Speaking notes used by Professor Brendan Drumm,, CEO of the HSE at the 4th National Health Summit: **Building a Better Health Service – there is a vision - can it be delivered?** – 12th June 2007.

The first thing I would like to say is that the Irish Health Service is not in crisis.

Yes, there are parts of the health system that need attention and we are working hard on addressing these shortfalls.

But it is unfair to ignore the fact that every day thousands of people receive excellent care through the public health care system and are happy with this care.

Last year we commissioned UCD and Lansdowne Market Research to undertake the first ever national satisfaction survey among people who use our services. The top line results show that people who use our services perceive them significantly differently to those who publicly comment on them.

The full results will be published in a few weeks time but the key message coming forward at this stage of the analysis is that patients have a high level of confidence and trust in the care they receive. For example 90% of people said they were happy with the quality of the care they received when in hospital.

These results are consistent with those from a patient survey published in 2005 by the Irish Society for Quality & Safety in Healthcare. It showed that 93% of patients were confident about the treatments and services they received in hospital; 9 out of 10 said they would recommend their hospital to a friend if they needed similar care.

Independent research among those who used our emergency services last year, again delivered similar results; 9 out of 10 emergency department
patients said that they were treated with dignity and respect and 3 out of every 4 said that they were satisfied with their overall experience.

The health service is getting it right for most of the people, most of the time. It is time to give our staff the credit they are due for providing a high quality of care.

While we accept that there are individual cases where our services fail to provide care up to the standard we would want, to use them to represent the whole health service is unfair to patients, staff and community as a whole.

Take our Emergency Departments. They see around 3000 people a day. Around 5% have to wait for admission and the majority of these people have to wait less than 12 hours. So in effect 95% of patients receive their treatment without having to wait for admission. Yet the picture is constantly being painted that all our Emergency Departments are dysfunctional. That is not true.

Brian Goggin, CEO of the Bank of Ireland, a few weeks ago said, in relation to the economy, there is a real danger we are going to talk ourselves into a downturn.

The same applies to health - there is a real danger we are going to talk our public health service into a crisis.

The debates during the recent election show that the public is discerning and well capable of separating the exaggeration and scaremongering from the reality.

I believe people now appreciate that following the line of least resistance is not going to deliver a world class health service.
They recognise that if we are going to make real progress, firm decisions have to be made and we must not allow our ambitions for the future to be thwarted by the vocal minorities whose motivation is questionable.

There appears to be an increasing acceptance that if we base our policy decisions on he or she who shouts loudest and ignore the compelling evidence, we will have more delayed or compromised decisions.

Let me take the issue of acute beds as an example. People have told me time and again, although the numbers are decreasing, that the problems of the healthcare system can be sorted out tomorrow by just building new acute beds.

To stop all of this criticism, some of it unfortunately quite personal, the easiest thing would be to put in 3,000 or so acute hospital beds. This would take 4 or 5 years and we would get a short term bounce in relation to elective waiting time reductions and so on. Furthermore, life would be a lot easier for all of us working in the HSE. We could simply continue to do things as they have been done in the past, with no pressure on us to change to more efficient practices.

However, patients would continue to be inconvenienced. They would continue to have to spend unnecessary time in hospital. Tax-payers would have to bear the cost of these extra beds leading ultimately to an unsustainable health care system in the future. Furthermore, by the time I've moved on, I can assure you the problems people complain of now will be back despite the massive rise in investment with significant recurring overheads.

When it comes to evidence that more acute beds will solve the current access problem there is a vacuum. One argument is that we need more acute beds because during the recession in the 1980s acute beds were closed and that is why doctors are having difficulty accessing acute beds for their patients.
On the surface that sounds reasonable. Indeed some refer to ESRI studies but they do not take account of the impact we will be having over the coming years by reorienting our model of care towards the community, reducing inappropriate admission, occupancy and addressing inefficient hospital practices.

Last year we commissioned PA Consulting and the Balance of Care Group to look at how we use our acute beds. Are we using these €5000-€7000 a week pieces of infrastructure efficiently? The answer is that in a significant number of cases we are not.

We found that on average 13%, and in some hospitals up to 34%, of patients who had been admitted, did not need admission.

We found that 39% of patients who were being cared for in an acute bed on a particular day could have been treated in alternative and more appropriate settings. For almost 20% of hospitals, half of their patients could, on the day they were surveyed, have received their treatment outside of the acute hospital setting.

For elective surgery patients, we found 3 in every 4 had been admitted earlier than they should have.

Interestingly one representative body which regularly advocates that the solution to the current difficulties is more acute beds has said publicly that this study “must be treated with a high degree of scepticism”.

While these statistics illustrate why consultants can face problems in accessing an acute bed for their patients, they show that more public acute beds will not make things easier for them nor make our health system more efficient. They will not address the high level of inappropriate admissions and hospital stays.
The findings show clearly that the way to improve access to our acute beds is not to provide more acute beds at enormous expense to the tax-payers but to tackle inefficient hospital process (such as those that result in patients having to wait in hospital several days for a test that could be provided on day one or indeed as an out-patient) and develop our community based facilities.

In hospitals we need more Consultants on duty in hospital more often. The bed use study I referred to earlier found that 43% of patients who were inappropriately placed in an acute hospital bed were there because they were waiting for a review or assessment - many were waiting to see a consultant.

The way hospitals are organised internally also needs to change. We need to have greater scrutiny of the length of time people spend in hospitals for common procedures and discharge planning must be universally applied. When people come into hospital they should know the day they will be leaving. Our research found that just 40% of patients had any type of discharge plan and just 17% had an estimated discharge date.

Within the community people need to have greater access to:

- Diagnostics and assessments outside of hospitals;
- Non-acute beds with therapy supports, such as Physiotherapy and Occupational Therapy.
- Home based care including GP Support, Therapies, Specialist Nursing, Community Nursing and Home Care Packages.

We are putting these types of facilities in place. For example we have made access to private sector diagnostic services, through GPs, much easier and this is having a significant impact on waiting times. It means that more people receive care in the setting appropriate to their condition and this in turn leads to less inappropriate admissions.
Preliminary results from our recently introduced Hospital in the Home service, is showing that patients with chronic lung disease who have breathing difficulties, and are treated by this new service need, on average, 9 days treatment. On the other hand similar patients admitted to hospital for treatment, on average, need 12 days of treatment. So, not only can we keep people at home, we can achieve results at least as good as with hospital care.

Last year we provided 1000 new nursing home places and this year will provide a further 800. Each month 50,000 people are now receiving Home Care Packages – an increase of 16% on this time last year.

The evidence is compelling. We need stronger links between hospital based services and community based services. In fact I would go as far as to say that we need to address the competitive forces that can exist between the hospital and community based services. The provision of service should be seamless.

Whether this can be done while we continue to have two separate service delivery units within the HSE is a challenge.

For example, one of the great successes in relation to our Winter Initiative Programme which was set up to enable us focus on meeting the increase in demand for services during the winter months, was the emergence of what we call Local Implementation Teams.

In eight areas around the country, managers responsible for primary and community care and managers responsible for hospital care worked hand in glove to find solutions to difficulties as they arose. This cooperation worked particularly well.

When we see how successful this level of cooperation is at a local area and then as you go up through the organisation, you find we have a National Hospitals Office and a PCCC Office, with separate budgets and separate plans, it raises the question as to whether this is in fact the best way to
structure our services in the long term.

So to summarise this point, future funding must be directed towards building up our Primary and Community Services not building up large volumes of expensive acute beds. We cannot do both. Acute beds would only provide a short term solution. Building up our Primary and Secondary Care can provide a solution for generations to come. More importantly, it will provide a much better service for the public, who should not have to endure time spent in a hospital bed for services that could easily be provided to them in the comfort of their homes.

So, what is our vision for the Health Service between now and 2010? What will the Irish Health services of the future look like? At its heart is co-location. Not the co-location we have heard so much about in recent months, but co-location of primary and community services; a one-stop-shop approach to providing public integrated care outside the acute hospital setting.

If we can deliver on our vision for the Irish public health service in the future everyone will be able to get in, through and out of the health service quickly and easily. The main entry point will be through local community and primary services - not hospitals – in the form of Primary Care Teams.

We are planning to establish 500 Primary Care Teams during the coming years, each serving a population of around 8,000 - 10,000 people. So far we have established around 100 teams.

Co-located primary and community services, with Primary Care Teams as the basic building block, will be able to meet the vast majority of people’s health and social care needs. They will be well staffed with a range of health professionals, well equipped with diagnostic equipment and people will have full confidence in these services.
Our hospital based services will no longer need to provide services that local community services and primary services can provide such as routine diabetic monitoring and treatment, rehabilitation services, many therapy services such as Physiotherapy, Occupational Therapy and Dietetics. They will focus on acute services and specialist services.

Our hospitals will be Centres of Excellence and they will provide results on par with those available through the most advanced health services around the world.

Central to this vision for the future, will be the relationship that patients have with the health service. They will have one main point of contact – a Key Worker. This Key Worker, as part of their local service, will be their advocate, will help them and guide them through the service so that when they need one or more service they will be organised around the patient’s needs rather than patients having to navigate through the service.

Some have described this reorientation towards the community as a utopian ideal. It is not, it is an absolute necessity for two reasons.

1. Firstly, in 30 years, 20% of our population will be over 65 years of age, up from today’s 11%.

With this aging population will come increasing incidences of chronic disease, such as Diabetes, Heart Failure, some Cancers, Chronic Obstructive Pulmonary Disease, Dementia and Arthritis.

At the moment, hospitals are being used to provide a substantial amount of treatments for chronic illness.

- It is estimated that 2 out of 3 patients admitted to hospitals as medical emergencies have exacerbations of chronic disease.
• 40% of all inpatient bed days are occupied by patients with chronic illness who, in volume terms, account for just 5% of all inpatients. In other words 5% of patients are using 40% of our acute beds.

If we continue to try and provide more chronic illness care through our hospital system over the next 5 to 10 years, we will have created an incredibly expensive health care system that a proportionately smaller working population will have to fund. On the other hand studies show that chronic disease management programmes can reduce hospital admission by up to 30%.

2. Secondly, and probably the most important reason is that people deserve to spend more time in their own homes and within their own communities rather than being removed from their communities and treated in hospital when this is not absolutely necessary.

Can we deliver on this? I believe we have a tremendous opportunity to do so.

1. Firstly we now have for the first time, a single national health and social care system. We can focus totally on what is required to deliver the full spectrum of high quality, consistent and easily accessible evidence based services. We are in a much stronger position to resist being distracted by local interests and pressures which have in the past, as has also been the case in other countries I should add, compromised and slowed decision making.

2. Secondly, people throughout our health services, be it working in our Payroll Department or working as a Clinician, are committed to their profession because they believe that acting for the benefit of others who need their help, is right and good. They want to make a commitment. They want to help those who are the most vulnerable.
This level of commitment was brought home to me during the recent industrial action by nurses and midwives, when there were incredible levels of cooperation between people (doctors, administrators, and indeed nurses) who were anxious to minimise its impact on patients and their families. People took up new tasks, adapted to new ways of doing things and it was a great tribute to the spirit that exists within the HSE.

But critically, the type of service transformation we need can only be delivered if all Consultants, Doctors, Nurses, Allied Healthcare Workers, Managers, Administrators and so on, accept that we have a responsibility as employees to contribute fully to implementing the programme of change.

3. The third factor is the demand for accountability from the public. This is a positive catalyst for change. It is something that we cannot overlook. The public health service is owned by the people, it is paid for by the people through substantial taxation. It is in fact indirect health insurance and the community should see it as such. The community is not getting free healthcare, it has paid for it through taxation. With private health insurance, and the way the system is structured, some people can in fact end up paying on the double.

While the HSE is the public body that is responsible for providing public health care, I do not expect that the public will wait indefinitely for the public sector to provide a world class public health care system.

There is a school of thought, well articulated by Canada’s Fraser Institute late last year, suggesting that because the public sector is not driven by the same forces that the private sectors is, in terms of providing goods and services that consumers demand, it cannot reach the same levels of efficiency that can be achieved by private sector providers.
Based on trends that are emerging in other countries there are alternatives to the public services being the sole provider of public health care. We in the HSE need to be very acutely aware that if we cannot provide economically viable public health care, the public may ask why should it not get the private sector to provide public health care.

4. Fourthly, I think our health system is well funded. One of the big changes that we will see over the coming years in relation to funding will be that we are going to move away from a situation where we will be incrementally adjusting budgets to a situation where budgets will be allocated based on performance. We will be linking budgets to population needs and moving away from a situation where services that exceed their budget are granted end of year funds to cover overspends. Efficient services should get more support.

Demands for health and social care are infinite, resources are not - so we have to balance the two and this in itself will leave some people unhappy and disappointed.

**Transformation Programme**

So how are we going to achieve our ambition of a health service that can be easily accessed, the public has confidence in and staff are proud to provide?

During December last, we unveiled the details of our 4 year Transformation Programme and itemised what we needed to do to deliver more co-located primary and community service and free up hospitals so they can concentrate on acute and specialist care.

We identified six prioritise:

1. We want to simplify the patient journey.
2. We want to make it far easier to access primary and community care.
3. We want to make it far easier to access excellent hospital services.
4. We want more chronic illness programmes.
5. We want to have more transparent and measurable standards.
6. We want greater staff involvement in our Transformation Programme.

We are planning to deliver on these 6 priorities during the next 4 years through a series of programmes and projects that will essentially change the way we do business, not only from a service level but the way our HR is organised, the way our Finance is organised, the way our Facilities are managed and our use of technology. We are planning to make major changes right across the organisation.

We now have a series of almost 100 detailed projects with people accountable for delivering on them by specific timelines with specific outcomes. It’s a very ambitious list. All the projects are not going to get off the starting blocks the same time; some need to advance before others can start.

The challenge is for us to be able to deliver on all of these interlinked projects while at the same time delivering our business as usual and secondly closing down projects that do not fit within our priorities.

There is a great opportunity for us to let go of the past and create a really great health care service. But let us not forget that requires a huge effort from all stakeholders. We cannot achieve it if some continue to hold on tightly to the past and expect everyone else to make the necessary changes.

Collectively we have to ask and answer the fundamental questions; Do we want more of the same or do we want a new world-class health service that will take us into a new era of healthcare.

If we want the later we must put our own particular interests aside and individually and collectively support the health transformation programme in whatever way we can. Thank you for the opportunity to address you this morning.