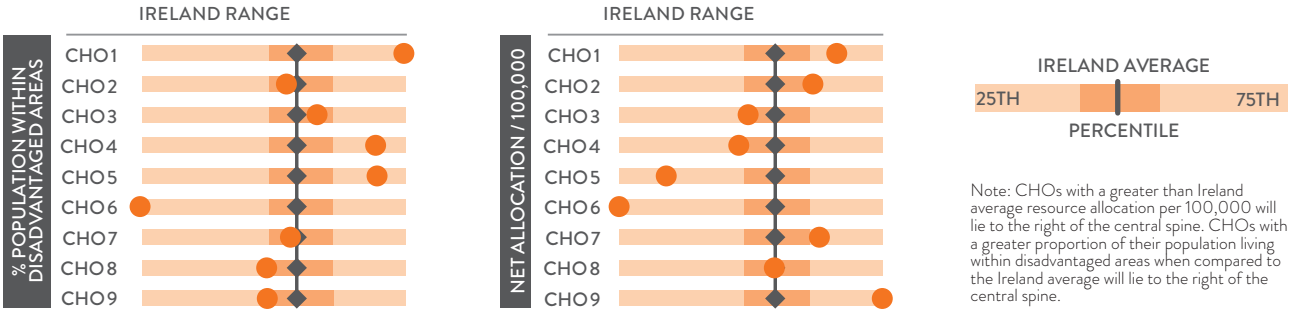
To access the full report go to: www.hse.ie/eng/services/publications/planningforhealth.pdf

ASSUMPTIONS

- The aim of this paper is to project the impact of demographic change on the demand for Primary Care Services funded by the HSE in 2017 and give a five year projection to 2022. Utilisation rates for 2015 where appropriate and applicable were used for these projections.
- Population projections are based on the CSO M2F2 scenario.
- No new service improvement initiatives are included in projections of activity or costs. In addition unmet demand and need is not reflected in the projections.
- An assumption is made that utilisation rates, unit costs, models of care and eligibility will remain stable between 2016 and 2017.
- Population projections by Community Healthcare Organisation (CHO) are based on CSO regional population projections and use the 'recent' internal migration scenario.
- Analysis by CHO Area involving rates are crude - per 1,000 or 100,000 where applicable - and are not standardised to a national population. Standardisation requires further analysis.
- Future demand for community services was derived from key performance indicator data collated by the Business Intelligence Unit. Various indictors of utilisation were provided and "referrals accepted" was chosen as the basis for projection since it best reflects overall service capacity and was common across these service lines.
- Data on claims made under the various Primary Care Reimbursement Schemes was obtained from PCRS via The Department of Health and analysed using PHIS; it has been cross validated with PCRS. Monthly trends were analysed to determine the basis for projections. Note that, in keeping with the rest of this report, PCRS projections illustrate the impact of demographic change only, the assumption being that existing levels of service will be maintained.

KEY MESSAGES

PROFILE OF ALLOCATION OF RESOURCES TO CHOs, 2016



Note: CHOs with a greater than Ireland average resource allocation per 100,000 will lie to the right of the central spine. CHOs with a greater proportion of their population living within disadvantaged areas when compared to the Ireland average will lie to the right of the central spine.

The HSE established Community Healthcare Organisations (CHOs) in 2015, to support health system reform. A comparative analysis of indicators shows that CHOs face varying challenges in responding to population health need. At the same time, the resources to meet these needs also vary across CHOs.

CONTEXT AND POLICY CHANGE

- The Primary Care Division was allocated a budget of €3,624.4 million in 2016, which was 28% of the HSE net determination for that year.
- In 2015 the HSE provided free GP Visit Cards (GPVC) to all children under 6 years and all adults 70 years and older. While coverage of GPVCs for adults over 70 years reached maximum, it was estimated that at the end of 2015 about 86,500 children under 6 years of age had not availed of their free GPVC entitlement.
- There was an increase in associated monthly costs to PCRS over 2015. Monthly GPVC capitation fees rose 3-fold across all age groups. For children aged 0-4 years, out-of-hours and other payments to GPs rose 2-fold.

MONTHLY INCREASE IN COSTS AT PCRS

GP VISIT CARD ↑300%

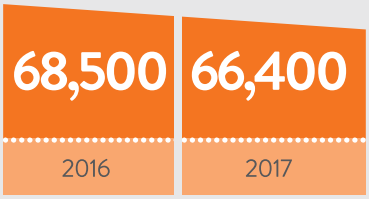
↑200%

OUT OF HOURS & OTHER PAYMENTS TO GPs FOR CHILDREN AGED 0-4

CHILD HEALTH

- The population of children (0-1 years) requiring newborn and infant Primary Care Services in 2017 is projected to be 66,400. This is a reduction of 2,100 from 2016 and a further reduction in the infant population is expected by 2022 (8,900 less than 2016).
- In 2017, demand for Nursing Services to children is projected to increase by 4% and by 9.3% in 2022.
- Between 2015 and 2017 the rise in demand for Physiotherapy, Occupational Therapy and Psychology Services will increase by 431 (1.7%), 270 (1.7%) and 189 (1.4%) respectively.
- There is a significant unmet need for Child Health Services. In December 2015, wherein age-specific data on waiting lists is available, there were 11,237 children waiting for Occupational Therapy assessment (69.2% of 2015 referrals); 13,099 waiting Ophthalmology assessment (74.3% of 2015 referrals accepted), of which 9,412 were waiting more than 12 weeks (53.4% of 2015 referrals accepted).
- Variation in current primary care utilisation by children highlights potential opportunities to better align service planning with population health need. For example, given that 25% of our children aged 9 years are either overweight or obese, increased utilisation of dietetics services by children aged 5-17 years could provide better population health outcomes.

BABIES REQUIRING PRIMARY CARE SERVICES



FROM 2016, A DECREASE OF ↓2,100

ADULTS 18-64 YEARS

- Demand for most Primary Care Services (PCS) by adults aged 18 to 64 years will increase minimally from 2015 to 2017 (<1%). A more moderate increase is expected in the medium term to 2022 (approximately 3%).
- In December 2015, there were 1,638 adults waiting Ophthalmology assessment (73.2% of 2015 referrals accepted), of which 1,275 were waiting more than 12 weeks (56.9% of 2015 referrals accepted). 1,436 adults were waiting Audiology assessment (71.7% of 2015 referrals accepted), of which 865 were waiting more than 12 weeks (43.2% of 2015 referrals accepted). Planning should take account of this significant unmet need.

ADULTS 65 YEARS & OVER

- In 2017 demand for Primary Care Services (PCS) by adults aged 65 years and older is projected to increase by 6.5% and by 24.9% in 2022.
- For larger services, the increased demand will be challenging. Between 2016 and 2017, physiotherapy referrals (adults aged 18 years and older) will increase by 2,229; occupational therapy referrals will increase by 3,617; and nursing referrals accepted will increase by 3,990.
- There is also significant unmet need for Primary Care Services among older adults. In December 2015, 2,318 older adults were waiting Ophthalmology assessment (94.5% of 2015 referrals accepted), of which 1,758 were waiting more than 12 weeks (71.6% of 2015 referrals accepted). 5,252 were waiting Audiology assessment (75.7% of 2015 referrals accepted), of which 3,084 were waiting more than 12 weeks (44.5% of 2015 referrals accepted).
- Only 273 referrals to Psychology Services were reported in 2015 for adults aged 65 years and older. However, at least half of all people with long-term conditions suffer from multiple co-existing conditions, with mental health problems being one of the most common forms of co-morbidity (Barnett et al, 2012). Addressing co-morbid mental health problems in primary care can improve health outcomes and reduce health system costs (Naylor 2012).
- Similarly, for Ophthalmology Services, a lower than expected rate of utilisation was observed for adults aged 65 years and older. Decreased visual acuity in older people is often remediable and is, for example, a critical factor in fear of falling, restriction of physical activity and falls (Lord 2006).

PROJECTED SLIGHT INCREASE IN DEMAND FOR PCS FOR ADULTS 18-64 YEARS IN 2017

PROJECTED INCREASE IN DEMAND FOR PCS FOR ADULTS 65+ YEARS IN 2017

PRIMARY CARE REIMBURSEMENT SERVICE (PCRS)

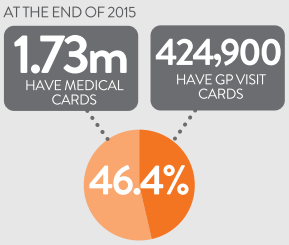
COST

- For the 10 PCRS payment headings (approximately 75% of the PCRS budget) demographic changes alone are estimated to drive an increase in total expenditure of €75.2 million from 2015-2017 and €290.6 million from 2017-2022.
- Expenditure across most selected PCRS payment headings will increase by 1.6% - 4.9% from 2015 to 2017. A larger increase can be expected by 2022 (5.0% - 19.3%).
- At the end of 2015, pharmaceutical fees (ingredient costs and pharmacy fees) comprised the largest proportion of expenditure for the 10 payment headings (57.4%).
- Ongoing active management of expenditure on drugs is necessary, to both control overall PCRS costs and to provide fiscal space for implementation of government policy to support universal access to primary care. A small decrease in the cost or volume of commonly prescribed drugs could offer potential to significantly impact expenditure.

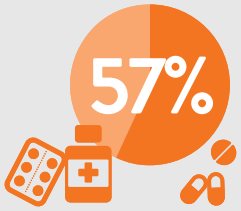
ACCESS

- In total, at the end of 2015, 46.4% of the population had access to either a GPVC or a medical card (9.1% had access to GPVC scheme, or 424,862 people, and 37.2% had access to Medical Card scheme, or 1,732,555 people). This compares with 41.4% at the start of 2015.
- Compared with pre-implementation of free GPVCs for children under 6 years, in 2017 demand for GP consultations in this population is estimated to increase by 65.7% (842,796 additional consultations) and in 2022 it will increase by 42.4% (562,814 additional consultations).
- Across all diseases, the number of Long Term Illness scheme claimants increased by 87% from the start of 2014 to the end of 2015. In the case of Diabetes Mellitus for example, the number of claimants increased by 40,446, thereby doubling the number of claimants with this illness.

FOR DEMOGRAPHIC CHANGES ALONE IN 10 PCRS PAYMENT SCHEMES - AN ADDITIONAL AMOUNT IS REQUIRED



OF THE POPULATION COVERED



PHARMACEUTICAL FEES MAKE UP OVER HALF THE EXPENDITURE ACROSS THE 10 PCRS PAYMENT SHCEMES

GP CONSULTATION DEMAND WILL INCREASE IN 2017

↑66%

INCREASE IN LONG TERM ILLNESS CLAIMANTS

↑87%

BETWEEN 2014-15

PALLIATIVE CARE

With population ageing, needs for Palliative Care Services are growing and will challenge existing services. For example, patients experiencing end-of-life with cancer alone, will increase by 5.8% and 23% in 2017 and 2022 respectively.

EXPECTED INCREASE IN PEOPLE RECEIVING END OF LIFE CANCER CARE IN 2017

↑5.8%

SOCIAL INCLUSION

There is a strong link between poverty, socio-economic status and health.

HOMELESS

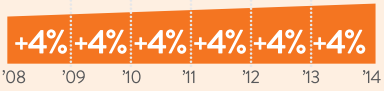
- The number of people experiencing homelessness is increasing year on year in Ireland. In February 2016, 5,811 people were recorded as experiencing homelessness, an increase from 2015. This number consisted of 3,930 adults and 1,881 children, comprising 2,706 single adult homeless and 912 homeless families.
- Most single homeless adults and homeless families live in Dublin.
- Homelessness is a marker for complex tri-morbidity: the combination of physical ill-health, with dual diagnosis (co-existing mental ill-health and substance abuse) and consequent high health care needs.

IN FEB 2016 THERE WERE

5,811 PEOPLE HOMELESS

ADDICTION SERVICES

- In 2014, 3,744 new and 5,779 return (total 9,523) entrants were recorded in the National Drug Treatment Reporting System (NDTRS) in Ireland.
- The number of clients registered for Opioid Substitution Treatment (OST) on 31st December each year, reported by the Central Treatment List (CTL), has increased from 3,689 in 1998 to 9,537 in 2015. Between 2008 and 2014, the rate of increase was less than 4% annually.
- In 2013, 3,578 new and 3,971 return (total 7,549) clients were treated for problem alcohol use in alcohol treatment facilities in Ireland.
- Between 2011 and 2013, the number of new cases treated and the number of cases returning for treatment for problem alcohol use decreased. Among 15-64 year olds, the incidence and prevalence of treated problem use decreased.



CLIENTS REGISTERED FOR OPIOD SUBSTITUTION INCREASED BY 4% ANNUALLY BETWEEN 2008 & 2014

TRAVELLERS & ROMA

- The 2011 Census recorded 29,495 Travellers living in the Republic of Ireland (0.6% population). The population pyramid for Travellers from 2011 Census data demonstrates the stark differences in the age profile of Travellers, compared to the Irish general population. This reflects a high birth rate, a primarily young population, and the effects of premature mortality.
- Compared to other children aged 10-17 years, Traveller children are more likely to report smoking, being drunk, cannabis use or drinking sugary drinks.
- There are no official statistics on the number of Roma in Ireland, with the estimated population between 2,500 and 6,000.

TRAVELLER CHILDREN MORE LIKELY TO REPORT BEING **DRUNK**, USING **CANNABIS**, DRINKING **SUGARY DRINKS**

Data sources: HBSC 2010, (Kelly et al, 2012)

VULNERABLE MIGRANTS: ASYLUM SEEKERS & REFUGEES

- Up to 4,000 Irish Refugee Protection Programme (IRPP)/EU Relocation & Resettlement Programme refugees & asylum seekers will arrive in Ireland by end 2017, as well as the increasing numbers presenting routinely in Ireland seeking asylum. This will put significant pressure on provision of health assessment/screening and routine health services. It is likely that all CHOs will be impacted.
- The current health assessment models for Asylum Seekers and Programme Refugees are not sustainable even for current numbers.

AS PART OF THE EU RELOCATION AND RESETTLEMENT PROGRAMME
ALMOST 4,000 ADDITIONAL REFUGEES & ASYLUM SEEKERS WILL ARRIVE IN IRELAND IN 2017

RESEARCH & DATA NEEDS

PRIMARY CARE

- Primary Care development is pivotal to health system reform in Ireland. However, information systems to support the planning, monitoring, and evaluation of Primary Care Services are not developed in proportion to their importance to the HSE nor are they commensurate with current levels of expenditure.
- Where it is feasible and appropriate, a more standardised approach should be taken to measurement of the Primary Care Service utilisation across service lines, using similar definitions for units of activity (new referrals received, new referrals accepted, new referrals seen, in-treatment, discharges etc) and using similar approaches to measuring characteristics of service users.
- Consultation with a GP is a key element of Primary Care. Robust information on the volume, process and outcome of GP consultations will be necessary to support ongoing health system reform and strengthening of primary care.
- The utility of information maintained by the PCRS for wider health system planning should be recognised, with capacity and capability developed to maximise its potential positive impact.
- A number of important strategic initiatives are underway in primary care. Criteria for business case approval and funding should include a requirement for appropriate evaluation, to ensure that envisaged benefits are realized and to inform future health planning.

SOCIAL INCLUSION

- Whenever relevant and possible, health service indicators should be reported by sex, age, socio-economic status and vulnerable/ socially excluded group, to enable equality monitoring of all services.
- Ethnicity data (an ethnic identifier) – as part of ethnic equality monitoring – should be routinely and systematically collected across all health and social care data systems, including: HIPE and performance monitoring, National Cancer Screening Service data, immunisation coverage data, infectious disease notification and the new National Maternity Healthcare Record.
- Data collection for problem drug use needs to be strengthened to enable counting of: (1) individuals rather than episodes of treatment - an Individual Health Identifier would enable this; (2) cases treated within Psychiatric Hospitals; (3) cases remaining in treatment without a break from one year to the next.
- Standardisation of data sources and data collection methodologies between Opioid Substitution Treatment (OST) and Treatment Demand Indicator (TDI) data should be considered, to enable meaningful collation and comparison.
- Data should be collected from Needle Exchange (NEX) programmes within HSE clinics, as it is for pharmacy-based NEX programmes.