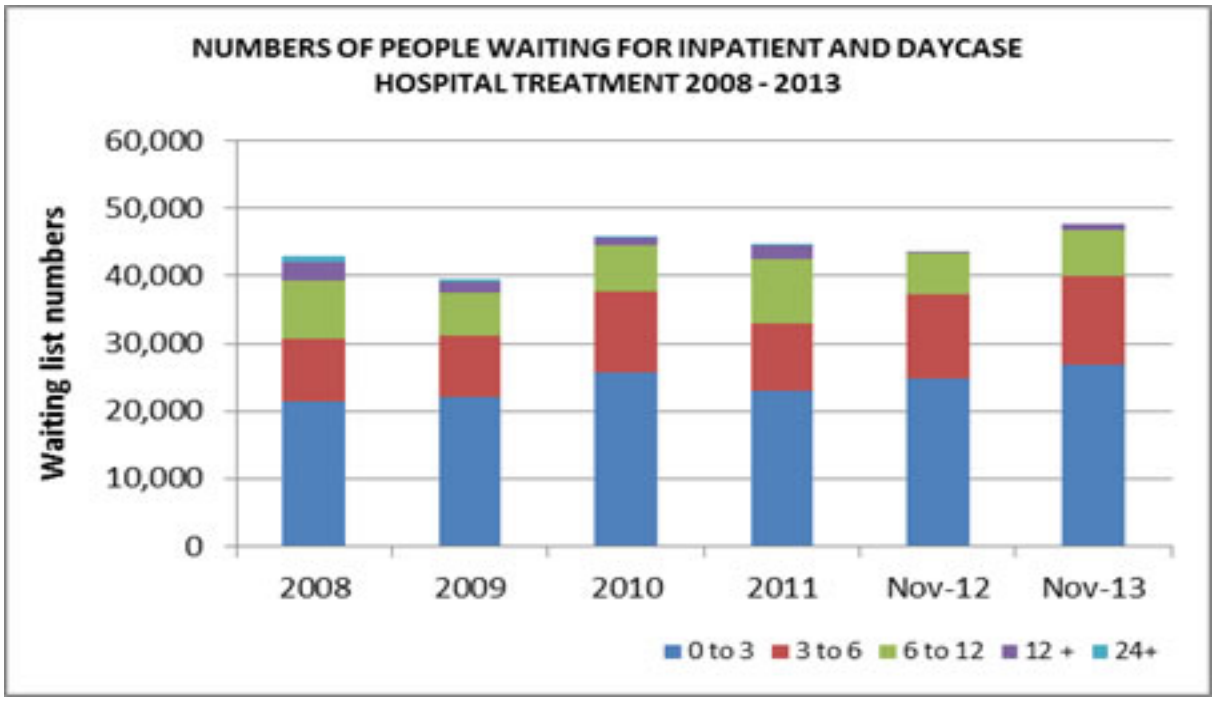
There has also been progress on the numbers of people waiting on trolleys in Emergency Departments. Trolley numbers reached their height in 2011. There was a 34% reduction between 2011 and 2013. However, when figures from 2008 are compared to 2013, a 3.6% reduction is counted (SDU/NTPF, 2014). There were over 57,000 people counted on trolleys in 2013.

Graph 5 shows the number of people waiting for inpatient and day-case hospital treatment. This shows progress on reducing waiting times in 2011 and 2012. The HSE has been successful in eliminating the longest waiters, ie those waiting over two years, which was a key 2011 Programme

for Government commitment. However, when figures for November 2012 are compared with November 2013, they show more people waiting, a trebling of those waiting over six and twelve months for treatment. The government set a target that no one would wait over eight months for treatment by December 2013. In November 2013, there were 2,458 waiting over nine months (SDU/NTPF, 2013).

These hospital wait times indicate increased demand on the public health system resulting from fewer people with private health insurance alongside an increasing, ageing population with a greater burden of chronic diseases (Burke, 2013b). They may also reflect the impact of continuous austerity budgets on the public hospital system evident in their declining resources and staffing, closed wards, fewer inpatients and hospital beds and more patients waiting longer for elective treatment. There were 941 fewer public hospital beds in 2012 compared to 2008, while numbers of delayed discharges remained chronically high, most recent figures show 718 delayed discharges (people in hospital beds who do not clinically need to be there) (Burke, 2013a, HSE, 2013c).

Graph 5: Numbers of people waiting for inpatient and daycase hospital treatment 2008 - 2013



6. Discussion and Conclusion

Indicators of activity in the Irish health system during the economic crisis show a relatively resilient system (as measured by activity) from 2008 to 2012 (Nolan, 2014 forthcoming). However, recent indicators from 2013 on, demonstrate a system under increasing pressure that can no longer continue 'to do more with less'. The indicators reveal a system that has no choice but 'to do less with less'.

'Doing less with less' can only be achieved by stemming the increases in medical cards (evident in 2013) and transferring people from medical card scheme to GP only scheme[6], which is cheaper as it entitles people to much less 'free' care. While the HSE cannot control emergency admissions, it can and may have to continue to ration day and inpatient hospital treatment as detailed in the 2014 HSE National Service Plan.

Under public sector agreements, the HSE is expected to have 2,600 fewer staff by the end of 2014 (HSE, 2013b). However, cuts to staffing are proving expensive as spending on agency staffing (who fill empty posts) was €234 million in November 2013, up €35 million (+18%) year-on-year (SDU/NTPF, 2013, HSE, 2014).

Other 'easier' to cut services such as home care are likely to continue to be rationed as well as transferring the cost of care from the State onto the patient. Cutting home care and raising charges for services and prescription drugs are short term measures that may work out more expensive in the long-term if people end up in hospital due to the absence of supports in the community or not taking essential medicines. The results suggest a limited window of benefit from austerity beyond which cuts and rationing prevail without structural change.

The 2014 HSE National Service Plan has a new and concerted focus on patient safety[7]. The HSE has described 2014 as 'one of the most financially challenging years yet faced by the Health Service' (HSE, 2014). Whether this quality focus can be maintained as well as seeking to provide higher quality care to more people with fewer staff and less money is questionable after seven austerity budgets.

Budget 2014 saw the extension of free GP care to children under six years old, however the government has admitted it does not have a plan as to how it will extend free GP to the whole population by 2015 (Department of Health, 2014). How this, and other commitments such as universal health insurance, can be delivered in the current environment remains very uncertain.

[6] GP only cards were introduced in 2006 as a cheaper mechanism of gaining access to GPs. Crucially, those with GP only cards have to pay for their medicines up to €144 per month and will not have access to the range of primary and community care services that citizens with a medical card are entitled to.

[7] This followed a high profile death in a maternity unit in an Irish hospital in December 2012 and the publication of the Francis Report in England into deaths in Mid Staffordshire hospital in February 2013.

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