Irish Nurses and Midwives Organisation
Working Together

SUBMISSION TO

THE

2017 HEALTH SERVICE CAPACITY REVIEW

September 2017

1.0 Introduction

For almost 10 years, the Irish health service has undergone unprecedented budget cuts which have affected every aspect of the service, its clients, patients and staff. In the same period, particularly between 2009 and 2014, funding for the health service was reduced, in real terms, by over €4 billion resulting in the premature contraction/curtailment of services without viable alternatives.

Health service capacity has been grossly affected, reinforcing the two-tiered health system, with an over-reliance on the acute health service. It has severely impacted the ability of frontline staff to deliver the highest quality of care underpinned by internationally proven best, evidenced based, practice and has had a negative effect on the health of the population through delayed access to services.

In order to move forward in developing a new transformational model of care, which offers a single tiered integrated health service for all, political consensus is required now and into the future. It will require current, and future, governments to accept transformational change. The achievement of this new model of care will require short, medium and long term actions, but will deliver significant improvements for individuals, families and the economy.

In commencing any review of health service capacity, both current and future, the challenges facing the health service must be immediately acknowledged. In that context, issues that must be recognised are:

- The absence of, but need for, workforce planning and implementation;
- the fact that our health service is currently understaffed, is not viewed as employer of choice by health professions who enjoy a borderless labour market environment;
- the huge challenges arising from our rapidly changing demography and ageing of the population;
- modern lifestyle issues including obesity, failure to exercise, alcohol and drug abuse; and
- the management of chronic diseases as citizens have multiple morbidities as they live longer.

Therefore, in relation to capacity, and the need to increase same to enable our health service to meet current and future demand, it is the view of the INMO that a major, radical and significant expansion of all services is required including:

- expansion of the nursing/midwifery workforce, by 25% through the use of an evidence based tool to establish and maintain safe nurse/midwife patient ratios;
- increase in acute bed numbers to bring us up to the OECD average;

- an increase in our public long stay bed numbers to meet known future demographic changes;
- expanded primary care services, including diagnostics, which should operate on an extended day basis on a seven over seven approach (seven days a week);
- innovative expansion of all disability services, properly staffed, to maximise the integration and independence of all citizens; and
- all of this to be delivered within a transformational shift, over the next ten years, to a single tiered universally accessible health care service (Sláintecare Report).

Below we have provided answers to the questions required by the Capacity Review Public Consultation.

2.0 What changes in models of care and in the way we deliver care are a) most urgent and b) what implications will this have on capacity requirements?

2.1 *Staffing Shortages/Staff Capacity*

Since the economic crash of 2008, Irish health services have come under extreme pressure from budget cuts which have been unmanaged and unplanned. This has negatively impacted upon the ability of frontline staff to deliver the highest quality of care, underpinned by internationally proven best, evidence based practice, and has had a negative effect on the health of the population through delayed access to services.

Safe staffing levels should exist in all health services delivering nursing and midwifery care. Ireland is experiencing a chronic and persistent nursing/midwifery shortage. HSE efforts to date have been slow to recruit and retain nurses and midwives throughout the country. A recent survey of Irish nurse and midwife interns stated that 75% of respondents would consider emigrating once they have completed their degree programme (INMO, 2017b).

This recruitment and retention crisis requires urgent attention. The Department must note, with concern, the reduction in applications, for nursing/midwifery; which indicate a growing awareness amongst school leavers, that the pay and conditions of the professions are not competitive and are not reflective of the responsibilities carried. In that regard, the INMO has concerns about the potential misleading headlines arising from a recent report, with regard to nursing graduate employment, published by the Health Education Authority (HEA).

The INMO in working as part of the Taskforce for Nurse Staffing and Skill Mix has welcomed the recommendations and subsequent testing at pilot sites around the country. It is essential that the work of the Taskforce progresses and that a national tool is developed which will determine nurse staffing based on patient acuity. This is vital to ensure a stable, consistent and adequate safe nursing workforce, now and into the future.

In reforming our health services, towards the primary care setting, adequate and appropriate workforce planning is essential. To date, little evidence exists nationally or internationally on staffing within the primary care setting. The INMO welcomes the recent announcement, by the Minister for Health, Mr. Simon Harris TD, for a three year programme of research on staffing. In developing a new model of care in the primary setting, it is imperative that any staffing research is carried out in all areas of the health service including, primary care.

In short, a key immediate requirement is to increase the staffing capacity of our health service and this must begin with setting a target of increasing the nursing/midwifery staffing levels by 25%.

2.2 *Single Tiered Public Health Service*

Universal health coverage (UHC) is a priority set by the United Nations Sustainable Development Goals (SDGs) by 2030. The INMO acknowledges the key importance of this goal and highlights the need for government to invest, in nursing and midwifery, in order to achieve UHC and the SDGs.

The two-tiered public health service has created instability, inequality of access and dissatisfaction amongst patients, clients and staff. The commitment to a single tiered health system, where access to care is determined solely by need and not ability to pay, is most welcome and will be strongly supported by the INMO. This system must offer, at its core, speedy access and quality assured services, to every citizen, if it is to become a cornerstone of Irish society.

A key area of this transformation must be the development of a health workforce plan which clearly identifies the human resources for health required to staff this expanded, comprehensive, public service. We cannot rely upon overseas recruitment (apart from the ethical dilemmas it creates) to staff our health service. We must, as a first goal, seek to educate and retain people in this country. This will require the new health service, which will be the largest employer in the State, to be a world class employer offering excellent pay and other terms and conditions of employment. In return for this the service can expect dedicated, committed and quality assured care from all staff. The organisational structures, clinical programmes and models which are to be developed, as part of this system, should be done so using clear governance configurations and aim to be simple, transparent and accountable.

While developing the organisational structures, clinical programmes and models to deliver this service, it is essential that current public health services are maintained, and fully supported, until alternative models of service are developed.

2.3 *Integrated Health Care*

International experience has shown that integrated care is more efficient, reduces costs, enhances the quality of care and improves the overall health and wellbeing of the community. However, there is no best practice model currently available. "Integration is easy to talk about but difficult to achieve. The implementation of integrated care is complex with many factors facilitating and hampering reform. In the Irish context, there are demand constraints due to demographic and epidemiological

changes, rising patient expectations coupled with supply constraints such as staff shortages, and continuing cost escalations through the development of medical technology and equipment. Supply and demand characteristics are not independent and may interact in complex ways. Organisation and regulatory factors, such as health system governance and financing, can also influence demand and supply." (Darker, 2013).

As part of any health service reform programme, the INMO agrees there is a need to move from a traditional approach, which focused on providing the best possible episodic care, to one which integrates care across providers. Services need to be joined up, across acute, primary and social care, so that the individual needs of patients are managed in a more integrated manner (Department of Health, 2017a). The key objective, within this reform programme, must be to develop, deliver and maintain highly integrated care pathways for every user of the service. This requires, as stated previously, a simplified organisational structure which clearly indicates responsibility for service delivery. This can only be done by devolving responsibility, for the provision of all care, to the frontline.

"The right workforce needs to be in place with appropriate management and support" (Houses of the Oireachtas, 2017). The importance of workforce cannot be underestimated and the focus on developing an integrated care model must include the development of an integrated workforce plan. Nurse and midwife staffing must remain central to the integrated care model. The work of the Staffing Taskforce must be enhanced and broadened in order to develop a system wide, evidence based, approach to staffing, which will meet the challenges and opportunities which integrated care will bring.

2.4 *Bed Capacity*

As a matter of great urgency, the current bed crisis requires immediate attention. There is insufficient bed capacity to meet demand in the acute, community care and nursing home sectors. This inadequate capacity is putting extreme pressure on Emergency Departments and acute hospital services throughout the country. The ageing population, combined with chronic diseases on the rise and sub-standard budgets, will lead to further problems, including patient safety issues, unless these problems are tackled in developing sustainable new models of care.

According to the OECD, the occupancy rate for acute beds is above average, at 93.8%, one of the highest in the OECD countries (OECD, 2016). There are currently far too few acute beds to cater for demand. This, combined with chronic staff shortages, too many patients being treated in the acute setting and an ageing population, are increasing pressures on the acute setting. For example, in 2015 adults aged 65 and over represented 13% of the population and 54% of the total hospital inpatient bed days and adults aged 85 years and over represented 1.4% of our total population but used approximately 14% of the in-patient bed days (Smyth et al., 2017).

The crisis within our Emergency Departments continues to cause serious concern and requires immediate attention. INMO Trolley/Ward Watch figures confirmed that 57,674 people on were trolleys in first seven months of 2017. Despite many initiatives, the number of patients, admitted and requiring inpatient care, left on trolleys, in

Emergency Departments or on wards, continues to increase (INMO, 2017a). The INMO welcomes the commencement of the second phase of the Staffing Taskforce, focusing on developing a framework for safe nurse staffing across emergency care settings, and insists that this framework and recommendations be central to this capacity review.

Existing residential care services are not equipped to deal with taking the burden from the acute services which poses another real concern. In 2017 there is a deficit of 1,460 long stay beds and 2,650 short stay beds. Old age dependency will increase from 18.1 in 2012 to 21.2 in 2017 (Smyth et al., 2017). Ireland is unique, amongst its European counterparts, in that the rate of ageing is above average. The CSO figures tell us that the over 65 age group grew 19.1% between 2011 and 2016. This trend is set to continue with "the old population" (i.e. those aged 65 years and over) is projected to increase very significantly, from its 2011 level of 532,000, to between 850,000 and 860,700 by 2026, and to close to 1.4 million by 2046. The very old population, (i.e. those aged 80 years of age and over), is set to rise even more dramatically, increasing from 128,000, in 2011, to between 484,000 and 470,000 in 2046" (CSO, 2013).

This mounting pressure on residential care services will have to be addressed. It is essential that the residential sector is resourced adequality to provide effective patient care which is accessible by all who require it.

In terms of waiting lists, despite the significant level of spending, there is unmet need. This means that that the level of services cannot keep up with demand, resulting in long waiting lists for services including speech and language therapy, occupational therapy, inpatient adults and children, day case adults and children, outpatients and GI scopes (Smyth et al., 2017). Longer waiting lists have a detrimental effect for health outcomes and "health systems should warrant timely access to necessary treatment and surgery" ((OECD), 2016). In May 2017, public hospital waiting lists rose again, to a new record of 665,618 patients waiting in a queue for some form of care (Cullen, 2017). There are also approximately 4,600 people now on waiting lists for home care (Department of Health, 2017b).

2.5 *Primary Care*

It is well established that the current dependence on acute health services is something which cannot continue. Currently, Ireland has the only European health system that does not offer universal coverage of primary care (Thomson et al., 2014). In developing a universally accessible public health service, primary care health services will be required to be the key stone of the service. A number of international and national reports and research, including the 2007 Capacity Review and the most recent Sláintecare Report, have identified the importance of developing a "model where the vast majority of healthcare is provided in the community" (Houses of the Oireachtas, 2017).

A strong primary healthcare system is key to improving the health and wellbeing of people and more specifically in the older population. As we face an increase in chronic diseases, co-morbidities and an ageing population, this development is now more important than ever. This year 559,620 people will have at least one chronic disease. Three quarters of the 29,095 deaths in 2014 were due to four chronic diseases -

cancer, cardiovascular, respiratory and diabetes (Department of Health, 2015). 17% of all hospitalisations in 2015 occurred due to these four chronic conditions. Ireland is also reported to have the highest rate for COPD and asthma amongst its OECD counterparts (OECD, 2016). The mounting burden of chronic disease is largely attributed to a well described set of modifiable risk factors. This is compounded by our ageing population, with increasingly complex health needs.

The INMO supports a primary care service which is accessible and equitable to all patients and clients. Our current primary care services will require radical reform which should include, but is not limited to the following:

- a clear and strategic nurse and midwife workforce plan. The work to date on the Staffing Taskforce, must progress and a national tool developed which incorporates primary care services;

- significant investment in and expansion of the current primary care services will be required;

- the full range of health professionals should be available to all and health professionals should work as a team to ensure that patient/client needs are met;

- all health professionals, providing primary care services in teams, should be directly employed. Staffing of primary health services should be on the basis of seven over seven approach;

- it is essential that the availability of community based, accessible, midwifery led services be linked to all primary care services in development;

- the shift to primary care will require, in addition to investment, a massive reorientation, not only of health professions and staff, but equally, the general public; and

- health promotion must form an integral part of the new models of health care, particularly in primary care.

3.0 How can current capacity be more effectively used?

It is the view of the INMO that current capacity does not, in any way, reflect the needs of the population. Resources cannot deal with the current demand facing the health service. The poor capacity results can be seen in the country's trolley watch figures and waiting lists.

3.1 *Nurse and Midwifery Staffing*

Providing appropriate nurse and midwife staffing is fundamental to providing a safe and effective health service. Currently, there is a chronic shortage throughout the health service. Research clearly identifies the importance of ensuring appropriate staffing and the benefits this can make to a health service.

Clear evidence exists associating positive patient outcomes with a higher number of registered nurses (Aiken et al., 2014, Ball and Catton, 2011). Research also suggests that an increase in nurse staffing is associated with increased patient safety and that a lower staffing ratio is directly associated with higher mortality rates (Aiken et al., 2002). Lower nurse staffing is associated with other adverse events and poor quality of care as well as poor patient outcomes including increased risk of falls. Other patient outcomes including increased rates of pneumonia, urinary tract and surgical site infection and pressure ulcers are affected by lower staffing ratios. Inadequate staffing levels were identified, by an independent inquiry, as a key contributing factor to the 'appalling' care experienced by patients at Mid Staffordshire NHS Foundation Trust (INMO, 2014).

In terms of midwifery, similar evidence is available. Research has shown that midwifery-led care can lead to benefits for mothers including less use of analgesia, fewer episiotomies or instrumental births and that lower staffing levels are associated with adverse outcomes in terms of safety and experience. (Gerova et al., 2010).

The work of the Staffing Taskforce, as stated previously, is a welcome development, and it should work in tandem with the capacity review being undertaken. The development of a national tool, determining nurse/midwife patient ratios, is essential to this process, as well as ensuring sustainable levels of nurse and midwife staffing into the future.

The National Midwifery Strategy must be implemented in full and form part of the new models of care with effective utilisation of resources. The ratio of midwife to births, at 1 to 29.5, is recognised as being an optimal staffing level for quality assured care must be maintained. The number of midwives must be increased in line with this report.

Skill mix is key to delivering safe, effective and appropriate nursing and midwifery care. The INMO supports grade mix of 80% RN and 20% HCA identified by the Staffing Taskforce. This should be examined in line with international standards once a comprehensive review of the HCA role is completed (Department of Health, 2016).

The INMO supports a grade mix of 60% Registered Nurse (RN) and 40% Health Care Assistant (HCA) in older person care services and supports a rich grade mix for RN to HCA in intellectual disability services. The grade mix in midwifery services will evolve in line with the Maternity Strategy i.e. 100% RM in all stages of labour. (INMO, 2016).

Evidence regarding the requirements and needs of staffing within primary care is weak, at best, and will require further investigation. The evidence we do have, suggests some worrying trends, which require attention. The Missed Care report published in 2016, stated that over 50% of respondents indicated missed care in their previous working week (Phelan and McCarthy, 2016). A study in the UK found that nurses working in the community rating there care as 'fair' or 'poor' had higher workloads then those rating their care as 'excellent' (Ball et al., 2014).

The Missed Care Report (2016) made a number of recommendations which the INMO fully supports, including but not limited to:

- recommendation 6: "It is recommended that, in order to fully utilise the community nursing service, it be provided with the physical, clinical and structural resources necessary to optimise the delivery of preventative and direct care services"

- recommendation 7: "Community nursing needs to be acknowledged as pivotal for delivering population health needs and its views must be included in all analysis and decision making and in professional, management and political fora. (Phelan and McCarthy, 2016).

In order for staff to work effectively within their environment, key supportive supports need to be in place. One of the key supports now and into the future are the ICT systems in place. Currently the ICT infrastructure running through our health services are inefficient and disjointed. Ensuring that the ICT infrastructure is fully developed and properly utilised will assist in effective utilisation of capacity.

3.2 *Quality of Care*

In order to effectively deliver high quality, safe and effective nursing and midwifery care, there must be, in the first instance, sufficient and appropriate nurse and midwife staffing levels in the health service. This currently is not the case and the INMO believes that, as a result, it is impossible to effectively manage current capacity, when it is at its limit. A study in 2014 found that "an increase in a nurses' workload by one patient increased the likelihood of an inpatient dying within 30 days of admission by 7%" (Aiken et al., 2014) and the Francis Inquiry into the mistakes and horrendous care experienced by the patients at Mid Staffordshire hospital, were found to be a direct result of chronic staff shortages (Francis, 2013). These statistics cannot be ignored when considering effective utilisation of capacity.

Nursing and Midwifery is central to the health service striving to provide high quality care to patients around the country. Despite the many challenges facing our health service, patients report a high level of satisfaction with the quality of care within Irish hospitals. This high level of performance, must be maintained while transitioning to new models of care.

To ensure the highest standard of care, the workforce needs to be motivated and supported. Health professionals, working in the public health service, require excellent remuneration, rewards and recognition systems. Continuing professional development programmes must also be provided to ensure high quality and safe patient care.

The recently launched Framework for Performance Indicators for Nursing and Midwifery must be progressed further in order to develop a dataset which can then be appropriately utilised in workforce planning, service planning, recruitment, retention and education priorities.

The feedback and experience of patients in the health service is essential for planning capacity. The recently launched Patient Experience Survey should also be utilised when, it is published, to draw out experiences and satisfaction levels with current health services. This should also be routinely repeated to view trends.

3.3 *Reconfiguration of Roles across Health Professions*

It is essential, when utilising existing and future capacity, that we move away from the traditional medical model of care so as we optimise the skills of all health professionals, thus ensuring the care pathways for patients are consistently adhered to, leading to, best possible outcomes and minimal delay.

Health professional roles must be fully utilised as a move towards a consultant led service begins, with less reliance on NCHDs, there must be a significant reconfiguration of the roles played by other health professionals, to optimise their contribution to patient care.

A transformed model of care will require very significant expansion of the role of the nurses and midwives, in all clinical areas, requiring a significant increase in the number of nurses and midwives, both in the hospital and community, who would be empowered to prescribe within agreed protocols.

3.4 *Removal of Private Care from the Public Hospitals*

The recommendation of Sláintecare, removing private care from public hospitals and health services, is essential to developing a new model of care and planning capacity. The INMO supports this recommendation and considers it essential that all funding should be provided through a system of general taxation with a declaration that the state will, over time, cease to subvent any form of private healthcare provision.

As stated earlier, all employees of the health service should be directly employed by the public health service. It is essential that any workforce plan must develop the Irish public health service to be the employer of choice.

There must be a phased abolition of all tax reliefs pertaining to private health insurance as well as plans to end the contracting of for services to provide direct care and a phased ending of subventions to private nursing homes.

Disability services must be provided by the State through direct provision. This will be central to developing a UHC which is accessible to those requiring the service.

4.0 What do you consider to be the priorities for capital investment over the next 15 years?

4.1 *Acute Services*

Increasing the number of beds throughout our health service is a priority. As stated earlier, the current bed capacity in all areas of the health service is at crisis point. One that cannot be ignored with the projected demographic. The Capacity Review of 2007 stated "under current practice, the demand for acute hospital beds may rise to unsustainable rates through 2030 to 2050 and beyond as Ireland's current population peak ages past 64 years old" (PA Consulting, 2007). These additional beds must be the required mix of day and seven day beds to reflect the changing nature of service delivery and the increasing shift to procedures done on a day basis.

It will also be necessary to greatly expand access to diagnostic and treatment services, over the seven-day cycle, in all major acute hospitals which will require investment in both staff and equipment.

Although plans are underway to develop the primary care services in order to ease the burden on the acute sector, this must not lead to reduced capacity within the acute sector. The general population is estimated to increase to 190,600 (4%) by 2022. Although the ageing population is significant, planning in the acute health services must ensure that services are accessible to all that require them into the future.

4.2 *Nursing Home Care*

The significant rate of growth in the population, aged 65 years and older, is set to continue, with a projection of 644,000 in this cohort for 2017. This is an increase of 19,800 (3.2%) compared to 2016. Projections suggest that by 2022 this cohort will increase by up to 21% (131,000). Furthermore, the 85+ age cohort is expected to increase by 3.7%, or 2,600 people, between 2016 and 2017, with an additional 16,100 people aged 85 years and over by 2022 (Smyth et al., 2017). Figures from the CSO show the substantial growth in the number of adults aged 60 and older that will be seen between 2011 and 2046. Life expectancy has also improved significantly. In Ireland life expectancy for males has increased from 76.9 years to 79.6 years and for females from 81.7 to 83.4 years (Department of Health, 2017a).

The reduced capacity, in our residential care sector, is projected to increase in 2022 to 5,910 long stay and 3,600 short stay beds. Applications for nursing home support are estimated to increase by 18.5% by 2022 (Smyth et al., 2017). The number of people, aged 65 and over suffering from dementia, is expected to increase significantly in the coming decades from 531,600 in 2011 to almost double (991,000) in 2031 (Pierce et al., 2014). These pressures will have to be addressed and a sustainable level of investment in capacity within the nursing home sector will be required into the future.

4.3 *Primary Care*

As stated earlier, the transition from a system based on acute hospital services, to an integrated one encompassing an excellent primary care service, will require vast investment, in a planned and committed way, over the next 15 years.

Chronic diseases have been identified as conditions which can be more effectively managed, within a primary care setting, are on the rise. For example, the International Diabetes Federation Diabetes Atlas (2013) estimate that there are 207,490 people with diabetes in Ireland in the 20 – 79 age group (prevalence of 6.5% in the population) which is in line with previous estimates that by 2020 there would be 233,000 people with the condition, and by 2030 there would be 278,850 people with the condition. (Diabetes Ireland, 2017).

Projections of obesity costs in Ireland indicate that if present trends continue, and no policy interventions are made, the cost of obesity will rise to over €4.3 billion in 2020 and to €5.4 billion in 2030. Ireland is projected to have one of the highest rates of obesity by 2030 (Irish Heart Foundation and Social Justice Ireland, 2015).

The projected changes in Ireland's demography, as well as increasing chronic disease and co-morbidities, will require a robust, well-resourced primary care service. Primary care centres must be built, complete with significant diagnostic and treatment services available within them, and it is recognised this will require sustained capital investment.

4.4 *Disability Services*

A particular challenge, over the next 15 years, in the area of disability, will be balancing the ongoing shift from institutional care to community based living facilities. This requires greater levels of infrastructural investment, where it is appropriate, while also involving the provision of intensive supports, in residential facilities where necessary, to optimise the lives, opportunities, potential and well-being of the person with a disability.

4.5 *Recruitment and Retention of Health Care Professions*

Globally, shortages of health care professions will continue to be problematic over the next 15 years. A recent study has projected that Europe will experience a shortage in health care professionals by 2030 (Liu et al., 2017). In Ireland, a study has described a projected shortfall of 5,618 midwives and 32,498 nurses by 2030 (Murphy et al., 2016).

Ensuring proper workforce planning and putting strategies in place to deal with these projections is a priority investment. Staff working within the health service must be regarded as essential to the health service. "A **paradigm shift** is thus needed away from seeing health workers as a consumption expenditure requiring containment, and towards recognizing health workforce investment as a strategy that can also spur socioeconomic development through the creation of employment opportunities" (Cometto et al., 2016).

Progressing the work of the Staffing Taskforce must be an essential part of all investment. Workforce planning is central to the success of the new model of care. The development of a national tool for determining ratios must be advanced and each area of the health service must be addressed including emergency, primary and nursing home care.

4.6 *Implementation of eHealth strategy*

E-Health is essential to ensure significant continuous improvements in efficiency, effectiveness, quality and safety of patient services and underpins organisational transformation and development. The availability of high quality, accurate and timely information is fundamental to enhanced provider-patient relationships with the resultant improvements in outcomes (Department of Health and HSE, 2013). Investment in eHealth will be crucial over the next 15 years.

According to the WHO governmental commitment to eHealth policy needs to be backed by sustainable funding for the implementation of eHealth programmes and actions for capacity-building and evaluation that are aligned with a national strategy for eHealth (WHO, 2016). On average, globally healthcare systems spend between

2% and 3% on ICT systems. The EU average for spending on Healthcare IT and eHealth solutions ranges from around 2% to 3%. In Ireland, the investment in Healthcare ICT is approximately 0.85% (Department of Health and HSE, 2013). It is now vital that investment in eHealth policies be prioritised and ICT infrastructure investments made in both acute and primary care sectors in order to enhance the new model of care.

5.0 Conclusion

In answering the questions in this document, the INMO has detailed what we consider to be the most pressing issues, in relation to capacity as guided by the questions. However, it is clear:

- existing capacity is totally inadequate; and
- any increase in capacity must provide for an increase in all health care staffing including, nurses and midwives;

if we are to create and maintain a world class health service for all.

To deliver all of this will require a willingness and commitment to fund, over the medium term, the inevitable additional costs that will be required in delivering a single tiered public health service which is fit for purpose.

The INMO is available, and would welcome the opportunity, to engage with the Department to discuss, in detail, all aspects of this submission.

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