The Social Protection Committee

REF:SPC/2002/APR/01 En/rev 1

Questionnaire on Health and Long-Term Care for the Elderly

ACCESS

1.1 HEALTH CARE[1]

1.1.1 Mechanisms for guaranteeing access

Briefly outline the general structure and characteristics of the health system (e.g. universal entitlement, or insurance based on compulsory affiliation). Describe the mechanisms for ensuring that it provides universal access? Describe the objectives of your system in terms of scope and coverage. Questions relating to scope could include:

- **Limitations in the type of healthcare which is covered e.g. on the basis of an assessment of the most urgent medical needs;**
- **does the system cover the entire cost of treatments or what contributions /co-financing are to be provided by the patient?**

Questions regarding coverage could include:

- **does the system comprehensively cover the whole population?**
- **Which groups are not covered or only partially covered?**
- **Are there separate provisions on the basis of income or means/ability to pay?**

Describe any specific provisions relating either to the scope or coverage of the system aimed at facilitating access to healthcare for older people[2]. Either in this section or under question 1.2.2, describe how policies for the provision of healthcare to the elderly and policies for long-term care are co-ordinated and integrated.

Answer:

The Irish health system is a mix of both public and private institutions and funders. It is primarily tax-financed and is available to all inhabitants, subject to rules on residency.

The current system of eligibility provides that any person, regardless of nationality, who is accepted by the health boards as being ordinarily resident in Ireland, is entitled to either full

eligibility (medical card holders) or limited eligibility (all others) for health and personal social services. Health Boards, who have responsibility for the delivery of health and personal social services, normally regard a person as ordinarily resident in Ireland if he/she satisfies the health board that it is his/her intention to remain in Ireland for a minimum period of one year.

Medical card holders are eligible for a full range of services free of charge, including general practitioner services, prescribed drugs and medicines, all in-patient public hospital services in public wards including consultants services, all out-patient public hospital services including consultants services, dental, ophthalmic and aural services and appmiances, and a maternity and infant care service. Eligibility for medical cards is primarily based on the notion of "hardship" with income guidelines drawn up by the Health Board Chief Executive Officers used as a 'means test' to determine eligibility. However, since 1 July 2001, persons aged 70 years and over are automatically eligible for a medical card regardless of hardship or means.

Non-medical cardholders have limited eligibility for health services, including all in-patient public hospital services in public wards and consultant services and outpatient public hospital services and consultant services, subject to certain modest charges. Dental and routine ophthalmic and aural services are excluded from outpatient services. Attendance at accident and emergency departments is subject to a charge where the patient does not have a referral note from his/her doctor.

There is a dedicated unit in the Dept Of Health and Children to develop and implement policies on care for older people. There are also dedicated units in all Health Boards to plan and oversee delivery of services to older people. The Health (Nursing Homes) Act 1993 **(see Annex 1** for Regulations made under this Act**)** provides for the payment of subvention to older people who opt for care in private nursing homes and who satisfy certain criteria. The Private nursing home sector caters almost totally for older people.

In accordance with the Health Strategy 2001 (Quality and Fairness – A Health System For You, - see www.doh.ie/hstrat/index/html), regional advisory panels/co-ordinating committees (including service-providers and consumers) will be established in all health

board areas for older consumers and their carers, to provide them with a voice. The National Council on Ageing and Older People is a statutory body (30 members with wide expertise) that advises Government on issues relating to older people, particularly health.

1.1.2 Assessment

Are there indicators in terms of performance regarding access to healthcare, e.g.

- **Waiting lists;**
- **Inequalities in regard to access to certain "flagship" or newly emerging treatments?**
- **Regional or income related inequalities;**
- **Specific groups likely to be not fully covered.**

Answer:

A range of approaches is currently in place to measure performance, including access to healthcare, such as:

- systems to monitor health outcomes and progress against strategic priorities at national level, such as the Public Health Information System (PHIS) and strategy indicators used for the National Cancer Register;
- systems to monitor the performance of programme/service areas, such as the hospital inpatient enquiry system (HIPE) and datasets such as the National Intellectual Disability Database;
- systems to monitor performance at health board and agency level, such as integrated management returns (IMRs) and service plan indicators.

A considerable amount of progress has been achieved in recent years in the development of service plan performance indicators, which is viewed as integral to development and improvement in access, quality, efficiency, effectiveness and outcomes of services.

A suite of Performance Measure Performance Indicators (PIs) focused on quality service delivery measurement was introduced in January 2002. These are largely actionable PIs, which can test the effectiveness of service delivery and are designed to enable monitoring, review and evaluation to assist in the drive to achieve VFM, combined with quality outcomes.

This set of PIs can better enable health agencies and the Department:

- to demonstrate progress
- analyse gaps,
- better target responses and
- evaluate results

over time and between regions in a comparable and shared context for improved service planning.

In relation to services for older persons there are currently five Performance Indicators to measure efficiency/effectiveness and equity/access, i.e.

- The number of re-admissions to acute hospitals within one week or one month of discharge for the same complaint/condition by speciality.

- The number of patients, over 65 years of age, on the waiting list for: *Cataract surgery, ENT surgery, Orthopaedic surgery,* and the number of cataract procedures completed on a day case basis and an in-patient basis.

- The percentage uptake of influenza vaccine among the medical card population aged over 65 years.

- The number of people aged over 75 years in continuing residential care, i.e. Health Board and other Nursing Home care as a percentage of the total population over 75 years.

- The percentage of people over 65 years of age who were in receipt of home help services (and the number of hours service provided), day care and respite care.

1.1.3 Challenges

What are the main challenges you face relating to the provision of access?

Answer:

One of the main challenges is the provision of acute beds for those in need of acute care. It is estimated that up to 50% of bed days in acute hospitals are taken up by persons over 65 years of age. There is a shortage of capacity in the acute system which the Government has recognized must be addressed over the next 10 years. An additional 709 beds will be put in place in the acute system generally over the next 6 to 9 months and of course older people will benefit significantly from this additional resource.

There are also challenges in regard to sufficient long stay care for older people. This is particularly so in regard to units operated by health boards. A Public Private Partnership (PPP) initiative is being developed for the provision of a significant extra block of beds in these units. The units are known as Community Nursing Units and are typically 50 beds in size, including 20 to 25 beds for short-term care. There will also be a Day Care Center attached to these units.

With regard to Community Care Services for older people, there is a particular difficulty in relation to the availability of paramedical grades to support older people in the community, for example occupational therapists and physiotherapists. The Department is working with training colleges to provide more personnel in these areas while Health Boards are intensifying their recruitment programs to attract these grades.

1.1.4 Planned policy changes

Describe any planned changes to the overall system or policy mechanisms under consideration.

Answer:

Please see above **(1.1.3)** where main policy challenges are outlined.

1.2 LONG-TERM CARE

1.2.1 Access to long-term care.

Briefly outline the structures and mechanisms in support of the provision of long-term care (e.g. direct provision via social services; coverage of the need for care via universal coverage, social insurance, social assistance and/or private insurance; supports for informal caring). Are such provisions comprehensive in coverage (aimed at the entire population in need of care or only those otherwise unable to provide); and comprehensive in scope (does it aim to cover all forms of care and their full cost or only some forms of care and part of the cost).

Answer:

Access to public facilities is on the basis of medical need. Access to private nursing homes under the Subvention Scheme **(mentioned in 1.1.1)** is also based on medical need. However, the rate of subvention is determined by (a) degree of dependency and (b) level of means. Funding of both schemes comes from the exchequer (i.e., through taxation). Generally speaking, care in a public facility is provided at minimal cost to the patient, while care in a private nursing home, even where a subvention is payable, can impose a significant cost burden on the older person or their family.

1.2.2 Assessment

Are there indicators of performance regarding access to long-term care, e.g.

- **Waiting lists for residential care places;**
- **Regional or income related inequalities;**
- **Specific groups likely to be not fully covered.**

Answer:

In common with most other EU countries, Ireland is experiencing an increase in the number of older people in the population. Economic and social progress and improved health care have combined to reduce premature mortality. In 1996 the number of people aged 65 years and over was 413,000. This is projected to increase to 503,900 by 2011, an increase in the order of 90,000 or about 6,000 per year. Between 1996 and 2011 the number of people aged 80 and over is projected to increase by over 25% (from 90,400 to 114,000). By 2031 this number will have increased by 125%, to approximately 207,000.

1.2.3 Challenges

What are the main challenges you face relating to the provision of access?

Answer:

The main challenge is to provide adequate facilities and services for the rising number of older people.

1.2.4 Planned policy changes

Describe any planned changes to the system.

Answer:

Under the 2001 Health Strategy, it is proposed to:

(a) Bring forward proposals on the financing of long-term care for older people;

(b) Amend the Nursing Home Subvention Scheme to take account of the expenditure review of the scheme. A large number of older people would like the option of receiving care in the home rather than in a nursing home. The recent expenditure review of the Nursing Home Subvention Scheme has shown that current funding arrangements do not effectively support home care. The Government intends reforming the operation of the existing schemes, including the Carer's Allowance, in order to introduce an integrated care subvention scheme which maximises support for home care. In addition, subvention rates payable in private nursing homes will be reviewed. The Department of Health and Children will begin work immediately with the Department of Social and Family Affairs to develop detailed proposals for the new scheme with a view to introduction as soon as possible.

2 QUALITY

2.1 HEALTH CARE

2.1.1 Standards

Are there national standards related to quality; targets in terms of access to medical professionals, hospital beds? Are patients' rights defined?

Answer:

A Charter of Rights for Hospital Patients was introduced in August 1992. It provides guidelines for good standards of practice in acute hospitals, including maternity hospitals. Although the Charter has no statutory basis, its objective is to ensure that the health service is responsive to the needs of the individual patient and that there is a code of practice available which sets out what patients have a right to expect when they make use of hospital services.

In addition, the national Health Strategy identifies as one of its objectives the introduction of standardised quality systems to support best patient care and safety. National standards and protocols for quality care, patient safety and risk management will be drawn up for all health and personal social services. While driven centrally, these standards will be developed on a partnership basis with relevant stakeholders and will be updated regularly. Quality assurance mechanisms will be introduced as a means of improving performance and preventing problems using a structured set of planned and systematic activities such as documentation, training and review. This approach will allow the quality of services to be benchmarked as well as improving consistency, increasing accountability and ensuring that good practices are spread throughout the system.

2.1.2 Assessment

Describe mechanisms for assessing high levels of quality of treatment and for setting and monitoring high standards in healthcare and long-term care.

What mechanisms are there to assess the quality of medical treatments? What criteria are used in making such assessments?

Answer:

Accreditation is an internationally recognised process, which combines self-assessment and external peer review of an organisation's performance against a set of pre-determined standards, with an objective to encourage health agencies to continuously improve the

Health Care delivery system. A pilot scheme for Ireland has been developed focusing initially on the major acute hospitals. Each of the participating hospitals will or have established an accreditation steering group and are required to appoint a Hospital Accreditation Project manager to ensure that each hospital is prepared to participate in standards development and the overall implementation of the scheme. While a whole-hospital accreditation scheme is already in place in a number of the larger teaching hospitals, this new approach to quality should result in much greater resort to benchmarking and performance management by reference to evidence and research based standards, adopted nationally.

The Health Information and Quality Authority (HIQA), which was proposed in the Health Strategy, is expected to be further developed in the forthcoming National Health Information Strategy. The role of HIQA will be to further develop quality assessment of public health services. It is hoped to have the Authority in place in the first half of 2003.

The Research and Development components of the Health Research Strategy launched last year complement and support the drive indicated in the Health Strategy 'Quality and Fairness' towards a more clearly evidence-based approach to health service planning and delivery and towards monitoring and evaluating this service for quality.

2.1.3 Promoting quality enhancements

What mechanisms exist for developing, promoting and ensuring accessibility to good quality practices? Is there a particular focus on developing, promoting and ensuring accessibility to such practices for healthcare for the elderly?

Answer: **(and 2.2.1)**

The Nursing Homes (Care and Welfare) Regulations 1993, **(see Annex 1)** prescribe standards which must be observed in private nursing homes in relation to a range of issues such as contract of care, staffing, accommodation, kitchen, and sanitary facilities, nutrition and inspections.

In relation to Mechanisms being put in place, **see 2.1.2 above**.

2.1.4 Challenges

What are the main challenges you face relating to the promotion of quality?

Answer:

The development of appropriate information systems to support the quality agenda; the willing participation of management and health professionals in the further promotion of programs dealing with quality, and adequate investment levels where relevant to maintain high quality standards.

2.1.5 Planned policy changes

Describe any planned changes to the system.

Answer:

The establishment of the HIQA and further development of the hospital accreditation system will be of considerable benefit in promoting changes to the system. The implementation of the National Health Information Strategy will be crucial in improving high quality standards in the provision of treatment and care. The Health Strategy contains a commitment to introduce national standards for community and long-term residential care of older people. In addition, in accordance with the Strategy, the role of the Social Services Inspectorate (SSI) - an independent body whose current role is to inspect children's residential services- will be expanded to include residential care for older people. Also, see **2.1.2 above**.

2.2 LONG-TERM CARE

2.2.1 Standards

Are their national standards related to quality? Are care recipients' rights defined?

Answer: **(and 2.1.3)**

The Nursing Homes (Care and Welfare) Regulations 1993, **(see Annex 1)** prescribe standards which must be observed in private nursing homes in relation to a range of issues such as contract of care, staffing, accommodation, kitchen, and sanitary facilities, nutrition and inspections.

2.2.2 Monitoring and promotion of quality

Is there a system of assessment and recognition of carers and care institutions? Where informal care is supported, are there policies in favour of quality (e.g. financial support for infrastructure/adaptation of homes; training of informal carers)?

Answer:

Nurses have full training and qualifications. Unqualified staff (Attendants) receive informal training. Nurses receive special allowance for nursing older people. Grants are payable for adaptations to homes to allow dependent older people remain in their homes, e.g., hand-rails, walk-in baths, showers.

2.2.3 Challenges

What are the main challenges you face relating to the provision of quality long-term care?

Answer:

a) Availability of qualified staff. In recent years difficulty has been experienced in recruiting nursing and paramedical staff because of general shortages of these staff and

b) Replacing existing stock of old residential accommodation.

2.2.4 Planned policy changes

Describe any planned changes in this regard.

Answer:

An integrated approach to care planning for individuals will become a consistent feature of the system. This will include the appointment of key workers for dependent older people such as those on the margins of home and residential care. See also **2.1.5**.

3 SUSTAINABILITY

3.1 HEALTH CARE

3.1.1 Expenditure and financing

Describe current levels of expenditure on healthcare and recent and projected trends. If it is possible to present separate figures for healthcare for the elderly, please do so. Describe financing mechanisms (social insurance contributions, general taxation, voluntary insurance including tax reliefs where relevant, patient charges). [Note: these may already have been described in the brief system description under section 1.1.1]

Answer:

The Revised Book of Estimates provides details of expenditure on the Irish Public Health Services by programme and service. An analysis of this expenditure from 1990 to 2002 is attached at ***Annex 2***. (See also **3.2.1**). The costs of providing care to persons 65 years of age and older impacts on a number of programmes of this Estimate. ***Annex 3*** estimates costs by Programme and service from the Revised Books of Estimates from 1990 to 2002 that can be allocated to this category of persons.

It is not possible to identify actual costs associated with the provision of certain services to over 65 year olds. Examples of such services are acute hospital services, ambulance services, general practitioner service, home nursing services, home help services and meals-on-wheels services, etc.

Persons aged 65 years and older account for 45% of the bed days in the acute hospital sector. It is therefore assumed in ***Annex 3*** that 45% of the costs in the acute hospital sector relates to persons in this age cohort. However, this assumption does not take account of the potentially greater complexity and cost of the treatment provided to persons in this age cohort. In relation to the other services, estimates of the expenditure on these services, which relate to persons in excess of 65 years of age, are based on the usage of these services by persons in that age cohort.

However, it is important to bear in mind that this analysis is only an estimate of the total costs of providing healthcare services to persons in excess of 65 years of age. A number of assumptions are made with regard to the proportion of total expenditure that relates to

persons 65 years and older. In addition, these estimates do not take account of the administrative costs of providing such services to this age cohort.

3.1.2 Expenditure trends

Give an assessment regarding trends in costs and in requiree funding. How can this be reconciled with other policy goals, e.g. sustainable public finances, in the light of the ageing of the population?

Answer:

Expenditure on health care has increased by 130% since 1997. The following are the main areas where investments have been made in health services programmes;- Continuing Care (including Services for Older People/Palliative Care), Acute Hospitals and Primary Care.

The Health Strategy has spoken about an additional €13 billion as being necessary to bring services in Ireland up to the highest international level. The Government is committed to implementing the Strategy but this is of course contingent on the state of the public finances.

The overall increase for health services this year was 16% and it is clear that the Government are affording priority to the health services in regard to exchequer funding. There are some difficulties for Government in regard to the public finances but these are being addressed while at the same time giving health services, as indicated, a definite priority. While there are problems associated with the ageing of the population, at this point the fact is that Ireland is in a more favourable position than other countries on demographics. However, there are certainly more people over the age of 80 living than ever before, which will create significant pressure on acute hospitals and on acute programmes. For example, it is estimated that the number of people over 80 years of age increases by 1500 each year.

3.1.3 Cost control mechanisms

Describe mechanisms to control spending:

- **the role of charges as a means of controlling demand;**
- **financial incentives/market mechanisms to ensure cost control in provision;**
- **mechanisms for raising the sensitivity of health institutions and professionals to cost considerations when deciding on treatments;**

Answer:

There are mechanisms in place to provide for charges being paid by patients towards services. An example is a charge of €40 which is levied on persons who do not hold a medical card and who attend at hospital Accident & Emergency departments without a referral note from their doctor. The charge is intended to discourage the inappropriate use of A&E Departments. When these charges were increased in January 2000, attendances dropped during that year.

There is a statutory charge for inpatient services in public hospitals (again for people who do not hold a medical card) of €36 per overnight or day case, subject to a maximum of €360 in any year, and there are charges in respect of private and semi-private rooms in public hospitals. However, these charges are based on the principle that those who can afford to do so are required to make a contribution towards the cost of providing hospital services. They are not intended as a means of controlling demand.

The main financial incentive for health services in Ireland is that under legislation Health Boards who have an excess of expenditure in any one year must apply that excess as a first charge on the next year. This has been of great significance in the Departments overall management of health service spending. Over recent years the level of excessive expenditure has been about 0.2% or less of total spend. This is a considerable achievement given the demand led nature of health services.

Another mechanism is the use of Casemix to encourage more cost effective use of resources. The Casemix Measurement System is, in essence, a system to measure the relative cost efficiency of certain acute hospitals in the Irish system.

There have been, in the past, VFM targets applied by the Department to the budgets of health boards and hospitals. Each institution in such programmes would have to achieve its VFM targets or reduce services. It is anticipated that such programmes will become a more common feature of cost control as management information systems improve and as Governments demand more cost effective approaches to health care delivery.

3.1.3 (contd.) Cost control mechanisms

Describe mechanisms to control spending:

- **controlling the cost of materials and products such as pharmaceuticals.**

Answer:

The price of drugs and medicines (ex-manufacturer) in Ireland has been subject to control since 1972 through formal multi annual agreements with the Irish Pharmaceutical Healthcare Association (IPHA), formerly the Federation of Irish Chemical Industries (FICI). More recently, other mechanisms have been developed to curb costs, for example Indicative Drugs Targets for general practitioners and increasing emphasis on the prescription of generic drugs. However, the Agreement with Industry remains central to the Department's overall drugs strategy aimed at containing the cost of drugs to the Exchequer.

The key features of the current Agreement are:

Duration of the Agreement

The duration of the Agreement is the period 1 August 1997 to 31 July 2004 after which twelve months notice to renegotiate may be given by either party.

Scope of the Agreement

The Agreement encompasses all medicines prescribable and reimbursable on the community drugs schemes and also drugs supplied to hospitals and health boards. All new medicines with a Product Authorisation, which satisfy the published criteria for reimbursement under the GMS and all medicines currently reimbursable on the GMS will remain reimbursable for the duration of the Agreement, subject to the usual deletion arrangements.

Doctors in the GMS Scheme are free to prescribe medicines of their choice from the list of medicines available under the GMS. Doctors are also free to prescribe medicines of their choice from this list under the other community drugs schemes.

The Agreement retains the right of the Department to influence the prescribing habits of doctors. This is particularly important in the context of our agreement with the Irish Medical Organisation to initiate cost effective prescribing in the community drugs schemes.

Prices

There are three pricing elements to the Agreement - the price freeze, the price of new products and the GMS rebate.

Price Freeze

There is a price freeze in the cost of medicines covered by the Agreement. The prices are subject to review should there be a cumulative, currency adjusted average increase or decrease of 10% in the indices of wholesale prices of prescription medicines in an agreed basket of European currencies. The relevant countries are Denmark, France, Germany, the Netherlands and the U.K.

New Products

The price of new products will be linked to the lesser of the currency adjusted U.K. price and the average price of the same product in the basket of nominated European countries as set out above.

GMS Rebate

The rebate payable by the manufacturer or importer to the GMS (Payments) Board is 3%. IPHA wished to drop this rebate in last year's negotiations.

Hospital Supplies

Supplies to hospitals or to health boards are at the Irish trade price less wholesale discount (currently trade price less 15%) on orders over IR£500. Hospitals and health boards will be free to negotiate better terms than this minimum discount of 15%.

Continuity of Supply

The Agreement contains a clause dealing with the uninterrupted supply of medicines to patients for which there is no therapeutic alternative available in the market.

Price Differentials between Ireland and the U.K

A clause is included to set up a mechanism to deal with any price discrepancies which emerge between Ireland and the U.K. for similar products.

Indigenous Industry

The same terms were agreed with the Association of Pharmaceutical Manufacturers of Ireland (APMI).

Control of Drug Costs

Community Drug Schemes

Approved prescribed medicines and products are available under the Drug Payment (DPS), General Medical Services (GMS) and Long-Term Illness (LTI) Schemes. To ensure equity under the GMS and DPS, there is a common list of reimbursable medicines for both schemes, which is reviewed and amended monthly. Approved items must comply with published criteria, which include authorisation status where appropriate, price and in certain cases intended uses. In addition, items should ordinarily be supplied to the public on prescription only and should not be advertised or promoted to the public.

Drug Payment Scheme

Under the DPS, individuals and families pay only the first €65 per calendar month of expenditure on approved items. On 31/12/00 (the most recent available figures), approximately 942,000 people (25 % of the population) had registered with health boards for the DPS, for which about 68% of the population is eligible. Monthly expenditure below €65 is effectively private prescribing and is not included in the cost of pharmaceutical services.

General Medical Services

Under GMS, people below the income threshold or aged 70 and over receive approved items free of charge. Approximately 30% of the population is covered under GMS.

Long-Term Illness Scheme

Under the LTI, people suffering from a prescribed disease or disability (such as Parkinsonism, cerebral palsy or diabetes mellitus) receive prescribed medicines for that condition free of charge. The medicines may or may not be on the common list. Around 83,000 people (2.2% of the population) are covered under the LTI, which is not income tested.

Supply, Purchasing and Pricing of Medicines - Current Supply/Purchasing Arrangements

General Medical Services
Under the GMS, medicines are supplied to medical card holders in the same way as non-medical card holders, through approximately 1200 retail community pharmacies contracted by the health boards.

Medicines dispensed through the GMS are purchased by community pharmacists as part of their normal pharmacy stock (GMS and private). The pharmacist is supplied directly by wholesalers or individual manufacturers. As they can be delivered within hours of being ordered by the pharmacist, drugs and medicines are available at short notice to meet individual patients' requirements.

As medicines are independently ordered by, and supplied to, pharmacies to meet the requirements of patients - often at short notice - the question of tendering for medicines does not arise. The Department does not purchase drugs and medicines for the Irish market. The GMS Payments Board reimburses pharmacists for medicines dispensed on the GMS Scheme, at the cost of prescription dispensed plus a professional dispensing fee, but without a mark-up. The normal retail mark-up for non-GMS dispensing is 50%.

According to the 2000 GMS Payments Board report, total payments for pharmaceutical services were **£456 m/€579 m** (cost of medicines = £350 m/€444 m + fees and mark-up = £106 m/€135 m).

Hospital Supplies
The position in hospitals and health boards is somewhat different. Purchasing is carried out by individual hospital authorities, groups of hospitals acting together or the health board, where it is the funding authority. The IPHA Agreement allows hospitals and health boards to combine and negotiate better terms than those in the Agreement. Therefore, their purchasing power can be maximised, achieving optimum benefit from the resources available for drugs and medicines expenditure. Clause 6.4 of the Agreement, which prohibits documentary tender, does not apply where the value of contracts exceeds the EU

threshold. All contracting authorities within the meaning of the Directive have been reminded of their obligation to conform to the procedure detailed in the Directives. In reality, tendering for hospital pharmaceutical procurement is unusual, for the following reasons.

(a) Hospital pharmaceutical procurement is mostly demand-led and hospital pharmacies must be able to respond instantly to demand. Accordingly, planned purchasing is not a regular feature of most hospital pharmacies.

(b) Most hospital pharmaceutical expenditure is for specialist patent-protected high-tech products, usually available from only one manufacturer or supplier.

Pricing of Medicines

The price of medicines is governed by the IPHA Agreement (see above), which sets maximum prices for reimbursable prescription medicines in the community drug schemes and for all medicines supplied to hospitals and health boards. The Agreement provides, among other things, for:-

(i) A freeze on drug prices.

(ii) A 3% rebate for all drugs supplied in the GMS.

(iii) Linking new product prices to the lesser of the UK price and the average product price in a basket of European countries.

(iv) Explicit recognition of the right of hospitals or health boards to negotiate better terms with individual manufacturers, importers or agents.

(v) Recognition of the need for continuity of supply to patients for whom there is no alternative therapeutic product available.

(vi) A safety net which allows for a review of the price freeze if the cumulative currency adjusted average increase or decrease in the wholesale prescription medicines indices in

a basket of European countries exceeds 10%.

The Agreement affords price stability, which allows the Department to tackle other elements of the strategy, including supply side initiatives such as the Indicative Drug Target Savings Scheme, which focuses on responsible and cost effective prescribing in the GMS, contributing to a significant reduction in the rate of increase in GMS medicine expenditure.

Comparison between GMS and Private Prescribing

Comparison between GMS and private prescribing is available only insofar as information on private prescribing has been available through reimbursed medicine costs under the DPS. However, it is difficult to make valid comparisons of prescribing patterns under these schemes. Regular DPS claimants are high consumers of medicines with significantly above average expenditure, and are not necessarily indicative of overall private prescribing.

Comparison with other EU Member States

Ireland has low prescription rates and costs compared to other EU countries. Ireland has the second lowest per capita consumption of medicines, the second lowest number of prescriptions per capita, and Ireland's total medicine costs as a percentage of total healthcare costs is the fourth lowest in the EU.

(vi) Cost Control and the approval process

There are cost control difficulties in allowing new products onto the list of reimbursable items under the current arrangements. Each month there are applications for approval of high-priced products, with an escalating impact on the drug budget. Under the current IPHA Agreement and arrangements, the Products Committee is in no position to refuse entry of such products to the common list of reimbursable items under the community drug schemes. Even if a product will have a large cost implication for the drug budget, it will be allowed entry to the list of reimbursable items if it fulfills all that is asked under the current agreements. The Department has initiated a review of the current arrangements for reimbursement.

3.1.3 (Contd.) Cost control mechanisms

Describe mechanisms to control spending:

- **The role of health promotion, disease prevention and, in particular, the promotion of healthy lifestyles for the elderly.**

Answer:

While the rationale for health promotion is usually set in the context of programmes for children and young and middle-aged adults, health promotion also has an essential role to play in improving the health and well-being of older people. However, it is important that older people themselves, health professionals and society in general are convinced of the value of health promotion in the lives of older people. Negative attitudes to ageing among people of all ages, and beliefs that older people cannot benefit from changes in behaviour, must be overcome. Older people must not be excluded from health promotion activities and preventive measures routinely offered to younger people.

Older people must be encouraged and enabled to participate in all aspects of life which promote their health and well-being.

The arguments for health promotion for older people are compelling. They include the following:

- A good quality of life will be maintained in well older people
- The effects of illness or disability in older people will be lessened
- The contribution of older people to society will be maximised
- Escalating health care costs associated with an ageing population will be partly offset.

Older people are a diverse group, most of whom are fit and healthy. Health promotion for older people is about prolonging the period of healthy ageing experienced by most older people and encouraging full and active participation in society. In some instances, health promotion for well older people may not need to be very different than for middle-aged or younger people, and older people may be included in programmes for the general population. However, special programmes which take account of the particular needs of older people are also required to enable and empower older people to increase control over, and to improve their health and well-being.

Both the younger (65-74) and the older (75 and over) populations include people in different categories of health status and dependency level. This diversity requires different approaches to health promotion for older people than for younger age groups.

While health promotion for all ages is about preventing illness, for older people it may also be about lessening the effects of illness or disability among those who are already ill or disabled. In addition, equal and early access to geriatric and other services is essential to ensure early recognition and treatment of illness and, where appropriate, planning for rehabilitation. For many older people, social interaction and other measures which improve quality of life, are essential elements of health promotion.

As a population group, older people are subject to certain considerations which attend the later years of life, and which have strategic implications for health promotion. The most important of these are as follows:

- Some people entering older age do so with chronic disease.
- The risks of cancer, heart disease, stroke and respiratory disease are higher in older people.
- With increasing age, older people experience an increased tendency to loss of fitness, mobility and strength. The very old tend towards physical frailty.
- Poorer vision and hearing contribute to less social contact as well as to an increased risk of accidents.
- Ageing is associated with less capacity to recover quickly from illness.
- Dietary and nutritional requirements change as people get older.
- Factors associated with ageing such as loneliness, more frequent bereavement, poor adjustment to retirement, inadequate income, poor health and functional incapacity may lead to psychological distress if not anticipated and appropriately managed.
- Mental health problems are an important cause of disability in older people. Depression is the commonest mental disorder; the prevalence of dementia increases with age.

The health of successive cohorts of older people will be affected by the extension and success of health promotion programmes to younger age groups; a healthy lifestyle acquired in early adulthood may well be maintained throughout life. This would result in those

reaching the age of 65 being healthier, with the real prospect of adding years to life and enabling active membership of the community for as long as possible. Although it may be more difficult for older people to change behaviours of a lifetime it is certainly possible, especially if they become partners in the health promotion process.

There is good evidence for using modifiable risk factors in older people as a basis for health promotion programmes. In one large randomised study in the US (Omenn *et al*. 1997), a multi-faceted health promotion programme for older people was introduced. The programme emphasised an increase in physical activity, a reduction of excess alcohol use, the identification and amelioration of hazards in the home and the detection and correction of visual and hearing deficits. The group receiving health promotion intervention had significantly fewer restricted activity and bed disability days during the first year of follow-up compared with controls. They had significantly less functional decline and significantly fewer persons suffered falls. After two years, with no additional intervention, the intervention group was still doing better, although as expected the differences diminished.

3.1.4 Challenges

Outline the main challenges regarding sustainability of healthcare.

Answer:

The main challenges are technology, patients' expectations and demographic changes.

As in all countries there is a growing demand by health institutions and professionals for access to the latest technology. This involves not only major equipment such as MRI, PET or Linnac for the treatment of cancer patients but also more particularly new drug therapies. Medical staff will very often demand that new drug therapies are fully available to their patients and an appreciation of their costs may very often be of secondary consideration by physicians. In virtually all major areas of treatment there are now new drug therapies which can have a powerful effect on the health of patients. There are also issues in regard to litigation whereby physicians may feel some vulnerability if latest treatments are not readily available. Health technology assessment, the drawing up of treatment protocols, clinicians involvement in management and continuing educational campaigns by management on the costs of new treatments and possible alternatives are some of the approaches that must be used by management.

There is no doubt that patients' expectations are far higher than ever before. This partly reflects a general demand in the economy for higher quality services to be delivered to the customer. It also reflects a more educated population which has easy access to medical information, on the Internet for example. There is certainly a growing impatience within the population on matters like waiting lists.

See also **1.2.2** in relation to demographic changes involving older people.

3.1.5 Planned policy changes

Describe any planned changes, in particular any initiatives focused on the provision of healthcare to the elderly.

Answer:

- A co-ordinated action plan to meet the needs of ageing and older people will be developed by the Department of Health and Children, in conjunction with the Departments of the Environment and Local Government, Social and Family Affairs and Public Enterprise;
- An action plan for dementia based on the recommendations of the National Council on Ageing and Older People will be implemented;
- Proposals on the financing of long-term care for older people will be brought forward.

3.2 LONG-TERM CARE

3.2.1 Expenditure and financing

In relation to long-term care, give estimates of current cost taking into account as fully as possible the impact across different policy domains.
Describe, where these exist, specific funding mechanisms for long-term care (e.g. targeted social insurance contributions).

Answer:

Annex 3 provides an analysis of the costs associated with the provision of health services for older persons in the period 1990 to 2002.

Annex 4 provides an analysis of expenditure that relates to the provision of long-term care for older people. Under the Community Welfare Programme, expenditure on item 3.14 and 3.15 relates specifically to the provision of long term care for older persons as does item 6.5 in the General Hospital Programme. In addition, expenditure on home nursing, home help and meal on wheels services is also related to the provision of long term care for older people who remain in their own homes

The Department of Social and Family Affairs administers the Carer's Allowance scheme and the Carer's Benefit scheme. The Carer's Allowance scheme is a means tested payment for carers on low income who look after people in need of full-time care and attention. Expenditure on this scheme in 2001 amounted to over €130.3 million. Approximately 55% of people receiving care from recipients of Carer's Allowance are over age 60. The Carer's Benefit scheme is intended to support people who must leave the workforce temporarily to care for someone who is in need of full-time care and attention. This is a weekly income support payment which is based on social insurance contributions paid by the carer. Expenditure on this scheme was in the region!of €2.5 million in 2001. However, the breakdown in expenditure between care recipients with disabilities and older care recipients is not available. All recipients of Carer's Allowance or Carer's Benefit receive an annual Respite Care Grant in June of each year. From June 2002, the amount of the respite care grant is €635.00 or €1,270.00 for people who are caring for more than one person. Expenditure on the respite care grants was in the region of €9.4 million in 2001. (See also **3.1.1**)

3.2.2 Cost control mechanisms

The role of charges in controlling demand for formal care.

How to ensure cost consideration in the planning and provision of long-term care: are there comparative assessments of different approaches (institutional/home-based; formal/informal)? Are there mechanisms for raising the sensitivity of care professionals and decision makers (e.g. social workers) to cost considerations?

Are there mechanisms for assessing long-term care and healthcare costs in an integrated way?

Answer:

Anecdotal evidence suggests that care in the community is best for the person and best economically. Research also confirms that this is the preferred option with older people. Therefore, such decisions are not based on economic considerations but rather on people's needs, wishes and national policy. The policy in Ireland is to maintain older people in dignity and independence at home in accordance with the wishes of older people, as expressed in many research studies; to restore to independence at home those older people who become ill or dependent; to encourage and support the care of older people in their own community by family, neighbours and voluntary bodies; to provide a high quality of hospital

and residential care for older people when they can no longer be maintained in dignity and independence at home.

3.2.3 Challenges

Outline the main challenges regarding sustainability of provisions for long-term care.

Answer:

A study to examine the future financing of long term care was undertaken by Mercer Ltd. This study considers the possible levels of future demands for long-term care over the medium and long term. It examines the strategic issues involved through an assessment of alternative financing/funding approaches and their feasibility in the Irish context. The study encompasses the financing of personal long-term care needs both in the community and in institutional care and the potential of the private sector or a combined public/private sector approach to develop new initiatives in this area. It is expected that this report will be published shortly.

3.2.4 Planned policy changes

Describe any planned changes.

Answer:

In addition to the publication of the report mentioned above, which is expected to stimulate debate on issues relating to long-term care in this country, the coalition parties of the current Government have agreed the following in their Programme for Government:

"We will implement a full range of policies aimed at supporting older people including delivering decent pensions and greatly improved care services".

"We will promote community facilities for the elderly, including community nursing units, in such a way as to actively promote independence".

The Government has also committed to:

- introducing measures to maximise support to those needing full-time care in the community,
- reviewing the means test on the Carer's Allowance, which is an income support payment for carers
- and
- significantly increasing the annual monetary grant which is paid to carers to assist with the cost of respite care.

The Health Strategy, which was published by the Department of Health and Children last year, echoes these commitments and it proposes developing an integrated approach to care planning and bringing forward proposals on the financing of long term care for older people.

ANNEXES

Annex 1

Annex 2

Annex 3

Annex 4