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The Irish Association for Emergency Medicine (IAEM) welcomes the opportunity to comment on resource allocation in the Health Service. Many of our members work in Emergency Departments (EDs) which are unfit for purpose[1] and are under-resourced both in infrastructure and personnel resources. IAEM is committed to equity of access and value for money for the taxpayer.

IAEM would make the following points:

1. The mechanism of how budgets are set for hospitals and devolved to departments within hospitals, including EDs, is not clear or transparent. As senior clinicians managing EDs we are unaware of what formula is applied to decide allocation of funds to EDs. A system that allows for money following the patient, appropriate payment for investigation and treatment delivered to patients and reward for completion of care (avoiding admission or referral) would certainly bring about more transparency and efficiency.

2. The current system whereby budgets for hospitals are not finalised prior to the commencement of the financial year is a root cause of many problems. It means that an individual hospital often does not know its funding allocation until the middle of the financial year. If the hospital then finds itself in an "overspent scenario" the impact on services is severe as there is only half a year to bring the budget back into line with available resources. A private organisation which arranged its finances in this manner would quickly end up in receivership.

3. The lack of multi-year advanced budgeting means that a hospital cannot prioritise service and/or capital development with any degree of certainty.

4. Many hospital buildings are old and require ongoing significant resource investment to maintain and improve the infrastructure. There is no provision for a "sinking fund" to maintain the existing infrastructure. Therefore, whenever some crisis work is required, planned services have to be curtailed to fund it.

5. There is currently no incentive for the Primary, Community and Continuing Care (PCCC) division of the Health Service Executive (HSE) to provide timely services to patients who are clinically discharged. The net result of this is manifested in large numbers of inpatients spending many hours on trolleys in Emergency Departments (EDs) because those inpatients who are ready to

return to the community are occupying acute hospital beds. This loss of clinical space significantly hinders the working of the ED, sometimes leading to complete gridlock for long periods of time. Research, both nationally and internationally, shows that patient mortality and morbidity rise as a direct consequence of this. ED overcrowding was declared a "National Emergency" by the Minister of Health & Children in March 2006. The current situation is at least as bad now as it was then. The current round of financial cutbacks, including service restrictions and ward closures, will only exacerbate this problem.

6. The acute hospital sector currently pays for services which are not part of its remit and results in it 'taking up the slack' for deficiencies elsewhere. Hospitals provide 'free' laboratory services to General Practitioners for patients for whom the PCCC is responsible. Similarly patients who are not in need of acute hospital services are often admitted to hospital because the appropriate resources are not available in the community. This worsens the overcrowding referred to in point 4.

7. If a patient's acute care is completed in the ED without having being admitted to an acute hospital bed on a ward because there is no acute bed available, this activity is not counted as part of the hospital's activity and is not resourced appropriately. This is despite the fact they have been 'admitted' to hospital and may be in the ED sometimes for days!

8. In an attempt to balance their books, hospitals often close wards or reduce surgical activity. This results in highly skilled senior staff being underutilised and waiting lists lengthening. This has a number of paradoxical outcomes. A surgeon who cannot operate on a patient as a public patient may find that he/she carries out the operation on them privately under the National Treatment Purchase Fund despite the fact that there was free theatre time available to undertake the procedure. Similarly, surgeons have been stopped from operating because they are too efficient and have completed the number of funded procedures for the year months ahead of schedule. Rather than being praised for this efficiency the surgeon may find his/her operating time reduced or the types of procedures he/she can undertake restricted. The lack of "joined up" thinking represented by the NTPF diverting public funds from the public to the private healthcare system against the background of ward closures, whilst providing good headlines in terms of numbers of procedures performed, is to the IAEM, a nonsense.

9. Arbitrary blanket edicts can have an untoward effect. The HSE currently has a recruitment embargo. The consequence of this is that the number of locums and agency staff employed across all groups of healthcare workers has risen dramatically as the need for these staff is not obviated by the post-holder retiring or resigning. The result has been an overall increase in costs rather than a reduction and the employment of staff that may not have the expertise, drive or skills of someone capable of successfully obtaining the substantive post.

10. There is a failure within existing funding to recognise that innovative methods of working may require initial seed capital so that they can commence. This is particularly the case with services that are designed to avoid hospital admission by providing a safe alternative. Thus, although a project may lead to a demonstrable reduction in costs, it cannot be implemented for the want of often modest investment. This is a particular area where Emergency Medicine has suffered. An obvious example is the ED outpatient management of venous thromboembolic disease which avoids hospital admission which would have been the way this condition was traditionally managed.

11. Resources do not follow the patient. There are large discrepancies in the resources provided to different institutions to manage the same workload. In most cases this is a reflection of historical under-resourcing of many institutions rather than over-resourcing of the better funded institutions. A comparison with international norms confirms this fact.

12. Best practice should be encouraged and rewarded rather than applying the disincentive of funding being withdrawn if a particular target is not achieved.

13. Resources sometimes become available with a short time span for their allocation for a particular purpose or the funds are lost. This results in hastily submitted proposals which do not always represent the best value for money or use of limited resources.

References

1. Emergency Department Task Force Report, Health Service Executive, June 2007
http://www.hse.ie/eng/Publications/services/Hospitals/ECTaskForce.html

Submitted on behalf of the Irish Association for Emergency Medicine

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