



Focus on quality in healthcare in Ireland

Healthcare in
Ireland

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Abstract

Purpose – The purpose of this paper is to summarise the recent debates and issues on the healthcare system in Ireland, which have come to the fore through media exposure. The implications for these debates on quality are suggested and questions are raised to stimulate further debate.

Design/methodology/approach – Recent reports and media opinion articles are reviewed in the light of the health reform programme and the increased prosperity due to the Celtic Tiger era in Ireland.

Findings – The Health Service in Ireland is not what it should be. Progress has been made but resistance at all levels is significant due to the mistrust and miscommunication between the managerial and clinical personnel which have built up during the past number of years. The trust of the public is at an all-time low. However, once patients are within the system they are satisfied with their care.

Originality/value – This is a discussion paper which raises more questions than answers and is timely with the focus on quality in healthcare, particularly now as Ireland prepares for a general election for a new government with healthcare a priority issue.

Keywords Public sector reform, Patient care, Information media, Medical management

Paper type Viewpoint

Introduction

In recent years the Irish health system has rarely been out of the media spotlight, with the Ministry of Health viewed as a poisoned chalice to all who take up the post. The Department of Health and Children is considered a bottomless pit, which takes a significant amount of the tax take without showing any apparent improvement in the service delivered. Rocked by scandals such as the Lourdes Inquiry (Harding Clark, 2006), Hepatitis C (Lindsay, 2002) and the Leas Cross Inquiry (Hennessy and Donnellan, 2006), to mention a few, the public opinion of the health service is of a system in imminent danger of collapse. Patient deaths show that the service is dysfunctional and the people that are most in need are suffering needlessly. Restructuring of the service has already begun with the reorganisation of the delivery of care by the Health Service Executive along with many other proposed changes. It is therefore timely to assess the focus on enhanced safety and quality of care being provided to the Irish population.

Concern about the quality of healthcare is not a new concept for patients, professionals or the government, however these concerns have become manifest in recent times due to the changes in healthcare and society. Increases in the complexity of the diagnosis and treatment of patients, as well as changes in patients' expectations,



in combination with government concerns regarding spiralling healthcare costs have combined to put healthcare foremost in the public mind. According to Øvretveit (2000) quality does not just include the excellence of the product being delivered, but includes the economics of the delivery of that product. Quality is defined as exceeding the customer's expectations, and has 3 main components; patient quality, professional quality and management quality (Øvretveit, 2000). The difficulty has been in the reconciling of these three apparently disparate points of view into a healthcare system, which delivers the best treatment, at the correct time, for the correct cost. This is a discussion paper which raises more questions than answers and is timely with the focus on quality in healthcare, particularly now as Ireland prepares for a general election for a new government with healthcare a priority issue.

Celtic Tiger and increased prosperity

During the period 1994-2000 in Ireland we have presided over the highest economic growth rates in our history – widely referred to as the “Celtic Tiger”. Ireland's annual average per capita GDP growth over the decade of the 1990s was 7.9 per cent, over three times the rate of most of its EU partners (Kirby, 2004). Ireland has moved from a traditional, rural society dominated by the Catholic Church to a modern, urban, industrial, liberal and secular society. The Celtic Tiger is seen as the culmination of this move to modernity, “the re-invention of Ireland”, a transformation equivalent to the change in Ireland which came about by the cultural and political movements of the 1890s onwards leading to an independent Irish state in 1922 (O'Donnell, 2000). This transformation has been achieved with the assistance of significant foreign investment (Tovey and Share, 2000). Unfortunately in the single-minded pursuit of modernity, we have tended to minimise or dismiss some worrisome aspects of this process, such as its entrenched problems of poverty and exclusion, illustrated not least in the experience of emigration, or the delivery of healthcare to the poor and underprivileged (Kirby, 2004).

Currently Ireland is the second richest country in Europe with a GDP per capita of \$37,738 (Friedman, 2005) and the second wealthiest country in the world in terms of assets (second only to Japan) (O'Sullivan, 2006a). However despite this apparent wealth, the Irish healthcare system lags behind, with Ireland at the bottom of the European healthcare league (European Health Consumer Index, 2006). This anomaly relates to significant under funding of the health service throughout the 1980s as well as numerous bed closures (Lynch, 1998). Between 1980 and 1989 health expenditure decreased by 7 per cent in real terms, but between 1990 and 2000 it increased by 78 per cent in real terms. Despite this apparent increase the share of GDP devoted to current health expenditure still fell from 7.8 per cent in 1980 to 6.3 per cent in 2002 (Wiley, 2005). There is overwhelming evidence that the Irish healthcare system has been improperly managed, significantly understaffed and loosely funded (MacAnthony, 2001) and significant inequalities have also been highlighted within the system including inefficient administration and stifling bureaucracy (Robbins, 1997).

Despite these issues, however, there have still been significant improvements in patient throughput during this time. Even though the number of inpatient beds decreased from 15,111 in 1980 to 11,891 in 2000, there was an increase in the number of inpatient admissions of 6 per cent. This was accomplished by more economic use of the beds with a reduction in average length of stay and increased use of day facilities (Department of Health and Children, 2003a). Outpatient activity increased in the same

period with over 2 million attendances in 2000 (an increase of 40 per cent over 1980) and casualty attendances increased by 8.4 per cent to 1,214,154.

Management of health services

Following an initial white paper on the health service in 1966 in Ireland, there have been a significant number of health documents including *Health: The Wider Dimensions; A Consultative Statement on health policy* (Department of Health (DoH), 1986), followed by *Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990s* (DoH, 1994) and *Quality and Fairness: A Health System for you* (DoHc, 2001). These government reports created a blueprint for the ideal healthcare system, however implementation has been lacking, whether due to lack of funding or political will. Tussing and Wren, (2006, p. 331) suggest that it is a system in crisis and is frequently “chaotic”. The 1994 Strategy was thought to be “very innovative for the period” with more than 200 proposed targets in 17 different areas (Wiley, 2001, p. 3). This viewpoint was continued in the 2001 Strategy Document with the key principles being; better health for everyone, fair access, appropriate care in the appropriate setting and high performance (Department of Health and Children, 2001). Each of these strategy documents developed and defined the legislation for the health service, and with each statement the goals and objectives evolved and became more clearly defined. This clarity became apparent with the Health Act of 2004 creating the Health Service Executive (HSE) and the establishment of the interim board for the Health Information and Quality Authority (HIQA) in early 2005. Prior to the establishment of the HSE the Irish healthcare structure had been in place for 30 years with approximately 60 different agencies/bodies No single one body was responsible at a national level so the service was seen an un-coordinated and fragmented with tension between national and local objectives. The purpose of the HSE is to create a single, unified health service with devolved and empowered decision-making at local level to improve effectiveness and efficiency of the healthcare system in order to achieve improved patient/client care, a better working environment for staff along with enhanced value for money.

However, the HSE has the added benefit for the Minister for Health and Children, of creating a buffer between the ministerial office and the public. Any questions directed to the Health Minister in the Irish Parliament are largely passed on to the HSE for answers, with the result that the information is not returned, and placed into the Irish Parliament record to be made available to the public. This adds to the democratic deficit as the previous health boards used to meet in public, while the HSE meets only behind closed doors (Hunter, 2006). As the key aim of the Health Strategy is to deliver high quality services that are based on evidence-supported best practice, the Health Information and Quality Authority (HIQA) is being established to advance this aim. The responsibilities of HIQA (and its structure) are in three main areas:

- (1) developing health information;
- (2) promoting and implementing quality assurance programmes nationally; and
- (3) overseeing health technology assessment.

This will define the Irish Health Service as three sides of a triangle with HIQA defining the quality and service required, the Department of Health and Children defining the strategy and future direction of the Health Service and the HSE in charge of the healthcare budget. However the healthcare landscape is littered with the bones of

previous medical reports, the Brennan Report (Department of Health and Children, 2003a), the Prospectus Report (Department of Health and Children, 2003b), and the Hanly Report (Department of Health and Children, 2003c) among the best known. While the aspirations of these reports might be noble, the implementation of them has not been simple. The Hanly report on medical staffing in the acute hospital system suggested that centralisation of services would be beneficial for the patients and more cost-effective for the Department of Health (Department of Health and Children, 2003c). However implementation would require the downgrading of some hospitals and the closure of others, and public outcry regarding the closure of local hospitals has meant that implementation of any of these proposal is political suicide (O'Regan and Deegan, 2004, O'Regan, 2006a).

Of course without the presence of clearly defined transfer protocols and a proper medical transport network, there is potential for patient care to be significantly compromised. The proposed downgrading of some provincial hospitals has met with enormous local opposition. Claims that patients requiring urgent thrombolysis may miss the "golden first hour" of treatment and die, have been used to good effect with over two thousand people at a recent local rally (Cryan, 2006, p. 6).

Media focus on healthcare crises

The Accident and Emergency (A&E) crisis in Ireland is never far from the newspaper headlines, with the situation only becoming a "national crisis" when the current government were berated on the national media where the health system was deemed to be "disgusting" (O'Kelly, 2006). This public outcry went to the core of the problem and gave voice to each person in Ireland. The Minister for Health proposed an A&E ten point plan in November 2004 claiming the situation would be solved before Christmas 2005. However it has taken significantly longer than that, with, on average, 40 per cent less patients on trolleys in A&E in 2006 (Newman, 2006) however this has come at the expense of the elective patients requiring surgery. A national newspaper headline "A&E crisis killing "three patients every week" outlined the fact that due to A&E overcrowding seriously ill patients requiring surgery have been cancelled (O'Regan, 2006b). By prioritising patients lying on trolleys in A&E (which is bad press), patients who require urgent surgery for cancer treatment or urgent vascular intervention have had their operations cancelled.

The Department of Health and Children introduced the Waiting List Initiative (WLI) in 1993 to deal with a persistent waiting list problem in the acute hospitals. This problem involved significant numbers of public patients waiting long periods for elective (non-emergency) hospital treatment. In setting up the Initiative, the Department set targets for the maximum length of time patients should have to wait for treatment in specialties with the longest waiting lists. The targets were that adults would not have to wait longer than 12 months and children would not have to wait longer than six months. WLI funding which was provided in addition to normal hospital funding was intended to incentivise hospitals and health boards to perform extra elective procedures; be targeted specifically at patients waiting longer than target times in the selected specialties; be ring-fenced i.e. kept separate from other funding of elective procedures.

The Waiting List Initiative became subsumed into the National Treatment Purchase Fund (NTPF) and now the situation regarding the waiting times and lists

have been even more obfuscated than before. The responsibility for collating the waiting lists now rests with the NTPF who may have a conflict of interest, as their reason for being is to reduce waiting lists. Progress is slow with the information for only 19 hospitals collected so far. This sample has 11,000 patients on waiting lists, with 6,600 waiting more than six months and 2,600 waiting over 12 months (NTPF, 2006). Almost 50 per cent of patients wait six months on waiting lists before being referred to the NTPF. This is contrary to the Minister of Health's statement that the waiting lists "have been effectively cleared" (Hunter, 2006). These figures do not take into account those patients who are waiting (sometime for years) for an outpatient appointment. However reduced waiting lists satisfy the political agenda and win votes.

Ireland has topped the league in one section of an EU health survey, as it has more Methicillin Resistant Staphylococcus Aureus (MRSA) infections than any other country with 315 reported cases of MRSA in the first six months of 2005 (O'Sullivan, 2006b). This is in conjunction with the first Hygiene Audit, which showed that 91 per cent of Irish hospitals fall below an acceptable level of cleanliness. However, the Minister of Health has responded with the fact that medical staff hand washing is the most important factor in reduction of the MRSA problem, which is somewhat disingenuous and it creates a more difficult situation for those people working in the frontline. While it is one of the factors in MRSA transmission – the overcrowding on hospital wards as well as A&E, is more likely to be a contributory factor (Kennedy, 2006a).

Medical scandals

Primum est ut non nocere (Inman, 1860). It may seem a strange principle to enunciate as a first requirement in a hospital that it should do the sick no harm (Nightingale, 1863). However, due to recent reports the public confidence in the health system has been severely dented. There have been many scandals, which have hit the headlines, and lives have been lost. A litany of issues, problems (both managerial and clinical) as well as substandard patient care, in both the hospital system as well as in the community, have been exposed both by internal whistleblowers as well as undercover media sources.

The infection of 960 women with hepatitis C following the administration of Anti-D immunoglobulin from an infected patient in 1976 (Lindsay Inquiry) was "the biggest scandal in the state" and rocked the government following a bitter confrontation with the families, leading to one of the biggest compensation cases in the states history (Murdoch, 1996, p. 270). It was found that despite the Blood Transfusion Board being aware that patients could be at risk, nothing was done to prevent or follow-up these patients (Lindsay, 2002). This lack of follow-up impacted hugely on their outcome because medical treatment for their condition was delayed, leading to significant morbidity and mortality. These failures were systemic as the board failed to apply the same procedure for anti-D immunoglobulins it did for other blood products, with no explanation proffered for including plasma from a donor who had been jaundiced (Murdoch, 1996).

Scandals in the Nursing Home sector in May 2005 sparked a public outcry at some of the practices seen carried out there through the national media. This prompted the government to close the nursing home which was highlighted following which an inquiry has been carried out. This report has been completed but had significant delays before being published (Kennedy, 2006b). The report by a leading gerontologist

outlines a catalogue of systematic institutional abuse (Hennessy and Donnellan, 2006, p. 10) and quotes his conclusion that:

Given the lack of structural funding, standards and oversights, the standards in this nursing home are very likely to be replicated to a greater or lesser extent in institutions throughout the long care system.

The case of an obstetrician at the centre of the Lourdes Inquiry (Harding Clark, 2006) illustrates the difficulties faced by clinicians working in small maternity units. According to the report, this obstetrician performed unnecessary Caesarean sections with 129 hysterectomies over 25 years, when 40 per cent of them were having their first or second baby. While it is likely that some lives were saved as a result of these hysterectomies, this number was consistently excessive compared to 59 caesarean hysterectomies performed by the other three consultants. This unit, at the centre of the inquiry, worked according to a system, which was outdated at the time and a throwback to earlier times. Each obstetrician appeared to work in isolation with no structure in place for review of the figures or discussion of any unit issues. This is not in keeping with best practice and has since been resolved. The report of the inquiry emphasised that there was no malice intended and that similar situations have occurred in hospitals in the UK (Bristol Enquiry). The recommendations made were that “organised resourced systems must be in place to evaluate outcomes and competence and act on unusual results” (Harding Clark, 2006). The report emphasised that “good decent hardworking people can unwittingly enable bad practice when support and safety systems are not in place” (Harding Clark, 2006, p. 54). None of the recommendations have yet been implemented.

The case of a young girl who died a few hours after having been sent home from an A&E in another part of Ireland again brings to media attention the lack of resources in healthcare in Ireland. The inquiry heard that an inexperienced A&E doctor assessed the patient as the A&E Consultant was not available on that day, and the surgical team was not informed of the patient. Following a second inquest a verdict of medical misadventure was returned (O'Regan, 2006c).

The death of a further patient has caused significant disquiet in the North-East of Ireland following on from the previous cases (Kerrigan, 2005). The report revealed systematic evidence of lack of engagement between management and clinicians that made a major contribution to the circumstances resulting in the death of this patient (Health Service Executive, 2006). It recommended that a major reassessment of management structures and process be undertaken to ensure effective manager/clinician engagement and future collaboration. The consultant surgeon on call that night was found to be in breach of best medical practice for not putting the patient into an ambulance and sending him to another hospital or not personally making the telephone call to the other consultant (O'Regan, 2006d). No managers were named.

Healthcare professionals themselves are calling for significant reform in the health services and point out that in a time of such affluence it is only right that some of our wealth is channelled into the health service (Ennis and Harrington, 1999). The regulation of medical care professionals is central to attempts at quality improvement. “Good Doctors, Safer practices” lists recent cases of poor clinical practice or criminal conduct, e.g. Shipman Enquiry and department of cardiac surgery in Bristol Infirmary

(Department of Health, 2006). It has been shown that older doctors and those who have been practising for many years have less factual knowledge, are less likely to adhere to appropriate standards of care, and may also have poorer patient outcomes (Choudhry *et al.*, 2005). Lack of certification is associated with an increased risk of disciplinary action, as well as increased mortality and prolonged hospital stay (Norcini *et al.*, 2002; Kohatsu *et al.*, 2004). This would support the introduction of competence assurance which is being covered by the new Medical Practitioners Bill in Ireland, currently under review. This bill would require all medical doctors to undergo peer review at fixed time periods (five years) to confirm their competence. If properly funded and approached in a non-adversarial manner it has significant potential. However the track record is poor with medical practitioners having been scapegoated in each of the individual inquiries, which showed significant issues with regard to management structures staffing as well as funding. Until this suspicion is overcome by real and guaranteed assurances, the medical profession are wary of any government initiatives.

Satisfaction with quality of healthcare

Despite all this bad press and repeated scandals people seem to be satisfied with their in-hospital treatment. A patient satisfaction survey was carried out in order to assess the situation pertaining to patient satisfaction in acute healthcare hospitals in Ireland in 2004. Out of a total of 4,820 patients surveyed by telephone 91 per cent of them stated that they would return to the same hospital if they required further treatment (Irish Society of Quality in Healthcare, 2003). Most of the problems related to communication and information, with most patients unaware of the daily hospital routine. Patients felt they were poorly informed regarding their condition or treatment but were given little opportunity to discuss these with staff. At discharge patients were rarely given information about alteration in their medication or how they should manage their transition from the acute hospital setting to home (Sweeney *et al.*, 2003). One of the defined goals of the National Health Strategy 2001 was to place the patient at the centre in the delivery of care, as there is significant evidence linking consumer feedback and participation in decision-making, which empowers patients leading to improvement in healthcare outcomes. Patients are being encouraged to become more involved in their own healthcare as providers identify it as a cost-effective and non-invasive quality control technique (Fallowfield *et al.*, 1990; England and Cole, 1992).

Public health initiatives which prevent rather than treat disease have been shown to be much more cost-effective. The smoking ban in licensed premises has already had a profound effect with bar-workers having significantly improved lung function one year following the legislation (Allwright *et al.*, 2005). While the current Minister of Health, may not be remembered for having an enormous effect on the health of the nation; however while Minister of State at the Department of the Environment she banned the sale of coal which has been linked with the reduction in deaths of elderly respiratory patients by 15.7 per cent (Treacy, 2001). The biggest public health challenge facing the future of the Irish health system is the rising problem of obesity with almost 50 per cent of men overweight (20 per cent of these are obese) (Sweeney, 2005). Obesity has now been termed an epidemic by the World Health Organisation, while here in Ireland one in ten children are obese (Kelleher, 2005) with 10,000 new children being classed with obesity each year. One Irish Minister has warned that this

is an urgent situation and one which the government must tackle urgently (Sweeney, 2005). The Report of the National Taskforce on Obesity has 93 recommendations that aim to tackle obesity by banning vending machines in primary schools, guidelines on food labelling, and guidelines on the detection of overweight and obesity (Department of Health and Children, 2005). In addition the Department of Health and Children has developed a new obesity public awareness campaign promoting the two main lifestyle areas of healthy eating and regular physical activity.

Conclusion

The Health Service in Ireland is not what it should be. Progress has been made but resistance at all levels is significant due to the mistrust and miscommunication between the managerial and clinical personnel built up during the past number of years. The trust of the public is at an all-time low, however once patients are within the system they are happy with their care. For the first time in history real change is occurring and the landscape is changing, however with all this restructuring it is important that the patient/client remains the focus and remains at the centre of the service:

It should be borne in mind that there is nothing more difficult to arrange, more doubtful of success and more dangerous to carry through, than initiating changes in the State's arrangements. The innovator makes enemies of all those who prospered under the old order, and only lukewarm support is forthcoming from those who would prosper under the new (Machiavelli).

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