Title: *'The Impacts of Health Care Reconfiguration on Patient Access to Services: A Case Study of Nenagh General Hospital'*

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List of Abbreviations

ESRI   The Economic and Social Research Institute

HIQA   Health Information and Quality Authority

HSE   Health Service Executive

IAIM   Irish Association of Internal Medicine

NAS   National Ambulance Service

NUIM   National University of Ireland, Maynooth

OECD   Organisation for Economic Co-operation and Development

WHO   World Health Organisation

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"Remember their faces and their names."

(David King, Save Nenagh Hospital Protest 2004)

Abstract

Access to health care is becoming a popular area of research in health geography especially in relation to service provision and policy planning. Since 2006, many changes to health policy have been made by the Irish government which have been both supported and opposed at a local level. The principal objective of this thesis was to account for the changes which have been made to acute care services in North Tipperary and look at how these changes have impacted the community in regards to access to care.

Using both qualitative and quantitative methods in the form of interviews, questionnaires and already available hospital statistics, conclusions were drawn as to how access to care has changed especially from the perspective of the community and workers within the medical community. Two questionnaires, one for the general public and one for medical professionals, focused on access to health care in North Tipperary and the attitudes of the two groups towards centralisation of care. The interviews conducted with medical professionals also focused on access to health care and the recommendations that participants had for a safer service. The hospital statistics studied were for used for the purpose of contrasting case studies into how the local hospital in Co. Tipperary has changed since centralisation began.

The results of this study revealed that the current reconfiguration process is not fully supported by either the public or medical personnel in Nenagh and Limerick and that the Health Service Executive reneged on their promise to work with the public and the health care providers to develop this new service and put support services in place at a local level. This has left the public and medical professionals regarding the health service in North Tipperary as unsafe and inaccessible and has resulted in extra pressure being put on ambulance personnel to provide high quality care to the patient- care which was once available to them at the local hospital.

Chapter One: Introduction

1.1. Introduction

"*Quality of care must come before convenience of care*" (Hoctor, 2009) was the phrase used by the Minister for the Older People, to justify the changes which the government was making in North Tipperary on the 21st of February 2009 during a protest organised in a bid to try and save acute services in Nenagh Hospital. This thesis examines the effects of health service reconfiguration on a rural community and investigates whether or not the effects of moving acute services are positive or negative. The focus will be on Nenagh, Co. Tipperary as Nenagh hospital was involved in the pilot scheme for health reconfiguration in Ireland. This reconfiguration of services saw the removal of emergency acute services from the local hospital to Limerick Regional Hospital, some forty kilometres away. The removal of these services by the Irish government was labelled as a dangerous move which could put patients' lives in jeopardy. In order to look at this idea further, policy prior to reconfiguration and after reconfiguration will be looked at in regards to Tipperary and will analyse health planning concepts from Hanly (2003) and the Teamwork Report (2006). This data, along with that to be collected during this research, will hopefully draw a conclusion as to whether or not the patient's life is at risk because of access. This research will be developed using methods which aim to show the reactions of the public and medical community to the health access and to ultimately determine whether access to care in Nenagh has changed for better or for worse.

1.2. Health Care Philosophies

Geography is a discipline well suited to critically investigating health systems and services as it deals with the population's interactions with its environment and how this varies from place to place (Barnett and Barnett, 2009). Health geography is the study of health and health care delivery in relation to geographical factors and can provide a spatial understanding of a population's health (Acury et al, 2005). It also includes the study of accessibility to health and health care providers (Luo and Wang, 2003). Health Geography is invariably a contested field of research as it is driven by policy and politics which are ever changing (Tomes, 2006). Health Geography in Ireland has been generally under- researched, with evidence from the existing literature focusing primarily on both the positive and negative sides of the current

health care system and not the solutions to the issues at hand (McAuliffe et al, 2006). In a world which prides itself on social justice and reducing inequalities in society, it is a wonder that even in the most developed countries, discrepancies can be found within social policy that can upset social norms (Percy-Smith, 2000) especially for people in rural areas.

Health care is an essential provision within a society and at some point in time, a person will have to make a decision in regards to his/her health. As people are constantly striving to improve their wellbeing and personal capacities within society, or manage ill-health, it is extremely important that health care provision be at an optimum level which benefits the people that use the services (Bandura, 1998). Many questions surround the idea of equity of health care and at some stage these questions must be answered, such as affordability of health care and where individuals should go to receive health care? (McDougall and Trotter, 2011). These are fundamental concepts which help form the philosophies of health care and the core of effective and efficient health structures.

Social justice is strongly associated with health care philosophies. With continuing increases in medical costs and the number of uninsured people, along with growing concerns about disparities in access to treatment, questions in relation to justice are being brought to the forefront of the health care debate (Powers and Faden, 2006). Strong core philosophies can help develop the ideal system which would enable the health care provider to enhance the care and freedom of the patient and instil values such as equity of care and participation i.e. that all people must be involved with planning and implementing their health care system (Campbell, 1993). As human beings we are all valuable social entities and have the right, not the privilege, to health care access (Papadimos, 2007). Human rights in relation to health care, is also becoming a more popular area of study worldwide, especially in terms of developing new health systems and structures. The right to universal health care is a good example of how people are beginning to demand an efficient service from their health providers which keeps the debate on health care reform at the forefront of health geography (Pimentel, 2011).

Although health care is considered a public right, it is not an equal entity nor is it fully accessible (Institute of Medicine, 2003). It is a demand driven entity across place and space in accordance with population density but is only located at certain points within reach of that same population (Hans, 2006). With population density and service placement comes spatial injustice and a decrease in accessibility to care, which, for many, is an inconvenience (Fleuret et al, 2007). Equity and efficiency, although keystones to health care provision, are often considered to be problems for those in rural areas, as sometimes it is incredibly difficult to provide a high quality service in rural areas. This has been addressed over a number of years,

through the planning and politics of care but a sustainable result has yet to be implemented where both the provider and the consumer are happy. This being said, the relationship between planning and provision rests solely on the geography of an area. However, geography cannot always be to blame for high rates of inaccessibility as other factors such as social, financial and functional elements, as well as the structure of the health care system, gender, ethnicity and social class all play a role in inhibiting a person's access to care. The main causes of exclusion in health care vary from country to country but in general are related to poverty, rural location, informal sector employment, unemployment, and factors linked to the performance, structure, and organisation of health systems (WHO, 2007a).

1.3.Access and Health Service Reorganisation

Access to care has become crucial to health planning and policy in the past number of years and with the world's population on the rise, it has never been more important to be at the peak of one's health. This means having proper access to emergency care as well as basic health services, when they are needed. With policy and planning, especially in areas where geographical considerations have a role, access must always be considered as a priority, especially equity of access. Through many observations both in the medical field and the geographical field, access has played an important role whether it be in the placement of services in an area, or measuring access rates to the service. Access to health care is a vast area of study and incorporates many ideals both relating to the landscape and the person using the service themselves. In order to determine how access to health services can be further defined, below are some explanations which may provide a deeper perspective into the issues highlighted throughout this thesis.

1.3.1. Social Access to Health Care

Social access can relate to separate health centres or hospitals which are specific to the social characteristics or social norms of a person (Scheppers et al, 2005 and Roberts et al, 2009). Different types of care can be provided at different centres in an area or with specific services which are related to a certain culture or practice i.e. holistic medicine, alternative therapies and so on. Social access to certain health centres can also be restricted by high cost, lack of appropriate infrastructure or social inequity in a given area (Townsend, 1979). The socio-economic status of a community is considered an obstacle to health care in the majority of texts related to

social inequalities and health access, and this will be discussed further in a later chapter.

1.3.2. Financial Access to Health Care

Finance is considered to be an obstacle in relation to accessing health services in Ireland. As health care is becoming increasingly privatized, money is beginning to have a greater stake in what services are available to a person, as well as where they are placed. Private clinics and practices may only be set up where money is being spent for profit, rather than in a location which is rural and needs the service. This is especially true for the likes of tertiary care such as plastic surgery and burn units and is becoming true even more so now, for basic health services.

Health care fees can often inhibit a person from accessing health care needed for a particular illness as many people are unable to afford private health care insurance. Finance therefore, can be described as a major factor aiding exclusion of social groups from a health system (WHO, 2010). Some governments often provide a universal health insurance scheme through their health system, which is considered to be a stepping stone for those who are below the poverty line into being able to afford basic health care coverage for themselves and their families (Annear, 2006). This has given relief to many health consumers, however there are some countries especially in the developed world, who have governments which do not provide such a service for their people. In relation to health reconfiguration, it has been noted that urban health care costs run higher than rural health care costs (Annear et al, 2007) and in the event that a rural hospital may lose its entire emergency services, costs will inevitably rise as will the financial barrier, and access to vital services will decrease as a result.

1.3.3. Functional Access to Health Care

Access can also be evaluated on a functional level whereby the structure and functionality of the service can be measured. The functionality of a hospital can be measured by the amount of services it provides to a community and how accessible the hospital is itself, for the people or for minority groups in a community (Farrell et al, 2008). An ideally located hospital in a local setting, can pose many benefits for an area as patients would have less distance to travel and still receive quality care. Having to travel less for the equivalent service to that in a regional hospital may

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provide peace of mind for those a great distance away and offer reassurance to the elderly. Minority groups also benefit from functional access in this way, especially members of the travelling community, the homeless, or those on an extremely low income as they rely on local services because they are so accessible and convenient.

1.3.4. Effective Access to Health Care

Effective access can account for quality of care and the day to day running of the hospital. Access can also be determined by staff numbers, opening times and waiting lists (Abram et al, 1983). Effective access in regards to a hospital and health care provision would ideally mean highly qualified and skilled staff in a centre with suitable opening times, low waiting times and a good range of health outcomes. Many health systems around the world rely solely on providing an effective health service to the population which is completely accessible, for example in France, where a high rate of GDP is spent on health care. The French health system is designed on a social insurance model offering health packages based on income levels. Although recognised as the most successful health system in the world (WHO, 2010) with 99% of the population being covered, it still has flaws in relation to emergency care provision in very rural areas as well as the rising cost of providing the service itself. However recent reforms in 2004 have brought about new changes which have formed new relationships between the public and private sector, encouraging doctors and hospitals to work together, something which should be considered for the future in Ireland (WHO, 2010).

1.4.   Rationale for selecting North Tipperary

The Mid-Western region in Ireland was one of two regions mentioned in the Hanly Report (2003) and became the pilot scheme for health reconfiguration. This involved the removal of acute accident and emergency services from the smaller more local hospitals- in this case Nenagh, Co. Tipperary and Ennis, Co. Clare to the regional hospital in Limerick. The ongoing issue in regards to North Tipperary is that because of this change, many people will be left without adequate access to emergency care. Accident and Emergency services in Nenagh and Ennis which were once twenty-four hour services will be replaced with minor injury clinics which will open from eight o clock in the morning until eight o clock in the evening and will leave North Tipperary and County Clare without twenty-four hour care. The

services removed will be replaced by day clinics and units which will be run primarily by nurses.

Over the past number of years so many changes have been put in place in communities such as Nenagh and Ennis which have caused unrest amongst the people living in these areas. As Nenagh hospital was the smaller of the two, reconfiguration of services occurred quite quickly (over a year) but replacement services which were promised to have been put in place in 2006 are still being waited for in 2012. This thesis will therefore explore how spatial access to care has been changed in Nenagh and how the results of this have affected the people in the Nenagh community.

1.5. Ireland's Health Structure

The health system in Ireland is divided into different sectors, each of which provides a certain level of care to a patient. If a patient becomes seriously ill, he/she will be referred on through the different sectors to receive the utmost care for his/her condition. The following sections will give a detailed account of each sector and what it provides for patients in Ireland.

1.5.1. The Primary Care Sector

"The most widely accepted definition of primary care is: 'first contact, continuous, comprehensive and co-ordinated care provided to individuals and populations undifferentiated by age, gender, disease or organ system." (Barbara Starfield, 1994, p1129).

An efficient and safe primary care system should be the keystone to any health system especially those that are being reorganised by governments in order to provide better services for the people. The primary care system in Ireland comprises of general practitioners, paramedics, advanced paramedics, general nurses, and community care and in some circumstances a primary care team, which may include social and psychiatric consultants. One of the main aims of the Health Strategy (Department of Health and Children, 2001) was to provide better health care for the whole population at primary care level. This agenda began a whole new phase of newly designed health care projects set up in order to provide a highly developed, high performing health system.

The parallel primary care strategy document, Primary Care: A New Direction was published in 2001, to focus on this sector in particular and to bulk up the number of general practitioners and public health nurses and establish primary care teams. These teams would be the driving force behind the new health system and would be the gatekeepers of the hospital system. If a patient could be treated within the community in a less medically controlled environment, it was deemed better for the patient as he/she did not need to use the secondary care service and would bring a halt to the secondary sector being blocked by unnecessary patients.

Although all citizens are eligible for primary care, access to the service is differentiated both financially and geographically. The issue of financial access plays a key role within this system as it is considered that there are two sets of people who use the primary care facilities. Those who have been given the medical card (due to their poor socio-economic status) are given free primary care, while the rest of the population generally pay for the service as they use it. In other national systems, however, primary care is free to all. Patients access their general practitioners without the fear of high fees, something that, although promised and discussed, has not become a reality for the Irish people thus far.

The World Health Organisation suggests that Primary Care should be accessible, affordable, and continuous, be comprehensive and be equal (WHO, 1978). Should a health service be able to provide a fully functioning primary care system such as the above, then the optimum service would be achieved for the patient. Due to rising costs in providing the service and the economic downturn in the Irish economy, it is getting increasingly difficult for the government to continue to provide a service that is both medically efficient and financially sound. In order to try and achieve at least a partially viable service, spatial reorganisation of the services has also been looked at in Ireland in relation to primary care and how it is being practiced.

Committing to changing the service for the better, the Irish government turned to international research into primary care and looked at examples of other health systems which have both excelled and failed in regards to achieving optimum care. These comparisons would enable the Irish government to look at more cost effective approaches and potentially save money while still providing an excellent service.

Policy was put in place to begin researching into primary care and the general health service to determine which areas were lacking and what could be done to solve the existing problems (Department of Health and Children, 2001). Research began into the spatial organisation of primary care services and the staffing of the sector as

well as looking into the clinical side, of setting standards for health care and its delivery. Later research proved (Health Research Board, 2006) that where primary care was less structured and less effective, costs were higher and there was less value for money.

The primary care sector is where many important decisions are made in relation to a patient and his/her long term health. These decisions can either hinder a patient's life or save it, hence the importance of getting the system right. This, however, can only be done with ample research and development into the sector and the amalgamation of specific specialist clinics at a local level into the primary care team. This would provide the patient with the utmost of care in his/her own environment, without further medical intrusion (Health Research Board, 2006). Research and development could also be practiced further at a local level by strengthening the relationships between the proposed primary care teams and the local hospital so patients can be diagnosed quickly.

Future policies predict potentially drastic changes for areas where primary care is limited, especially due to the fact that General Practitioner numbers are lower in Ireland than the EU average (WHO, 2010). Plans include investing more in primary care infrastructure and in educating primary care teams further to be able to deal with complex situations at a lower level. One example is the proposed shift from using secondary care as the first port of call i.e. the local hospital, to using the community care centre instead. Although arguably this is what should have been happening all along, it is the cost management of both facilities and the staffing of the new teams which may pose bigger problems. Changes such as these are welcomed in theory but it is with practice that flaws soon appear.

The new government has begun to build the foundations for the new service with the former system being slowly dismantled to make way for a more attractive universal system. These changes must be monitored carefully as with health, shortfalls cannot be allowed to occur especially when dealing with a patient's life. Steps must be taken to have the necessary procedures in place (Teamwork, 2006) because whatever changes may be made in the future to the primary care sector will surely have knock-on effects to the secondary care sector.

1.5.2. The Secondary Care Sector

Secondary care in Ireland consists of hospitals in the community which are networked together or are linked to a regional hospital a distance away. These hospitals are run by those who are not in first contact with the patient i.e. consultants, doctors and general nurses. Secondary care mainly refers to acute care which is necessary treatment for a short term illness, injury or health condition (Department of Health, 2001). The Accident and Emergency clinic or Emergency Department is where this patient is first admitted to care and evidently admitted to hospital. Secondary care also includes other care facilities which may not be on hospital grounds such as psychiatrists, physiotherapists and clinical psychologists. More often than not, unless referred, access to secondary care by self-referral is not possible and patients can only access this second level care through their G.P. at primary level.

During the last two decades, the Irish health system provided a substantial amount of care in community hospitals and many minor care issues and illnesses were treated locally. These hospitals also performed serious acute operations for a time which helped saved countless lives and was worked on a "*treat and transfer*" basis. This meant that the patient was given care to keep him/her alive and then later transferred to the larger hospital for further care, when a bed became available. Often more care was needed for the patient that could not be given in the secondary care sector and the patient was transferred to tertiary care to avail of this service. This led to a minimal amount of patients being treated and transferred to regional centres and kept the tertiary centre from an overcrowding crisis. In some local hospitals, 97% of patients were treated onsite with only 3% being transferred onto regional hospitals. This kept the secondary care sector at a local level still, which helped the patient more, knowing that he or she was in a safe environment close to home. Full maternity services were also provided in many secondary care centres which were vital services to most local communities.

The Department of Health and Children published the Acute Hospital Bed Capacity Review in 2002, in a bid to change the number of beds across the state. It attempted to predict demand for hospital beds, calculating projected need through estimates in demographics, primary care and surgical procedures (Department of Health and Children, 2002). This was done using the previous year's statistics and calculated that 2,840 beds needed to be put in place before 2011 to keep in line with demand. A separate report on the Committee on Accident and Emergency Services

(Comhairle na nOspidéal, 2002) was undertaken to begin reviewing the structure of accident and emergency units across the state. The report highlighted where the challenges were within the system in relation to access, bed capacity, management of beds and better use of care. In 2002, recommendations were made to each department in order to quash obstacles and create a more serene environment for both staff and patients. This would require a large amount of reorganisation within the service to bring accident and emergency up to scale.

In 2003, the European Working Time Directive was introduced to Ireland and proposed that working hours would be changed in relation to junior doctors. Junior doctors have provided an on call service for secondary care hospitals for years and have allowed hospitals to have a 24-hour service which has proved to be invaluable, during times of crisis. This was particularly important to patients in rural areas who became seriously ill during the "out of hours" official working time. These patients were able to access the service locally without having to travel long distances for the same care. The implications of implementing this European policy meant that the on-call service was removed and care was reduced to shift work by the local consultants. This was met with opposition from all sides of care as it was considered to be reducing the quality of care given to the patient, as well as costing the Irish public more money. This was further discussed in the Simap Directive (2001) from the European Parliament and which was passed before the working directive was put into action in Ireland. The Irish reading of the EU Working Directive was perceived as "disjunctive" towards the European reading and therefore the European rule preceded the Irish rule. From this directive on, the secondary care system in Ireland began to change drastically in relation to access to care at secondary level and created barriers between the patient and access to emergency care in the local hospital.

Also in 2003, the National Task force on Medical Staffing, commonly referred to as the Hanly Report, was published which provided details on a new health service for Ireland. This would involve drastic changes at secondary care level which included the removal of all acute services provided in secondary care hospitals, thus passing on all these services to the regional hospitals. It also suggested a reversal of the old statistics for the local hospitals whereby 97% of patients would be going to the regional hospital and 3% would be treated in the local hospital. All of these patients were expected to now go to Accident and Emergency at their centre of excellence after 8 p.m. Local action groups began to dispute this new policy to try and save their local service from being taken at such short notice. Protests were arranged on a local

and national level and thousands marched in the streets explaining the austerity of the new changes to the people. However, the Irish government promised that these changes would have only minimal effect (Burke, 2008, 2009 and Layte et al, 2009) on those using the service. They did not however, foresee what those changes would actually mean for the people living in rural areas of Ireland.

The Teamwork Report of 2006, which was a revised copy of the Hanly Report, was published so as to quash any opposition groups and any fears which were drawn from the findings of the previous Hanly report. It had however one new strategy- to completely re-structure the Irish health care system and only use twelve hospitals outside of Dublin for the emergency needs of the rest of the population. Each of these hospitals was to be renamed a centre of excellence and was to become the first step in changing the secondary care sector. Proposals included the downgrading and the immediate movement of all acute and emergency services from the local to regional hospitals creating a top heavy service with no extra finances or services put in place to take on new patients. The hospital catchment, the area a hospital draws on to fill its beds, (Gilmour 2010) for Limerick Regional hospital increased by 110% in the Mid-West region which saw three local acute hospitals lose their services in favour of the larger facility.

The reconfiguration process began actively in 2007 with a number of small hospitals losing 24-hour emergency services followed by specialist clinics and further losses of intensive care units. Stripped of their services, secondary hospitals bore the brunt of budget cuts, staff cuts and much more and the once busy hospitals turned to quiet care centres taking patients strictly from 8a.m. to 8p.m. This meant that all other cases outside these hours would have to be transferred immediately to the centre of excellence. New changes to the skill levels of health care workers, under the Croke Park Agreement (a public sector workers employment rights agreement) were put in place which included the up-skilling of emergency medical technicians to paramedic status. This would require the new paramedics to treat the patient at the scene and be able to administer certain types of medication to ease a patient's illness or injury and prepare him/her for hospital. This would in the long run potentially cut staffing costs as paramedics would be able to carry out a range of duties which before were done by doctors or nurses.

Advanced paramedics who have been trained are responsible for administering the same level of care a doctor may, at a scene, in terms of intubation. Although part of the primary care system, paramedics and advanced paramedics were the strong link

between the primary and secondary sector and remain so to this day, even with increased responsibilities.

1.5.3. Tertiary and Quaternary Care

Tertiary and Quaternary care is mainly given in both national and regional centres of excellence where there are specialist clinics and units. Consultants who have specialised in certain areas practice in these hospitals and put their skills to work on extreme emergency cases and carry out complicated operations. Tertiary care includes specialist paediatrics, geriatric care and emergency care. Quaternary care caters to those who need transplants, poison and burns treatment and emergency critical care.

In Ireland, although there are many tertiary hospitals, not all cater to the above list and patients have to travel further to one single centre in Ireland to gain access. This in particular relates to the poisons and burns clinics where Dublin is the only centre which deals with poisons and Cork being the centre which provides an additional burns/plastic surgery clinic. This specialised consultative care can only be obtained through primary and secondary sector referral. Other care within these fields may also include cancer care, advanced neonatal care, cardiology and neurosurgery. There has been no policy as of yet, to introduce quaternary care into regional centres which may due to low expertise and lack of adequate facilities.

1.6. Aims and Objectives

The aim of this research is to study the geographical change in access to acute emergency care in Nenagh, Co. Tipperary. People living in North Tipperary must now travel to Limerick to avail of emergency acute medical care that they once received in Nenagh General Hospital. The objectives of this research are:

1. To discover if access to health care in North Tipperary has changed since 2006 and if so, how has it affected the Nenagh community and those in rural areas?

2. To discuss the factors which affect access to care both spatially and economically and determine if those factors apply to the case in hand in North Tipperary and if they could possibly impact negatively, on patient outcomes.

1.7. Thesis Outline

- *Chapter One* is this chapter, the Introduction, which gives brief background information to the study of health geography and the issues at hand in today's world, with particular focus on Ireland. This introduction also presents the aims and objectives of this research and offers the reader an opportunity to have an open mind into reading research which is considered to be of delicate nature.

- *Chapter Two* is a review of the academic literature which surrounds health geography and access to care. The core focus of this thesis, health, is looked at with regard to why it is so important in today's society. Health systems, structures and models are discussed in relation to their relevance and the issues surrounding them, such as planning and politics. Health reform is referred to and it takes into account both arguments, those for and against new health policy and relates this policy to the same health models which are active around the world. Health systems and health service research are also discussed in relation to the reconfiguration of health services in many European countries, especially the United Kingdom, Ireland and France and so on. Finally, access to health is examined in terms of care in Ireland and abroad and a brief focus is put on access to care and human rights. Media reports as well as articles written by medical professionals are also included in this literature review.

- *Chapter Three* focuses on health policy in Ireland and documents the origins of the Irish health service from the 1800s to present day. Changes in health planning and health policy are noted as well as the controversy that surrounded the changes from the perspectives of both the public and the Department of Health. The Irish health system is fully explained and the chapter explores the new health service proposed and what it will offer in terms of accessibility and reliability to the Irish people.

- *Chapter Four* outlines the methodological approach taken during the course of this research. The approaches taken were to discover whether or not access to acute emergency care would change for the people of Nenagh during reconfiguration and also, when the process of overturning the old health system has been completed. As this is a fragile subject for this community, care was taken in the design of the methodology to ensure that results received would be of high benefit to this study.

Statistics gathered from hospital data were also used to supplement the results. Quantitative statistics were drawn from the census data available online and two questionnaires were designed, one for community members and another for medical professionals. Qualitative data was also collected to support the previous data in the form of interviews with medical professionals and those who are involved in planning in the health sector. All of the above provided a rich data source from which to draw a conclusion to the issues on access to care in Nenagh, Co. Tipperary.

- *Chapter Five* examines the results obtained from the community questionnaire. This questionnaire looked at how the people in the Nenagh community perceive access to care and their opinions and beliefs on the changing health service. It also looks at the statistics gathered from the acute services in the Mid-West region which were reconfigured and lost acute services as a result. The analysis of the above will be presented on charts and graphs in the chapter.

- *Chapter Six* examines the results of the medical professional questionnaire which documents the medical perspectives on the changing health service. These medical professionals included consultants, nurses, general practitioners, paramedics and advanced paramedics working in the Nenagh community but who are also subjected to work at the centre of excellence from time to time. Interviews are also discussed with planners and political representatives in the community in regards to health care. This analysis will also be presented on charts and graphs as well as quoted throughout the chapter.

- *Chapter Seven* is a discussion of the results collected above and links the results with the research questions proposed in this thesis. The results are correlated to answer the questions in relation to whether access changed and if so, by what means.

- *Chapter Eight* concludes this thesis and aims to provide a holistic view on access to care in Nenagh. The research questions are re-stated and evaluated in order to discover if any have been answered to any extent. Finally, some recommendations are added which may or may not be of any benefit from a planning perspective and also a local perspective for the future of the health service in the area.

The above outline of chapters allows for a clear understanding of what the study of health geography offers both theoretically and practically. It also allows for the decision to be made by the patient, about the level of equity and access currently available to him/her through his/her health service, using the example of the Mid West region.

Chapter Two: Literature Review

2.1.   What is health and why is it so important?

Health is defined in the Oxford Dictionary (2012) as "*the state of being free from illness or injury*". It is derived from the old English word for heal (hale) which means whole. This suggests that health concerns the whole person and his or her integrity, soundness or wellbeing (Naidoo and Wills, 2000). It is otherwise defined by the World Health Organisation (WHO, 1946) as "*a state of complete mental, physical and social wellbeing, not merely the absence of disease or infirmity*" and it is this definition which has been cited in all areas of health research (Üstün and Jakob, 2005). It was concluded at the Ottawa Charter in Geneva that health is a fundamental human right and is considered a world-wide social goal, to achieve the highest possible level of health for all through the action of both the health sector and other social and economic sectors (WHO, 1986). When a person does not keep himself or herself healthy, it can affect how he/she interacts with the world around him/her especially within his/her own community. This in turn defies the nature of health ethics, which include the responsibilities of an individual to keep healthy with respect to the community the individual lives in (Mann, 1997).

Health is expanding into each aspect of everyday life and, linked along with social politics, creates the term "*health society*". A healthy society can be defined as a society which has:

"*a high life and health expectancy rate, an expansive health and medical care system, an expanding health information market, an increased importance of health as a life goal, a prominence of health in political debates and finally the right to health as a key component of modern citizenship*" (Kickbusch, 2005 p101).

This health society values social change and the new social movements for health. It is more identity and issue based than before and shares an honourable commitment to health as a basic human right (Kickbusch, 2005). With increased demands in the economy, people are now working outside the regular eight to five working day creating a new twenty-four hour society, the likes of which can be seen in major capitals around the world (Rajaratnam, 2001). As shift work and overtime become a social norm, the effects of these working conditions can have a great impact on a person's health as well as economic productivity (Parsons and Fox, 1952; Arendt, 2001) and a decrease in one of these factors can affect the

other massively (European Commission, 2007). Therefore, investing to improve health for the population is not just an ethical policy for states, but also one which can boost economies and benefits for their country (Frewen, 2011).

As death is the only certainty of life, it is a given that all societies change with time so as to prolong life as much as possible through healthy living (Bury 1997). Health also provides a security blanket to society and when challenges face that sense of security, like an illness or an outbreak, implications can be deadly to the running of society (Nettleton, 2006, Holloway, 2004). Health is considered a social fabric and links the people in a community together. It is through this notion that sociologists and geographers have emphasised the importance of studying health and have fought to have health research recognised especially in regards to health inequalities. Functionalism is of such importance to health society and an optimum level of health is a prerequisite for the smooth running of modern society (Parsons, 1952). To keep society running smoothly requires education and health. Education is vital for this purpose and for educating communities especially on practices which keep a person healthy and in turn the community healthy (Khanna, 2012) thus making health a community issue as well as an individual one.

Health care is the diagnosis, treatment and prevention of disease, illness and injuries in humans and is delivered to the patient by highly skilled practitioners through primary, secondary and tertiary care facilities (Farlex Medical Dictionary, 2012). The Institute of Medicine (2003, p6) also defines health care as "*the extent to which health services provided to individuals and patient populations improve desired health outcomes*". Health care varies across societies and communities and is a significant part of a country's economy. In order for health care to run effectively, health systems and structures are put in place. Effective health systems and structures provide a society or community with a sense of wellbeing and this contributes to the good health of the people within the community. Often a government will work with the people living in a country in relation to providing care and health services in certain places (Balloch and Taylor, 2001; WHO, 2007). This is to ensure the adequate placement of services so that each person has sufficient access to a service in an emergency. These range from acute emergency services to maternity services, with examples of this in both Europe and New Zealand.

Health is a necessity of life and the phrase "health is wealth" suggests that to become rich or produce something in life you need your health and that good health is all that is needed for a long life (Wanjiku, 2011). As the human environment changes so will health as more challenges will be faced with new illnesses and diseases being discovered. Therefore, health could also be described as a potentiality or the ability to be able to change oneself with

the changing times and conditions in order to function better in the present and for the future (Institute of Medicine, 2002). This suggests health is an important factor in everyday life and good health can only be achieved through health education and the provision of adequate health care services in a person's environment. This, along with economics, encourages a government to aim for the ultimate goal of achieving a health society free of disease and illness where people can function and live happy and fulfilling lives. The right to health must be delivered through a service that is economically efficient, affordable and accessible to all.

2.2.   Health Geography in today's society

The study of health and medicine is not a new concept and can be traced back to historical times when ancient civilisations began to research into prolonging life and curing disease. The study of health was first officially documented in 400BC by Hippocrates who proposed that in order to study medicine you must take into account all the factors which influence the world around us, as these same factors are the ones which influence health (Pringle, 1996). Medical geography seems to have emerged from the many health catastrophes which plagued European cities from early Victorian times and resulted in new breakthroughs being discovered in accounting for the causes of outbreaks as well as their cures. One such study, which is considered to be the founding of medical geography, was conducted by a physician, John Snow, who began mapping the outbreak of cholera in London. Through his research, he was able to identify the disease and suggest how to contain it (Draak 2005 and Briney, 2012). Another example from the USA occurred in the mid 1900s, where dentists began to map areas where children had fewer cavities. Discoveries concluded that the groundwater in these areas had a high percentage of fluoride (Briney, 2012) and this research ultimately led to fluoride being used in dentistry. This introduced the study of medical geography which is classed as mapping demand and supply or the geography of an illness and inevitably allowed for the development of health geography which involved developed as a wider perspective.

Health geography is considered to be the study of health care delivery and the social context as well as other factors. Today, with increasing emphasis being put on the importance of one's health, the need to study health changes and health delivery across societies is becoming imperative. Health geography is recognised as research which is based on incorporating geographical techniques into health care on both global and local scales and health statistics (Lohn and Steinwachs, 2002) with governments and other agencies often distributing questionnaires on health, including questions on national censuses, giving

geographers a wide range of statistics to work with (Rosenberg, 1998). It also takes into account the impact of the environment or location and climate on a person's health as well as health access and service distribution (Agency for Health Care, Research and Quality, 2012). This gives health geographers the challenge of trying to gain an understanding of health issues and in turn provide recommendations to combat global health problems, based on the geographic factors influencing them.

Medical geography is closely linked to health geography but is still considered to produce research which is of independent significance, to the latter. Research has shown that geographers only tend to focus on one area or another but rarely mix both studies (Meade and Emch, 2010 and Draak 2005). However as one study, medical or health geography can be described as a branch that uses the concepts and techniques of geography to study health, disease, mortality, and health care (Draak 2005, Dummer 2008). It can also be agreed that the study of health geography has produced new goals in developing theories around place and space and continues to look at the relevancy of these new theories along with critical thinking, within the discipline. This study of place and space in regards to public service provision, location theories and demographics, has played a key role in the reconfiguration of medical services and using location analysis to assess health outcomes.

2.3. Health Systems, Structures and Models

Research carried out by health geographers has proven valuable to governments when they are introducing health systems or new structures into their environments. A health system is defined by the World Health Organisation (2005) as the overall total of all the organizations, institutions and resources whose primary purpose is to improve health. Health systems require staff, funds, information, supplies, transport, communications and overall guidance and direction with the goal of providing services which are accessible, responsive and financially fair, while treating people with decency. Some researchers believe, however, that this definition is lacking as it does not mention the integration of public and private services or primary and secondary services (Gatrell and Elliot, 2009). Health systems are referred to as open systems as they can be influenced by outside variables and differ widely in performance in many countries with factors such as finance, education and income levels affecting health status (Murray et al, 2000). Differences in design, content and management of health systems can result in differences in relation to health outcomes and fairness. It is through developing an effective health policy that a health system with a high performance rate can follow and develop as a successful operational framework (Murray and Frenk, 2000).

2.3.1. Health Systems and Health Service Research

Geography as a discipline is well suited to understanding health systems and services due to the nature in which it incorporates a "*whole system*" way of thinking. This takes into account the population of a place, how the population interacts with its environment and how this is different from place to place (Gatrell and Elliott, 2009). Health systems deal primarily with the delivery of care and the provision of a wide range of medical services. In recent times health systems have also come under pressure due to growth in demand from the physical and social environment (Janssen, 2011). This can be attributed to economic growth or decline and also the politics behind health in a country. However, an important part of health service geography is to understand not only the spatial organisation of health services but also how, where and why such systems change (Barnett and Barnett, 2009). Inequalities within countries can greatly affect a person's health also. With populations aging, health is becoming increasingly expensive for governments to provide, especially at a community level. This is mainly due to the expectations that a community has in regards to health provision.

Health services research is a study which examines access, use, cost, quality, delivery, organization, financing, and outcomes of health care services in order to produce new knowledge about the structure, processes, and effects of health services for individuals and populations (Institute of Medicine, 1994). Research such as this, plans to identify the most effective way of managing and organising a health service which delivers high quality care, reduces medical errors and improves patient safety (Gatrell and Elliot, 2009). This research is important to health geography as it is used to understand community values more fully, due to health care becoming more patient-centred (Barnett and Barnett, 2009). The efficiency of a service depends on not only the framework of the system, but also the government regulation of the system. The framework must be designed in order to reach out to all of the population at the community level, from primary care right up to secondary and tertiary services so as to provide a fair and equitable service.

2.3.2. The Importance of Health Models

Health models are made up of a collection of systems which can be affected greatly if change is made to the social environment (Haas and Selinger et al, 2010) and are modelled on basic health philosophies and principles with the hope of producing a sustainable health system. Looking at health in other countries, there are continuous references to four basic health models. These models are known as the "*Beveridge Model*", the "*Bismarck Model*", the "*National Health Insurance Model*" and the "*Out of Pocket Model*" (Reid, 2010). The Beveridge Model is designed on a system where health care is provided and financed by the government through tax payments. Countries using this system include Great Britain, Ireland, Spain, most of Scandinavia and New Zealand (Jonas and Kovner, 2011). This system can provide care for all at a reasonable cost but cannot ensure a quality based service.

An insurance based system such as the Bismarck Model can achieve a high standard of care but cannot ensure that it will be affordable to all, through payroll deduction (Cichon and Normand, 1994). Countries using this model include Germany, France, Belgium, the Netherlands, Japan and Switzerland. However, using a combination of both of these models could afford a country, a health service with a reliable financial base (Lloyd, 2010). The third model, the National Health Insurance model, provides care with payments being taken from a government run insurance programme that every citizen pays into i.e. a universal insurance program (Jonas and Kovner, 2011). The final model, the Out of Pocket model, is one which is practiced in poorly developed countries, where without money it is usually complicated to access adequate medical care.

As mentioned before, a health model deals with the way in which care is delivered to a population and varies from country to country depending on history, politics, culture, the economy and national values (Saha, 2012). As health frameworks in countries are liable to change with the governing politics, it is essential that new health structures maintain their core values- to provide quality and equal care to all (WHO, 2007a). To take an example of each of the health models would be to look at countries such as Great Britain, France and Canada. Great Britain follows the Beveridge Model which is health care that is financed and provided by the government through tax payments. In contrast to this model is the French system. France is home to the best health service in the world in terms of equity and access and has its roots in the Bismarck Model. Insurance plans are paid for jointly by

employers and through payroll, with all of the population having their own plan. There is tight regulation of fees and the plan providers do not make a profit from their customers.

Canada is a prime example of the National Health Insurance Model which has a government run insurance program that the population pays into, and provides full cover. This is a low cost system (Saha, 2012). The Out of Pocket Model operates in parts of Africa, India and China where there is no solid central health system and only people with money have access to much health care. Often medical services can be traded for goods or other services and there is no government health plan or insurance scheme.

2.3.3. Health Policy and Planning

Health policy refers to the decisions, plans and actions which are undertaken to achieve specific health care goals within a society (WHO, 2012). Health policy is directly associated with health care delivery and includes the financing and actual delivery of care as well as access, quality and equity of care (Kereiakes, 2004). Health policy was derived so as to prevent health inequalities from increasing (Whitehead et al, 2004). Many countries have begun to also incorporate human rights into their policy making. The World Health Organisation specifies that every health policy must have some connection to health related rights and demands that governments integrate the right to health into government policies (Gruskin and Tarantola, 2009). The United Nations Declaration of Human Rights (1948), states that every person has the right to a standard of living and necessary social services which includes medical care. This has been explored further by Amnesty International which has put much emphasis on lack of access to care for minority groups across countries, especially in Ireland (Amnesty International, 2011).

2.3.4. Health Models and Health Planning in Ireland

The new universal health system proposed for Ireland aims to link aspects of the three main health models, to ensure access, equity and quality of care to all. The Irish government proposes to look at aspects of the Bismarck Model in relation to introducing a social health insurance but also market competition (National Health Insurance Model) as well as trying to maintain its patient-centred approach

(Beveridge Model). The ultimate goal for any health system is to improve the health of the population and enhance the responsiveness of the health system for the population. A country's health care system is a reflection of its basic ethical values. In countries that have decided medical care is a human right, everybody has access to the doctor (Reid, 2008). If the government is to fix health care in Ireland, it will first have to answer to this question: Is the responsibility ours as a nation, to make sure that any Irish person can get health care when he/she needs it, where he/she needs it?

2.4.   Health Reform in Ireland

Health care is not as safe as it should be (Kohn, 2003) when there are numerous access issues for rural patients to try and overcome, to obtain the care they need. Population dynamics can inpose huge costs on a government's budget especially with health services and providing an efficient service to a population. Health strategies are always changing- the reality is they have to operate in a state of continuous change in order to aim to adjust to economic, political and social demands (Hurst, 1991). Careful planning and provision must be practiced when placing health services particularly in rural areas, with already limited access. Health reform is recognised as a change or creation in health policy that affects health care delivery in a place (Baker et al, 1994) and aims to improve access to health care, improve the quality of health care and also decrease the cost of health care.

Modern health reform in Ireland began in early 2000 with plans to overhaul the Irish health system and provide bigger and better services to the population. In 2003, the Hanly Report was published which described a new service that would put Ireland firmly on the map, in terms of quality health care in Europe. As health reform continued on the continent focusing on health insurance schemes and access to care, the Irish government began to re-organise services and downgrade local hospitals from twenty-four hour emergency centres to twelve hour clinics. The motion to do this was put forward in the Teamwork Report of 2006 which was a re-draft of the former 2003 document. Briefly, the Teamwork Report suggested placing just twelve major hospitals outside of Dublin which would have twenty-four hour emergency services. The remaining general hospitals would be reconfigured into day clinics. This approach was opposed by many in both the political and medical fields and prompted additional health research in the area before any health policy changes were made final. The Irish government concluded that this was the right step for Ireland and, in 2007, hospital reconfiguration began around Ireland beginning with the Mid-West region.

The theory behind the move was that all patients would be treated in local centres during the day, lowering the dependence of non-fatalities on the larger emergency rooms. When the local clinics closed in the evening time, patients would be transferred to the centre of excellence to be treated. This potentially created a top heavy health service with vital services being placed in distant regional hospitals and not enough emergency cover left behind in the smaller local hospitals.

This created consternation in towns across Ireland who spoke of the lives which would be lost due to the changes (Carney, 2006). The people were not alone then with their concerns, as there was and still is a belief amongst health geographers that the endogenous approach may be best in terms of providing health care particularly on a small island like Ireland (Burris, 2004). Decentralising health in a failing economy was a bold move by the Irish government and additional concerns grew as to where funding for both the service and the staff to man the service would come from. Atkinson (2000) argues that in order for a decentralised system to work political culture must be infused with local organisation so that the system can be effectively controlled by dual management. Black (2002) agrees and states that discussions about reconfiguring specialist health services in larger hospitals are sometimes overshadowed by wider discussions on centralising all services, especially when the public opinion differs in wanting the maintenance of a local service.

Traditional studies of health service delivery were concerned with the role of space and how it affected the organisation and distribution of health services and patterns of use (Barnett and Copeland, 2009). Centralisation has been seen to work and fail in other countries for example in the United Kingdom, where services are now being decentralised. This was also the case in Germany, The Netherlands and Norway (Pedersen, 2002). However, according to Anderson (2010), centralisation means more cost effective care and offers better access to preventive services with Bustamante (2010) also agreeing, referring to centralisation offering more expertise and more services to populations who would otherwise have had to be treated in a local hospital, which he deems as having "*a low grade of specialisation*". In contrast to this opinion we have the idea of decentralisation where it is believed that giving autonomy back to the localities will improve services.

Decentralisation relates to the transfer of formal responsibility and power to make decisions regarding the management, production, distribution and/or financing of health services, usually from a smaller to a larger number of geographically or organisationally separate actors (Vrangbaek, 2007). The logic of decentralisation is based on an intrinsically powerful idea in that smaller organisations, properly structured and steered are more agile and accountable than larger organizations (Saltman et al, 2007). This has been extremely

difficult to implement in some regions due to politics and the state government not wishing to hand over control (Mills, 1990) and due to the sensitivity of the subject in the political world, the concerns for distribution of power and allocation of resources increases. For decentralisation to work fully within a developed society, rules must be implemented so that consultation between the "*bottom up*" and "*top down*" approaches would not fall to the wayside (Vaughan et al, 1990). This emphasises another issue in relation to decentralisation not being cost effective and having many hospitals in the one area providing the same service increases expenditure (Peckman et al 2005, Saltman et al 2007). In Ireland, this is not a new issue. Government reports dating back as far as 1936 proposed to rationalise hospitals which provided poor quality of care to too many people (Burke, 2009) thus proposing that centralisation was a way forward for the Irish health service. However the issue of distance especially across Ireland's somewhat difficult geographical terrain has created difficulties for patient transportation and staffing, in areas where centralisation has already begun.

Health geographers as well as health care providers are now looking at Geographic Information Systems (GIS) to identify optimal spatial patterns in service utilisation and in new delivery systems (Villalon, 1999). Although often quite quantitative and efficiency focused, using such systems can inadvertently show discrepancies in planning in regards to "*bottom up*" and "*top down*" approaches (Cromley and McLafferty, 2002). GIS is also effective in organising and analysing the effectiveness of a service in terms of demand and limited budgets, thus being an ideal partner to health models and planning (Houghton 2004, 2006; Kalogirou and Foley 2006; Davenhall, 2010). As geographers began to focus on the spatial distribution and inequalities in health care provision, it became clear that the way in which countries organised their health system, had a major impact on health inequality dimensions (Meade and Emch, 2010). From this we learn that health reform and planning have major roles to play in reducing social isolation and decreasing health inequalities (Braveman, 2003; Mead, Dodson and Ellway, 2006).

2.5.   Access to health care

In every community, people will become ill and will require access to health care facilities and treatment (Holloway 2004; Nettleton 2006). Whatever the nature of the health problem, a patient's health outcome depends to a large degree, on the person's ability to access his/her local health care services. Unfortunately, health services are often planned or reconfigured with little consultation with the members of the community who use and pay for such health services, especially in rural areas. Speedy access to care has proved to be a crucial factor in

saving a patient's life and treating the patient within such a fragile time frame leaves a lingering question as to why some populations in the developed world are deprived of such a lifeline.

For many years policy makers and health researchers have tried to establish a conclusive definition in regards to what exactly access means in relation to health care so as to provide better health services or recommendations for same, through health reform (Khan, 1994). Access to health care has been recognised widely as the interaction between a health service system and potential users in a given area and which is regulated by public policy and health planning (Goddard and Smith, 2001). Health care access relates to intricate measures whereby there may be sufficient "*access*" to care but care still may not be "*accessible*". Services may be provided in ample amounts in a region giving the population the ability to access care and benefit from the care system, however, barriers of accessibility, including financial, physical and cultural barriers may inhibit a population gaining an equitable amount of access to the health care system (Graves, 2009).

In Europe, access to health care is of high importance to society and national health policies clearly show this through using advanced health planning techniques and health organisational models. Governments have committed to assuring their people that their access to care will not be compromised. Unfortunately this cannot always be guaranteed and health inequalities protrude through the gaps left by ineffective planning and operation of services (Davis and Gold, 1981). Patients will only have a good health outcome if access to a health service is sufficient. Access can be measured by looking at different components of a health system such as coverage and utilisation. Effective health coverage refers to the proportion of the population in need of an effective intervention who have actually received the intervention (WHO, 2005). The utilisation rate relates to the number of times in the year the population actually uses the health services but can refer to how under-used a service is also (WHO, 2005). The utilisation of health services represents effective access to health care which is considered to be the result of the interaction between supply and demand factors (Acuña et al, 2001). If demand is not there for a service it may not be provided in a community but likewise if there is demand, it may not be financially possible or feasible to provide that service in a particular area. Therefore the inability to gain access or to utilise a service, can hinder a service as well as the medical staff providing the service. This can often result in staff not updating skills due to low input into the service (Jacobs et al, 2011). This demonstrates that access barriers can influence each other whether it be a physical barrier geographically, or an organisational barrier such as finance or planning.

2.6. Access to Health Care in Ireland

In Ireland, the concept of appropriate access to public health has been discussed over and over again from a political and medical perspective. The Irish health service is built as a two tier model (Nolan and Nolan 2005, Harvey 2007, O'Shea 2009) with one tier being designed as a public service and the other being managed by private health providers. Primary care in Ireland is delivered by the General Practitioners who are the gatekeepers to the local hospitals and who refer their patients for acute care in these hospitals. General Practitioners are located within the community in single practices which are slowly being turned into primary care teams (a collective of practices), in line with national policy. Community care is provided by a wide range of other health professionals including nurses, pharmacists, carers, therapists, social workers and many more and also includes elderly care. Acute health services are delivered in both private and public hospitals across the country. There is also a private secondary system consisting of at least twenty private hospitals operating parallel to the public system. It is here where access difficulties are most prominent.

An individual's ability to access appropriate and affordable health care in Ireland can often depend on whether the person has private health insurance or his/her eligibility for a medical card. Difficulties in accessing services such as specialist clinics have been duly noted as a re-occurring problem for some, especially those who are financially strained. Those who earn below a certain monetary band or live below the poverty line in Ireland are given a medical card which enables them to free primary and secondary care. The disadvantage to this is that long waiting lists are endured for the most basic of services due to the sheer amount of people on this scheme. Currently 39.5% of the Irish population have no private health insurance and hold a medical card or GP Card, the latter entitles a person to free GP visits (CSO, 2011). The long waiting lists highlight the issues regarding the supply or lack thereof, of staff and equipment, in primary and secondary care, and the demand for such services. This shows that needs are not being met by health service providers.

Private health insurance customers, which amount to 49% of the population (CSO, 2011), are regularly able to 'skip the queue' or be seen almost immediately by the consultant due to paying extra waivers. Private insurance, however, does not cover costs in relation to primary care. In 2007, medical card holders were three times as likely to be on in-patient waiting lists and twice as likely to be on outpatient waiting lists as privately insured patients (CSO, 2008). It was found that people who can afford private health insurance gain access to some hospital services faster than those with similar health needs but who have no insurance (Department of Health and Children, 2010). This system has been deemed inequitable by

those with severe illnesses, who are trying to access services through the public system with severe illness. However, the number of individuals who hold private medical insurance is decreasing due to the rising cost of premiums, which is putting more pressure on the public system to treat patients quickly and effectively.

Government health policies in Ireland such as the Quality and Fairness and the Primary Care Strategy (2001) have tried to address the issue of access and equity of access especially for minority groups and migrants (Amnesty International, 2011). Cost as a barrier is especially taxing on those who do not meet the requirements for the medical card scheme and who are not covered by private insurance. As a GP appointment can cost any price between €40 and €75 per visit, it is imperative that care be made affordable to those who fall between the gaps because of their economic status. It is the responsibility of the government to make sure that access to care is affordable and suitably available without discrimination to any group. This is an urgent issue to be resolved as often individuals who are ill and are not covered by insurance or on the public supplement scheme, may not attend their General Practitioner or Primary Care team with their illness simply because they cannot afford to pay the costs (Nolan, 2006).

As local hospitals will have limited opening hours (HSE Protocol, 2009), they will not allow for emergencies and will have working times which may or may not be convenient for patients, especially those who are working. Staff could possibly be re-deployed to the centre of excellence to help if pressure is mounting there, leaving the clinics with just nurses to run them. Furthermore, at the centre of excellence, there have already been accounts of staff absenteeism (Deegan, 2012) with staff taking leave or sick days to recuperate from long day and night shifts which may have influenced stress levels and pressure on the staff themselves. Having already burdened staff in a centre of excellence along with a continuous influx of ill patients to be seen, is not a safe environment for any patient to be in. In August 2011 alone, there was a 7.37% absenteeism rate in Limerick Regional Hospital for nurses who were on sick leave including certified, uncertified and unexplained absence (Freeman, 2011), a number which increased to 10% when nurses were rostered on to work in October 2011 (Deegan, 2012). This was a figure which the HSE deemed too high as it represented a huge lost opportunity for service delivery, productivity and continuity (Freeman, 2011). This has cost the health service millions with the HSE having to renege on its previous statement of trying to cut down on agency staff.

The Health Information and Quality Authority (HIQA) is an independent body which assesses the quality and safety of delivering health care in Ireland. In 2007, HIQA reported that they recognised the challenge of providing timely and appropriate access to local

services whilst at the same time providing safe services that secure the best outcomes for patients. It was recommended by this organisation to remove acute services from local to regional hospitals so as to provide a safer service, with the patient getting treatment from the most skilful of staff. Deegan (2011) reported that stress is becoming a major agent in staff absenteeism especially in the new centres of excellence, due to increased work load and longer hours. When Emergency Department staff are absent, it costs more to replace them with agency staff and waiting hours are subsequently increased for patients because numbers are down. HIQA reports that these factors can often be off-putting but safety must always take precedence and the patient must still be brought to the regional hospital (HIQA, 2007). Ireland's new health reconfiguration policy of specialisation and centralisation proposals are arguably not patient-centred, not soundly evidence-based and are not the only way of meeting the requirements of the European Working Time Directive (Barton, 2004).

In addition to the above literature, attitudes towards acute health care in relation to urban and rural settings amongst medical staff have also been discussed. Acute medicine varies widely from injury clinics and emergency rooms to intensive care units and is seen as an area of medicine that is costly and would be better used if provided in one central centre. This central centre would have a team of doctors who would attend to patients rather than the service being provided in a local hospital by an individual consultant. In Ireland, there seems to be some prejudice building up between consultants who work in rural local hospitals and those working in the city hospitals. The rural consultant is often described as 'another breed' of health professional, willing to cope with relative professional isolation and ready to take on unfamiliar cases, but is also often described with less flattering characterisations (Barton, 2004, Ricketts, 2009). Despite many firmly held perceptions of differences, little is actually known about what the rural consultant does that is different from what the urban consultant does (Ricketts, 2009).

Another factor which must be taken into account is distance and health outcomes and how both of these influence each other. There is research to suggest that distance can have a severe effect on a patient's illness and in some situations, the emergency services can be the difference between life and death for a patient (Carney, 2006). There is incontrovertible evidence that 30% of patients with major trauma die unnecessarily because of lack of appropriate care ideally within the first hour (Barton, 2004). Another study concluded that:

"*...research from the United Kingdom found that trauma victims attended by ambulance paramedics actually had a higher death rate than those attended by standard ambulances*" (McKee, 2002 p63).

Two reasons were suggested; first the process of resuscitation delays transfer to hospital and, second improvement in tissue perfusion increases the risk of bleeding on the way to hospital (Nichols, Dixon and Hughes 1998 and McKee, 2002). Further international evidence shows how distance impacts a patient's recovery rate and patient results. There is some direct research evidence on the relationship between distance from hospital and outcomes for patients. One study in England and Wales covering 100,692 deaths found increased mortality when patients were a greater distance from the nearest hospital. The conditions for which this was significant were diabetes mellitus, asthma, and mortality in the first 28 days of life, and road traffic accidents (Jones, 1996). In Canada, a study in Montreal of 360 severely injured patients showed that those who did not reach hospital within one hour of the injury had a 3-fold increase in the risk of dying within 6 days of admission compared with those who reached hospital within the hour (Sampalis et al, 1993).

According to the Irish Association of Internal Medicine (IAIM, 2003), 95% of patients can receive quality care locally and this figure is also included as part of the National Health Strategy (Barton, 2004). For IAIM and for the vast majority of those involved in providing primary and secondary care to local communities around the country, what is needed is a patient-centred service that provides a local service to patients when and where they become ill, twenty-four hours a day, anywhere in the country (Barton 2004 and McNamara 2004). There is international research which suggests that having services such as twenty-four hour emergency services at a local level is the most suitable for the patient as it allows for better equity within the service (Black, 2002).

As the Irish constitution does not state any form of health rights within it, the fact that Ireland has signed international treaties in regards to the matter should merit attention. The human rights framework does not dictate the particulars of government health care policy, but it does require equity of access. This is not being delivered for people living in Ireland (Amnesty International Dublin, 2011). Although Irish health policies include important values such as equity and accountability, resources are not fully in place to support the implementation. It was also found that the current health care financing system in Ireland lacks transparency and gives rise to serious inequities in access to care (Department of Health and Children, 2010). This may suggest that planners and policy makers may have to review the current circumstances. Although it may not be cost effective to have twenty-four hour services in every local hospital, it may be equally cost effective to look again at population demographics and reconsider service movement. Interventions aimed at facilitating access to health services need to be implemented at district level, as this is known to constitute the

most appropriate geographical situation for primary health care (Jacobs et al 2011, Ekman et al 2008; Lawn et al 2008; Rohde et al 2008).

Other governments have reversed decentralisation within their health services due to health access being insufficient to a significant portion of the population (Saltman et al, 2007). Deconcentration (Saltman et al 2007) is a form of decentralisation whereby authority and responsibility are shifted to lower levels of the Department of Health. Deconcentration is thought to improve access to care by allocating financial resources according to local needs and making more money available by spending it more wisely. It also aims to tackle the lack of opportunity by targeting marginalised groups in an area as well as planning to enable accountability whereby health care providers are more responsive to the preferences and expectations of the local population (Bossert and Beauvais 2002, Bossert et al, 2003). Health service providers and communities should therefore maintain communication and find compromises that meet community demands but also reflect the capacity of the service (WHO, 2010).

2.7.   Conclusion

The study of health geography in relation to health reconfiguration and access rates is still in its infancy at the present time. There have been many studies completed in relation to access with GIS and physical barriers but not on people's perspectives of health care. Health reconfiguration is costly and can be a great financial burden to any government especially in rough economic times. Over a ten year period the cost of reconfiguration would be unbearably high as it would include changes to the actual infrastructure of the health system. These costly changes would include costs for buildings and site developments which could run very high especially if the regional hospital being renovated has little or no available space to be used. This has happened in the case of the Mid-West region where local hospitals were upgraded during the late 1990s and the suites which were built to house the "*Emergency Departments of the future*" are now closed. This is costing the Irish tax payer a large amount every year but these costs were not fully explained or taken into account in the original Hanly Report (McNamara, 2004).

Staff costs will also be high as will new technology especially in regards to ambulatory care. One case which has been noted as being of extreme cost to tax payers was the reduction of the amount of patients an ambulance was able to cater to (Culliton, 2009). Presently Irish ambulances can only carry one patient whereas before, two patient

ambulances were available. This has also been discussed as an access barrier in many cases as there are fewer ambulances in stations due to the high expense of the new vehicles.

With new European policies being introduced and standards increasing, more governments are looking to create a change for the better- a change which will be sustainable for the future. Investments in research and development must be increased, as time goes on, because of populations living longer and a possible increase in global birth rates. Health brings a freedom very few realise until they no longer have it and it is up to both the government and the people to come together and move together on such issues as health policy and planning, without being in breach of any ethical codes. A person's geography should not influence the way in which he/she receives health care and it is only through further health service research and planning, that governments will find a suitable health service for their people that will be patient-centred, as promised, and abide by both national and international law.

Revising the above literature, common themes such as access, efficiency and quality appear when studying health geography and health policy. Service reorganisation is inevitable but addressing issues in relation to the placement of services has to be considered on a more in-depth scale than it may have been in the past. This may then contribute to an emerging balance between providing a good service from available resources with assessing patient needs and the demand for the service. Therefore it is only through careful health planning and the consideration of patients' needs, whether through centralisation of services or otherwise, that an effective health society will be obtained and managed. The following chapters of this thesis will investigate how these health service tensions have emerged in one location and also how they operate and are perceived by the general public and medical practitioners.

Chapter Three: Health care in Ireland

3.1.   History of Health care in Ireland

Provision of substantial health care began in Ireland during the 18th century with the first hospitals being set up in Ireland during the 1720's to provide for the sheer amount of people suffering from poverty and disease. These hospitals were run by doctors in the community and worked from accepting donations from the wealthy (Harvey, 2007). In the 19th century, health care was linked closely with religious organisations and the church began managing hospitals around the country (Fitzgerald Report, 1968). After the famine, the colonial state created workhouses and dispensaries for the very sick and very poor in Ireland. After winning independence in 1922, the new Irish government began to reform health and although it was not a priority at the time, services were set to a standard of acceptable care for the poor (Barrington, 2000). Through the early decades of the new state, health care was provided on a needs basis at a local level and county councils were given ownership of the local hospitals as well as a say in what services were provided. This local-led system ran through to the 1970s and was funded by a mix of lotteries and state contributions.

The most significant time for health in its early years was in 1947, when a separate Department of Health was first established. The Irish government then set about creating a form of welfare state with universal health care for all. Under the umbrella of social insurance, the government, led by Dr. Noel Browne, wanted to provide a free public health service like that in Britain, and developed a White Paper (1947) with the hope of improving health care in Ireland. This attracted heavy opposition in regards to how this system would actually be financed as the Irish state was still new and not yet on solid financial ground. Basing the system on that which was in operation in Britain at the time, an Irish system was born which promised to take care of its patients and give quality of care to those who needed it (Nolan and Nolan, 2005). Arguably, a two tier health system eventually developed and allowed patients two forms of access- private care and public care. This system was not welcomed by the church as hospitals were handed over to the state and contraception was encouraged (Harvey, 2007) but medical professionals believed it would open up new opportunities for patients and professionals alike. This new two level system opened the gates for private health insurance providers, to create a niche for a "better care" strategy and although efforts were made to improve public health insurance, privatisation began to take

hold of the primary and secondary care sectors slowly and created a path which guided the Irish health service into a new era.

In the late 1960s, the government released the local authorities from responsibility for health care and began to reorganise the system to suit the needs of the changing times, moves which were originally cited in the Fitzgerald Report (1968). Health boards or regional care centres were set up, whereby a number of hospitals were brought together as a collection of networked services in a region rather than as standalone hospitals. This centralised care geographically to some extent, from local led services to regional bases but still allowed for acute services to be provided at a local level in smaller hospitals. Eight boards were originally set up, each with a common goal- to provide community, psychiatric and emergency care to the Irish people. These eight turned into eleven during the 1990s and were nicknamed "*the eleven kingdoms*". This change occurred in the East where the population was at its greatest and health care needed to be under stern control. Three sub-regions in the greater Dublin area were created for this purpose. Medical professionals, local councillors and people of other medical or official backgrounds were given places on these health boards and it was these people who dictated the services in local hospitals. These locally manned health boards would also set the basis for what would become, in the future, one of the most controversial health services to be on offer to citizens of an EU state.

Another significant turn of reorganisation began in 2003, following on from the 2001 policy discussions, with the publication of a number of reports, including the Brennan Report (2003) and Prospectus Reports (2003) where proposals were put in place to unify health services under one centralised governing body taking the '*local*' even further away from the service. The eleven kingdoms were disbanded to an extent and power was taken again from the health boards and given to the new health organisation- the Health Service Executive or HSE. This shifted autonomy of health services geographically further away from the people. Centralisation began to take form slowly, having services reduced first in 1970 with 32 units to 11 units by 1997 into one national agency and again in 2005 to four super regions. This HSE system was primarily based on the success of the National Health Service (NHS) in the United Kingdom and was believed at the time to be the best step forward for health care in Ireland. The Department of Health became solely responsible for creating health policy and the HSE for implementing policy. The Minister for Health became theoretically accountable for the health service through the Dáil and would be answerable to the Irish people for whatever might go wrong with providing a safe and equitable service. This change came into being on the 1st of January 2005 following the 2004 Health Act- the third of its kind in just over fifty years.

3.2. Health Policy in Ireland

In the early days of the Free State, there were few policies in regards to health due to it being lower on the priority list than other departments. Through the decades to follow, only structural policies in regards to health care were implemented and it was not until the 1990s, that policy in relation to the provision of services was seriously looked at. The two most influential formal policy documents of the late 20th century were "*Shaping a healthier future*" (1994) and "*Quality and Fairness- a health system for you*" (2001). Although the Fitzgerald Report (1968) also played a key role in early health reform, the two previously mentioned policies relate more to the changes which are discussed throughout this thesis. These policies moulded and shaped the Irish health service into the service which is used today. Both of these policies focused on different strategic aspects of the actual provision of care at a local and regional level and also the way in which health care is delivered. The new system devised would provide an accessible and equal service to all- a service which the Irish people would feel safe using and a service that could be trusted especially to provide the best service possible at the most accessible point to the patient.

As part of the European Union, Ireland also had to obey European rules in relation to health care and has had to evaluate health policies according to the United Nations also. Standards had to be set in order to increase life expectancy and improve the standard of living making sure to provide for the human right to a sufficient health service. Health policies of the 1970s and 1980s focused on disease prevention and health promotion as well as shortening the length of stay in hospital and these continued to hold a strong grip right into the 2000s when the emphasis was put back on health promotion, healthy living and community care services. This move handed responsibility over to the patients to take control of his/her own health and to better his/her lifestyle with the intentions of improving his/her health in the long run. This was supported by the introduction of clinics and support services to combat drug use, alcohol abuse and obesity in communities. The inclusion of these services has contributed to stabilising health philosophies to maintain an efficient health society.

3.3. Health Inequalities in Ireland

There are many social determinants that cause inequalities in society. Health is just one of those, but it is an important one, as it can change the way a person lives. The social conditions in which people live and work can help create or destroy their health (WHO,

2004). Low income, a low standard of living and little or no access to care are all factors which lead to health inequalities. Social, Economic and Environmental factors all play a vital role in a person's health and depending on a whether a person is above or below the poverty line, can often determine if that person has basic access to health care- something that he/she are entitled to as European citizens.

Health inequality is a term which is used to describe a form of lack or deficiency in society and refers to the unfair differences between social groups due to social and economic conditions (WHO, 2004). In Ireland, inequalities are deepened throughout health care due to the nature of the two-tier health system. The two tier health system consists of both a private and public system working together in the same hospitals. Patients who are able to afford private health insurance are allowed to attend consultants at a time that is both convenient to the consultant and the patient while also avoiding the public waiting list. The public patient waiting list is for those without private medical insurance or for those who are eligible for the medical card. These patients can be waiting up to a year or more to see the same consultant. Private insurance holders can arrange appointments through their GP or may be able to organise an appointment themselves, because of their ability to pay privately. Because of this, low income families may have very little access to good secondary care and must use the public system whereas middle or high income households can benefit from using the private insurance system, if they can afford it.

Since 2008, the economic downturn has also affected many household incomes in relation to being able to provide health care for one's family. This can impede a person's ability to access sufficient care and also pay for the service and needed prescriptions. Many who are ill may choose not to attend their local general practitioner until their condition has worsened simply due to not being able to afford to pay the fees. Therefore, those who are poorer or disadvantaged are more likely to suffer more during their lifetime and may die younger than those who are a social step higher in society (Farrell et al, 2008). This shows that everyone does not have equal rights in terms of care in Ireland.

A person's geography can determine many things, where he/she may work, where he/she may go to school or who he/she may marry. Geography plays a vital role in health and is sometimes, unfortunately, the cause for many health inequalities. Those who were living a relatively long distance from his/her local hospital will now be even further away because of reconfiguration and will be in some way deprived of access to acute services.

Age is also another factor and with Ireland having a low overall mortality rate, people are living longer. There are more elderly people in the country who need better health care services, at both primary level and secondary level. The average age of rural communities

tends to be older and because of this, it can be difficult for the elderly to find ways of travelling to hospitals and their primary care teams to get medical assistance. New policies linked to austerity have led to cut backs within certain areas and more elderly care units are being shut down and beds are being cut each year (see Table 6.12 in the discussion chapter). This is creating fear amongst the elderly, especially those with a long term illness who cannot afford or do not have the means to travel to the new centres of excellence for care. Poor education on health can also contribute to poor health. The Irish government has tried to educate the youth through health promotion programmes in schools and offering adult education courses in the same area as part of a wider attempt to improve population health.

Mental health services are also a part of reconfiguration and hospitals which dedicated a number of beds to this sector have had to let them go with the budget cuts or they have been reduced and moved elsewhere. Deinstitutionalisation has been favoured in some respect as it has offered long stay psychiatric patients better accommodation while they receive care in community settings. There was a mental health unit originally planned for Nenagh, under the previous Minister for Health Mary Harney (24 beds at a cost of €5 million), however, the permit for such a unit expired shortly after construction and funding was withdrawn due to unknown circumstances (O'Duffy, 2010). There are currently no mental health services available for psychiatric patients in North Tipperary and patients must travel to Limerick or Ennis for services as Clonmel is now exclusive to South Tipperary only. The loss of such a service to an area, especially during these times, when mental health is extremely fragile, is considered to be unjust.

The Irish people may be waiting quite some time to see some change in the socio-economic status of society and witness whether or not the newly proposed universal health care system will help close the gap of the social ladder or open it further.

3.4. Critical Issues with Irish Health Policy

Issues can often arise from policies which are made with the intention of helping a patient and these issues can often escalate into long standing problems, if they are not dealt with and are left to linger.

3.4.1. Overcrowding

Over the past number of decades, the Department of Health has been dealing with ongoing issues in relation to hospitals and overcrowding. Overcrowding is deemed the

most important and highly controversial issue in health care (Wall, 2011) in that the changes which occurred during reconfiguration were to solve the issues, but in fact, have made them slightly more prominent. Overcrowding is often seen to be an issue just in emergency care; however it does filter into other areas of care such as recovery services. Often, there is an influx of patients into the emergency room and staff are overwhelmed with the sheer amount of what they have to deal with. On many occasions, patients have been left waiting hours upon hours to receive care from a consultant or even just to be seen by one. This is a major hindrance to accessible care and deters people from using the service. Also, because of the indignity overcrowding has caused to patients, top consultants have begun to brand overcrowding as a human rights issue (Gilligan, 2012).

New policy such as the Mid Western Integrated Services Project (2008) was formed to link closely with reconfiguration and promised to help the staff cater for the extra amount of patients as the catchment area grows. In 2009, promised extra acute services and care facilities were expected to be put in place as was an increase in bed numbers in these centres, but the fruits of this policy have yet to be seen. Emergency room overcrowding has many effects, including placing the patient at risk for poor outcomes, prolonged pain and suffering, long waits, dissatisfaction, ambulance diversions in some cities, decreased physician productivity, increased frustration among medical staff, and violence (Derlet et al, 2009). In 2011 a nationwide scandal mortified the health service in two hospitals due to overcrowding. In Limerick, at the centre of excellence, a 35 year old man waited two days on a trolley to be transferred from one hospital to another. He was suffering from Crohn's disease and was diagnosed as a minor case by doctors. Sadly, he suffered a major heart attack just before the transfer was about to happen. In Mayo, a young girl also passed away as a result of pressure on staff to get to other patients and her critical condition was left undiagnosed. These are just two stories chosen from the hundreds who have suffered as a result of overcrowding and malpractice. Mr. Feargal Hickey, the president of the Irish Association for Emergency Medicine (IAEM) reported in 2011 that there could be as many as three hundred and fifty excess patient deaths in our hospitals each year as a result of emergency unit overcrowding. Yet the Minister for Health, Dr. James Reilly recently remarked publicly on RTE, "*Nobody is going to die because of health cuts. That is a certainty*" (RTE, 2011).

Overcrowding can also have serious effects on patients who are already seeking care within the hospital system. In March 2012, the centre of excellence in

Limerick issued a crisis report stating that "*those only in urgent need should seek treatment in Limerick Regional Hospital*". This affected at least fifty patients who were already seeking treatment and waiting for operations in the hospital by consultants. It resulted in four operations being cancelled and forty five outpatient appointments being cancelled (RTE, 2012).

Solving the problem of overcrowding will not only require a major financial commitment from the government and local hospitals, but will also require cooperation from managed care. Unless the problem is solved in the near future, the general public may no longer be able to rely on emergency rooms for quality and timely emergency care, placing the people of this country at risk (Derlet and Richards, 2009). Now with health care regions expanding and catchments increasing, it may now be a necessity to review past findings on bed capacities in hospitals and look to restoring those beds which have been cut across the care network of primary, community and hospital care.

3.4.2. Waiting lists and Bed Shortages

Waiting lists are considered to be another grievance of the Irish health care system and given that nearly 70% of the Irish population use the public health service, it is a growing concern that waiting lists are seemingly getting longer rather than shorter. Large waiting lists are an area of high concern and need to be dealt with more so as a priority rather than an issue. There was in the past, a National Treatment Purchase Fund which paid for operations in private hospitals for those who were waiting over a certain amount of time on the public waiting list, but the patient had to be eligible under certain circumstances (National Treatment Purchase Fund, 2004). A recent Freedom of Information report indicated that there were a total of 60,000 people on outpatient waiting lists for medical care in Irish hospitals in 2011. Some patients were waiting up to two and a half years for first appointments with specialists (Fowler, 2012). Bed shortages are being reported around the country also especially in the centres of excellence due to increased numbers. Another dynamic which adds to shortages are seasonal factors. In some areas of the country, the tourist season can also increase bed demand and attendance at emergency rooms. This can also add to the pressure already within the medical environment and put further strain on services and staff. It can also further lengthen waiting lists depending on how long the extra strain is prolonged. The winter season can also put unnecessary pressure on the health

service with the elderly suffering during the colder months which in turn creates extra demand for beds.

Each year the health service increases bed prices to try and cover extra costs. This issue came to light in 2010 when costs were raised significantly to try and combat the service falling into further disarray. The cost of a hospital bed in 2011 ranged from €683 to €789 per day in a local hospital and ranged from €889 to €1,014 per day in a centre of excellence. The new cost as of 2012 ranges from €750 to €813 per day in a local hospital and can range between €933 and €1,046 per day in the centre of excellence (Citizens Information Website, 2012). This has changed significantly and although those who avail of free medical care through the medical card system do not foot the bill for their hospital stay, it is still an added cost to the tax payer. Not having a medical card incurs a cost of €75 per day to the person themselves with a maximum of €750 per year. The above costs supposedly includes medical pay, nursing pay, blood, medicines, medical and surgical supplies, theatre, intensive care units, radiology, laboratories and other areas and other support staff, even if they are not used by the patient. An individual breakdown of the price of each item is not available. The high cost of a public bed shows how the closure of a bed can lead to considerable cost saving for a hospital but to the detriment of the patient.

3.4.3. Medical Staff and Staff Moratorium

Another offset within the public health system is the fact that staff, amongst other areas in the public service, are taking significant pay cuts but are expected to provide a more efficient and rapid service. Since the economic downturn, the public service workers have been hit the hardest and many have had their wages reduced by a third as well as having to pay a high tax rate and higher state contributions. The introduction of the property tax and the probability of water charges will also be an added cost to the public sector workers. With budget cuts, comes added responsibility and staff are encouraged to take on more duties in order to fill out the service.

Emigration has also delivered a blow to the public service especially within health with many newly trained nurses and doctors heading for Australia, Canada and England. Medical staff contracts are also changing significantly due to the new staffing moratorium in a bid to save money within the service. Since this change over €160 million has been saved between 2011 and 2012 already but shortages are expected to reach a loss of 10,000 staff by the end of 2012 since contract changes first

came about in 2007 (Cahill, 2012). The nursing sector has suffered the biggest loss of frontline staff with a 7.14% drop between 2007 and 2011. Before the new minister for health took up office, he proposed that the money spent on agency staff to fill working gaps would have to be stopped as it was costing hospitals 36% more to employ them (Cahill, 2012). However in 2011, €76 million was spent on agency nurses to fill gaps and no action as been taken as of yet to discuss the matter any further or act on it for the future (Cahill, 2012).

3.4.4. Shortage of Consultants

With more consultants reaching retirement age each year and nobody to take their place, a further crisis is brewing with the severe lack of encouragement within the Department of Health itself to promote up-skilling in the practices. Public system patients are being turned away from operations as there is no consultant available at the given time to perform the procedure on them (Hunter, 2009). This adds further stress to the staff as well as the patient and puts increased pressure on the consultants who are left to deal with the issue. Emigration, as mentioned before, has cost Ireland large amounts of valuable trained health care professionals and this is causing major disruption to the health service (Cahill 2012). Many junior doctors are finding work elsewhere or are leaving to take hold of better opportunities which may be on offer to them beyond Ireland (Burke 2009a). Amid the confusion, the government are still choosing, to lag behind in health care development even though many professionals are trying to advise the HSE and the Minister for Health on better strategies (Burke 2009b). With a consultant led service in place in Ireland and very few consultants to run it, only time will tell whether or not the system which is currently being developed will be the system which will prevail and provide or fail and falter.

3.5. The Future of Irish Health Policy

With €543 million cut from the Irish health service in the 2011/2012 budget, the future of Irish health policy to some remains bleak. Since 2002, health expenditure has risen almost 67% (Department of Health and Children Ireland, 2011) showing that an effective budget is indeed needed to curb costs but one which should have as little impact as possible on services. This rise in cost was predicted (Barton 2004) early with projected costs of reconfiguration being too high to meet. With growing numbers of people having to travel to

centres of excellence for more basic health services and then overcrowding in the centre preventing them gaining easy access to the service, many patients are falling through the cracks and are slowly turning their backs on the Irish health care system. As is seen already along the border of Northern Ireland, many patients from the Republic of Ireland are choosing to access care across the border in Daisy Hill Hospital, Newry and other hospitals (Southern Health and Social Care Trust, 2012). Down the country, people have no other option but to wait or to try and gather funds together, if possible, to afford private health insurance. This is a quite chilling realisation for most people and as the economy goes further into the black hole, people simply cannot afford to provide care for their families and are suffering through public health care.

Past policies to eradicate the two tier health system have failed and while Ireland may be moving towards a more equitable service, it will soon have to make drastic changes in order to meet the needs of a newly growing population as well as an older population. Health is one of humanity's basic rights and this has been explored further in Universal Declaration of Human Rights (1948) which clearly states:

> *"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services..."*

In 1966, Article 12 of the International Covenant on Economic, Social and Cultural Rights made the right to health legally binding, when it said that every country signing the Covenant should recognise *"the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".* Ireland ratified this Covenant in 1989 (Amnesty International, 2012).

The Department of Health has published a number of reports each beginning with what the people of Ireland should expect from their health service. The new health strategy outlined the core values of the new service which stated that the future of the Irish health system would revolve around a newly organised system which was described as:

> *"A Health System that supports and empowers you, your family and community to achieve your full health potential, is there when you need it, that is fair and that you can trust and encourages you to have your say, listens to you, ensures that your views are taken into account."* (Quality and Fairness, A Health System for you, 2001)

The politics of health in Ireland needs to be creatively reformed in order to redevelop health service provision. Professional advice in health care planning from an Irish perspective should be sought, rather than expecting a current model already in use elsewhere to fit appropriately to Irish demographics. Health Minister James Reilly has fully backed the proposals for a universal social insurance scheme to be put into place in Ireland in the coming years which will supposedly eradicate health inequalities from the Irish system, despite health professionals suggesting otherwise. This study hopes to shed some light on the human rights side to health in rural Ireland and how vital it is to have a carefully planned health service in operation based on patient need and demand. Health is such a fragile entity and needs to be treated with care and respect because of what is at stake. Ireland needs its leaders to lead, and to lead with passion. The right to health locally has to be delivered to prevent future casualties for the people of Ireland and North Tipperary.

Chapter Four: Methodology

4.1.   Introduction

The purpose of this chapter is to discuss the mixed methods approach behind this research as well as the empirical research techniques which were used during the course of collecting the required data. Fieldwork was conducted between October 2011 and April 2012 amongst two groups in the community- the general public and medical professionals. The main data collection methods used in this research study included questionnaires and semi structured interviews. Listed below also, are the research goals of this and the following sections discuss in detail the approaches taken and the reasons behind why specific groups of people were chosen.

4.2.   Research Goals

The main aim of this thesis is to explore is: "The reconfiguration of acute health care from Nenagh General Hospital to Limerick Regional Hospital will potentially decrease access to health care for the people of North Tipperary". The research goals for this project are as follows:

1. To evaluate how access to care has changed for people in North Tipperary and document the perspective of the local community on health reconfiguration in regards to Nenagh Hospital.

2. To examine access to care in relation to health outcomes for the patient and to determine using the opinions of medical professionals, whether or not there would be more positive health outcomes if acute emergency services were restored to local hospitals.

Evidence based research is research based on supporting theories which already exist and strengthens them by providing an insight into solving social issues (Gattrell and Elliot, 2009). In addition to this, evidence based research may be used to measure institutional performance and predict social change i.e. hospital performance and preferred hospital choice for patients. Prior research in the health service has been conducted by HIQA, the ESRI and the World Health Organisation into how effective the Irish health service is in terms of finances and delivery of care (HIQA 2009, ESRI 2010 and WHO 2009). Evidence already published on health reconfiguration in Ireland has dealt with policy and practice from the

medical planning point of view, rather than from the staff and patient's point of view. Previous discussions on reconfiguration identify both positive and negative dimensions. For instance Barton (2004) proposes that reconfiguration is the wrong choice for Ireland suggesting that there was no evidence to support the notion that large regionalised centres produced a better standard of care and were better value for money than smaller hospitals whereas Anderson, (2010) believes it is the right step for Ireland to take stating that centralisation means more cost effective care and offers better access to preventive services. Evidence of reconfiguration within the United Kingdom proved to be unsuccessful (Barton, 2004) in that distances were increasing while patient survival was decreasing which resulted in the British government "*discontinuing over twenty years of centralisation of hospital services*" (McNamara, 2004). Statistics published through case studies in America and the UK stated that for every minute a patient had to travel in an ambulance, his/her condition deteriorated by more than 1% depending on the patient's problem (Nichol et al 1996; Wilde 2009)**.** Although only proved to be the case on a sample of patients, this research has provided a valuable input into this project in terms of reinforcing the hypotheses.

There are areas in this field of Health Geography where evidence from the population who are directly affected by policy change is difficult to find. As previously stated in an earlier chapter, it is recommended that the government should work with the people of a community to ensure that adequate health care facilities are put in place. Documenting perceptions of health care changes from the people who use the service first hand, could offer invaluable information to health care planners and indeed policy makers as to where a system could be directly improved. This could also prove to be a cost effective procedure in some ways as utilisation of a service may increase and could possibly result in generating a profit. Perceptions of medical personnel who are not always fully aware of when health policies are changing may also offer advice to planners as they deal first hand with patient trends and have a part in managing the demand for particular services.

4.2.1. Descriptive Study

Statistical research looks at population statistics and explores characteristics in relation to choices which looks at questions such as who, what, where, when, why and how. This is of particular importance to this study as the research design includes a survey asking the above in relation to health reconfiguration in one community. This research provided factual information which was based on the topic from both the medical and patient side of the dilemma. This particular approach was used to acquire

qualitative research and relate it to observations made earlier in the study. Other data intended to be used included national statistics on health service provision which will work with the collected data to form an overall mixed methods approach of both quantitative and qualitative material. In relation to social science within the health geography field, this study was essential to this piece in order to explore and explain the reason behind why choices were made by participants and how their views were either supported or opposed by medical participants. This has provided qualitative data which could be used to formulate a new hypothesis which may be explored further in the future.

4.2.2. Correlation Study

Correlation studies are important for research as it can be determined whether or not relationships exist between variables which can in turn, either support or oppose a hypothesis. Although suggestive in finding relationships, it cannot prove that one variable is responsible for change in another. This method was essential in this research for finding the relationship between geographic access to care, utilisation of the service and health outcomes of the patient.

4.3. Case Study Strategy

Case studies are effective in terms of providing a large amount of information on a particular subject in one account. Many believe that case studies are of minor importance to research, as they are weak and very limited. Kaplan and Duchon (1988 p573) describe a case study as:

> "*A case study examines a phenomenon in its natural setting, employing multiple methods of data collection to gather information from one or a few entities (people, groups or organisations). The boundaries of the phenomenon are not clearly evident at the outset of the research and no experimental control or manipulation is used.*"

Due to the nature of health service change occurring at the site and how contemporary the issue is, a case study in this instance proved advantageous. Although multiple choices are preferred for the purpose of the case study strategy (Kaplan and Duchon, 1988), the choice to only include a single site in this research was made to test the hypothesis and determine to what extent the people in Nenagh have been affected by the change in health services.

Research techniques which were used in order to gather data for this case study strategy included community observations, semi-structured interviews and survey distributions.

4.4.   Research Design

Previous findings from research, completed at an undergraduate level, were an encouragement to continue my studies further, into the health geography of North Tipperary and the impacts of health reconfiguration on the area. Within the Nenagh community, there is a strong ethos on uniting together and on many occasions over the past number of years, the people living in Nenagh have organized rallies in opposition to health changes. As a member of the Nenagh community, I believe that the intentions of the government to commit to such reorganisation tactics were good but that more consultation on the ground should have been carried out, prior to setting such policy.

Realising that strong links existed between health and geography, observations began by attending community meetings and conferences on the issue and documenting the results as time went by. Many have researched the area of reconfiguration to an extent and it is hoped that this research will continue to add to the current literature already available and provide a unique insight into health reconfiguration at an endogenous level. Two hundred and eighty participants, from a range of social backgrounds took part in helping to develop research for this study. This sample size was chosen as acceptable for fulfilling the aims of this thesis and also produced an adequate number of results which could be linked back to the research being presented. Inclusion of those from all social backgrounds was also a necessity, so as to add to the validity of the results. There is often little to be gained from studying large sample sizes in small areas (Marshall, 1996). The aim of this research design was to create a link between patterns of change, from hospital data and policy amendments with opinions of stakeholders in the health service. These would then be compared to the public perspective on how health care should be, in the eyes of the patient. This triangulated approach was carried out using simple but effective measures to achieve the results.

4.4.1. Selection of site

Nenagh has featured heavily in the media over the past number of years since reconfiguration began. Services were removed from Nenagh swiftly over a period of four years and each move impacted the community in a different way. This site proved suitable over many other sites in the Mid-West region, mainly because no services have been put in place to replace the clinics which were taken during reconfiguration. Other options were considered i.e. looking at County Tipperary as a whole, but the final decision on Nenagh was made due to the site being part of the pilot scheme, as mentioned previously.

4.4.2. Data Collection

For the purpose of this research study, both qualitative and quantitative data was required. Both quantitative and qualitative research look at studying phenomena, with qualitative research primarily focused on the direct involvement with a setting or site and the gathering of explanatory data having the potential to create new theories and ideas. Qualitative researchers tend to be concerned with meaning and are interested in how people make sense of the world and how they experience events (Willig, 2001). Qualitative data for this research came in the form of surveys which were designed with both open-ended and closed questions. The expression 'survey' is normally applied to a research method designed to collect data from a specific population, or a sample from that population, and typically utilizes a questionnaire or an interview as the survey instrument (Robson, 1993). They are usually accepted as a key tool for conducting and applying basic social science research methodology (Rossi, Wright, and Anderson, 1983).

Two surveys (one for the community participants and one strictly for medical professionals) were drafted and sent to both the supervisor of this study and a consultant, to identify any possible flaws which existed. Recommendations were made by both parties and the questions were suitably changed in order to achieve optimum results. Thirty of these were distributed across the faculties of the health service with general practitioners, advanced paramedics, paramedics, consultants and nurses completing the survey. Semi-structured interviews were also conducted within North Tipperary Ambulance Service, with paramedics and advanced paramedics, who

are effectively now, the bridge between the patient and the consultant in the hospital, general practitioners and public representatives within the community.

A sample of two hundred and eighty questionnaires was distributed into the community and conducted using door to door and on-street methods. This was done by a team, including the researcher, during certain times over a number of months. People were asked if they would like to participate in this study through means of answering a set of questions about healthcare in their areas. Robson (1993) tells us that the sampling theory supports stratified random sampling as an efficient choice because the means of the stratified samples are likely to be closer to the mean of the population overall. The participant was then asked to review the questionnaire and only submit it if the answers given were honest answers. According to Leung (2001), there are distinct advantages in using questionnaires in that they are less expensive and easier to complete. Robson (1993) indicates that postal surveys are extremely efficient at providing information in a relatively brief time period at low cost to the researcher; however, this method was not favoured during this research in case of poor return rates.

4.4.3. Data Analysis

Analysis is necessary because findings require evidence. Evidence is something that is able to convince us of the existence of a certain kind of knowledge, or a certain phenomenon (Ryan, 2006). Using the raw data gathered from the hospitals, pattern changes were clearly seen from 1999 to 2010 which was in line with policy change. This cemented the belief that the regional hospital in Limerick was now serving a larger catchment area due to rising numbers in bed costs and bed usage. Questionnaires from the public were numbered after they had been collected in order to get the final count. Two hundred and eighty questionnaires had been distributed with two hundred and fifty considered to be fully completed in line with ballot procedures (Marshall, 1996) i.e. if a question was left unanswered, it was considered invalid. The primary focus of the data analysis was on the key questions which were asked in the survey in relation to access to care. These answers were grouped together and examined concerning the amount of male participants versus female participants, hospital choices and so on.

After the primary data was extracted, the surveys were categorized according to similar themes and patterns and were then further analyzed to draw the data and

then re-categorized. This made it easier to look at the data being taken from each question and also allow connections to be made between each category and question. For data interpretation, emergent themes which were not documented already were explored and statistical results were pooled together into an SPSS (Statistical Package for Social Sciences) computer program. This data was analyzed and projected onto tables and presented charts and correlations were tested between similar questions. The open ended questions proved valuable for answers which could be used in the study and be quoted as direct participant responses. The same procedure was used to analyze the second questionnaire which was given to medical professionals. A comparison was then carried out between the two surveys which had a number of similar questions in order to tie them together. Key findings were noted and made ready for further explanation within the results and discussion chapters of this study.

Interviews are an important part of any action research project as they provide the opportunity for the researcher to investigate further, to solve problems and to gather data which could not have been obtained in other ways (Cunningham 1993, Patton 2001). The semi-structured interviews which were conducted with members of the North Tipperary Ambulance Service proved to be a great asset. The ambulance personnel were chosen to participate in these interviews due to their role in patient care as they are the first care the patient receives before being admitted to hospital. They are also the professionals who must care for the patient while travelling the long distances to the hospitals. Information from this perspective was important to gather as it helped to link the questionnaires between consultants and patients and also fill in gaps on the knowledge of the new health system. It also gave a unique un-researched perspective on reconfiguration in rural areas and the impacts it has not only on patients but on health professionals also.

4.4.4. Ethical Considerations

Anonymity and confidentiality were maintained throughout the research and there was no disclosure on any of the questionnaires both in the community and in the medical field of personal details. Burns and Grove (2005) explain the importance of anonymity whereby the researcher cannot link the subjects to their responses. In this study, participants were briefed beforehand that their personal details were not necessary so that results would not be affected, particularly from the medical professionals. Participants were also made fully aware of the nature of this research

project and were given the choice to participate or not in the study. This was acceptable ethically, as it gave autonomy to the participant on whether or not they wished to volunteer for the survey. Participants were made aware that any answers which required extra written information may be used and were asked to not proceed with the questionnaire, if this was a problem for them. Ethical approval from the NUI Maynooth was not a requirement for this project.

4.4.5. Theoretical Framework

Each category produced a similar theme which was combined with literature previously studied to form a theory based on what was collected which supported the aims of this project. The qualitative data from the surveys produced results in relation to a community perspective on reconfiguration and the advantages and disadvantages whereas the quantitative data from hospital statistics and figures provide a base from which past case studies can be compared with the present. This integrated data has benefited this research project and has left room for further study within this area of health geography.

4.5. Strengths of research conducted

The data collected proved to be very informative, especially data which was extracted from the questionnaires and interviews. Little research has been undertaken to date in consulting with ambulance personnel, consultants and patients together and this niche has added a specialty to this project. In addition to this, being able to add public perceptions to this study has also provided the means for further research in this area in the future.

This triangle of voices, described in the research design, will hopefully offer some foundations on which new studies may be based. It may also offer an insight into a deeper approach to the fundamentals of human geography and to how people perceive their sense of place and space over time, especially when changes are made their social environment. This research may in fact also show how the rapid changes to a person's environment can cause fear, and that irreparable decisions made at an exogenous level can often have severe consequences on even the smallest of communities. It is also the hope that this thesis will perhaps offer some restitution to those who have fought so hard to retain acute services in their local hospitals.

4.6.   Summary

This chapter has shown the methods which were used to accumulate the data. Through qualitative and quantitative research, the results have shown that health has become a major issue in Irish society. The next chapter will discuss the results in detail and how they are applicable to this research study.

Chapter Five: Results from the Community

5.1.   Introduction

A questionnaire was distributed between December 2011 and March 2012 as part of the research for this thesis which highlighted the public perspective on the issue of access to care. The sampling method of this particular questionnaire has been outlined in detail in the previous methodology chapter. On-street questionnaires were completed at different times as well as at events in the local community. This allowed for a proportional sample of answers to be collected from the Nenagh community. Efforts were made to have the questions as comprehensive as possible especially for members of the public who are not overly knowledgeable on this specific type of research. This was done so as to collect as much usable data as possible in a short space of time.

The questionnaire was designed to take roughly five to ten minutes to complete depending on the length of answers given by the participant. This was deemed appropriate so as not to be a nuisance but also to give the participant ample time to ask questions regarding access to health care in Nenagh. Surveys were distributed by a team of five people, knowledgeable on the subject at hand, which was formed prior to the events. This process helped collect data quickly and effectively.

A range of key questions in relation to access were posed and members of the public were encouraged to openly ask questions about the research at hand. These questions will be explained in further detail later in this chapter. This proved a success on the days which were chosen by the team to collect data and interest in the topic was considerable with some participants requesting answers to both the local and national health issues. Some participants approached the issue of health access from a highly political perspective, asking for the team's politics and their own opinions on the issue. This approach was discussed during meetings by the team, prior to conducting the research and the volunteers were asked not to discuss their own stance on the subject in case of interfering with data outcomes.

The Nenagh community has a considerable amount of political representatives at work, both on the town council and as government representatives. The politics of the town are considered to be predominately Labour and Sinn Féin with fewer Fianna Fáil and Fine Gael voters. This divide is a very interesting one to study as it gives an insight into two completely different political perspectives both on a national front and at community level. The attitude to the struggling health service in the community has caused alarm in the past

between political parties which encouraged leading political representatives from both Sinn Féin and the Labour party, to come together in a bid to bring acute services back to Nenagh. However, in the last election, the issue of health services in Nenagh acted as a front for one representative in particular who used the issue as a pawn in the campaign to get votes. This has since changed the politics of the town again towards a more nationalist view especially since Nenagh is now set to lose its Coronary Care Unit before Christmas this year (2012). When reconfiguration began in Nenagh, the perception of the people was that the politicians would not let this happen to the town and that services would be restored if the right party was supported. The issue became a very delicate one to discuss at public meetings and council meetings and accusations were tossed back and forth between rival parties in a bid to secure a vote. The change in government, however, has made no difference to the downgrading of acute services in Nenagh hospital, thus leaving the general public with the perception that all three main parties in government have the same policy in relation to the placement of acute services.

Details of the questionnaires will be presented below in further detail. There is a copy available for inspection in the appendices (Appendix A).

5.2. Participants Profile

This section will deal with questions one to five of the survey which posed questions about the background of the participant. Questions in relation to whether the participant was single, married and employed or unemployed were discredited for this questionnaire as they were statistics which were not specifically needed for the objective at hand.

5.2.1. Gender

Out of the 200 questionnaires which were distributed to the community, 94 were completed by male participants accounting for 47% of the total number of surveys and 106 were completed by female participants or 53% of the total.

5.2.2. Age

Age is a key factor especially when it comes to health care as often it can define the level of care you may need i.e. the elderly may need more care facilities available to them than the people who may be younger and more agile. Age was also an important

factor to take into account as responses could be differentiated to allow for more critical analysis. The majority of the questionnaires were completed by those in the 30-40 years age group. The smallest number of questionnaires was completed by those in the 60 years plus category which was quite obvious on the day as there were very few elderly people around at the times when research was conducted. Table 5.1 outlines the percentages of respondents in each age group.

Table 5.1: Age Category of Survey Participants

Age Category	% of Respondents
18-29	21.5
30-39	29.5
40-49	29.0
50-59	15.0
60+	5.0

5.2.3. Locality

On deciding the questions for this survey, a question regarding the participants' locality was suggested to determine where exactly people are in the pilot area for this research. As there are many small towns and villages which surround Nenagh, it became a valuable and important part of this study to see where people travelled from, when attending Nenagh hospital and how far they would have to travel post reconfiguration for the same level of care. The longer a person lives in a community, the stronger their attachment is likely to be to that community (Hobbs, 2008). 137 participants answered that they were from the Nenagh town area, with the remaining 63 participants stating that they were from the surrounding hinterland. These areas were further broken up into a subcategory manually to pinpoint the exact location of the participants.

Table 5.2: Participant's proximity to Nenagh Hospital from the hinterland.

Number of Participants	Name of town or Village	Distance to Nenagh Hospital
4	Ardcroney	7.40KM
9	Ballycommon	2.10KM
3	Ballingarry	23.30KM
11	Borrisokane	17.54KM
3	Cloughjordan	17.86KM
4	Dromineer	10.62KM
2	Lorrha	29.61KM
3	Moneygall	19.31KM
6	Newtown	8.50KM
9	Portroe	11.91KM
5	Puckaun	9.98KM
2	Rathcabbin	37.65KM
1	Terryglass	29.93KM
3	Toomevara	11.42KM

Table 5.2 also lists the average road distance to the local hospital and shows it in some cases to be quite a substantial distance. This point has been touched previously in the literature review (Jones 1996, McKee 2002, Barton 2004, McNamara 2004, Carney 2006, Propper et al 2007, Saltman 2007, Burke 2009a/2009b) where distance in regards to patient outcomes was discussed. None of the above towns/villages have primary care units located locally and Nenagh hospital was their first port of call for emergency care.

5.2.4. Employment within the health sector

Prior knowledge of the situation helped participants on the day adhere to the questions asked in the surveys. Some expressed that they were former employees or knew of people working in the health sector, especially in primary care, who loathed the changes which were being made to local services. It was essential to discover how many participants in the community had worked previously in health care as it would add extra clarification on how much acute services are needed in the local area. Just 32 participants or 16%,

previously worked within health care and the table below presents the employment details of the above.

Table 5.3: Health Sector Employment

Health Sector Employment	Number of Participants
Respite	8
Hospital Porter	4
Home Help	12
Carer	8

Feedback from these participants suggested that the removal of services would be critical especially to the elderly in the area who may refuse to travel further distances for care, no matter how essential it may be to their welfare. Reactions from those working in Nenagh Hospital currently described it as a "*once bustling hospital, with high expertise*" and which has now been reduced to "*the bones of a nursing home*".

5.2.5. Twenty-four hour Emergency Care

Question five on the survey asked the participants where they believed the nearest hospital with 24 hour care was to them. This question was included as people are still turning up to Nenagh Hospital after hours looking for emergency care, forgetting that they now have to travel to Limerick. Prior to complaints by hospital staff of this happening, a large sign post was erected outside the hospital detailing that all emergency and maternity care must be directed to Limerick Regional Hospital after 6p.m. each evening, as there are no doctors on site after that time as well as a leaflet sent to clubs in the town (Appendix B). This sign caused distress within the community and due to further breaches; another sign was put up in two languages, English and Polish, to cater to minority groups. Fortunately, only 2% of participants chose Nenagh Hospital as their 24 hour care facility, with 98% choosing Limerick Regional. This suggests that although the public may not be satisfied that they have to travel for care, this sample of the population proved to be fully aware of having to travel to Limerick.

5.3. Exploring access to care in the Nenagh Community

Questions six to ten explored the various forms of care facilities available in Nenagh and people's awareness of the existence of these facilities. As discussed in the literature review, primary care facilities should be the first port of call to a person who is seeking emergency care (Department of Health and Children 2001, Nolan and Nolan 2005, Tussing and Wren 2006, Saltman 2007, WHO 2008, Layte et al 2009). Knowledge of primary care facilities can often be lacking within a society (Carney, 2006) and because of this, access based questions were asked to the participants which proved to be interesting. This further confirmed that knowledge of services within the community is not always made completely clear and that many only learn of changes when they need to use a service.

5.3.1. The Primary Care team

As part of the new health system, the Minister for Health, Dr. James Reilly, himself a GP, suggested that there was a need for a closer knit primary care team in every town across Ireland which would potentially decrease pressure on both the local hospital and the centre of excellence. The Teamwork Report (2003) clearly states that primary care facilities of a high standard would be put in place before any acute service was removed from a local hospital and that unless full and effective pre-hospital services were put in place, down to the most local level, and proven to be effective by all objective measures of performance, the HSE would not achieve its intention to implement international standards of acute care, as it would find itself unable to proceed to the next step (Ryan, 2010). Unfortunately due to neglecting the promise made above, problems have come about due to back up services not being put in place. Medical professionals in the Mid-West have reported that the reconfiguration process is causing a number of difficulties and inefficiencies in the local health system and that patients are now waiting longer (Ryan, 2010).

It was proposed that primary care centres would be built in the hinterland of Nenagh in three places, Borrisokane, Portroe and Cloughjordan as these towns and villages themselves had quite large populations to justify service provision. Funding was provided to build these care centres which were built and are currently vacant. Some General Practitioners have however set up practices closer to each other, along with other medical professionals such as physiotherapists and psychologists with assisting nurses

who act collectively as a team. When asked about a primary care team in the community many participants did not know what a primary care team was or who it consisted of.

Table 5.4: Knowledge of primary care team facilities in Nenagh amongst the public.

Participant's knowledge on whether a primary care team exists in the Nenagh area.		
Yes	111	55.5%
No	25	12.5%
Don't Know	64	32%

It seems as though the people in Nenagh are confused as to whether there is a solid primary care team in situ in the community or not. It was observed that number of participants chose "Yes" because they knew that their G.P. was a primary care provider but did not know if he was part of a team. The answer to this is what has been previously mentioned above, and that these professionals are not all located on the one site, as was perceived to be the case. The health centre which was built for this purpose, in the grounds of Nenagh hospital, now holds offices of administrative workers. This site cost €4 million to build and was built with the idea of also including a mental health clinic.

5.3.2. Emergency Room

The question asked was in relation to where the participant believed their nearest "emergency room" was. Each participant was briefed as to what an emergency room was when asked and were told that this referred to an Accident and Emergency Unit. The purpose of this question was to discover whether or not the community believes that Nenagh hospital still functions as a full emergency care unit during the allotted times. This was re-introducing the concept of local access to care with the aim of discovering if Nenagh was still a first choice for some in the public domain. 89% of participants chose Nenagh Hospital allowing for the belief that to the community, Nenagh is still a choice and still functions to the best of its ability, with whatever services it has left. 11% considered Limerick to be their preferred nearest emergency room with a comment on one survey suggesting that

> "*it's easier just to go there and wait rather than be turned away from Nenagh for being five minutes late on time and having to go on to Limerick anyway*".

5.3.3. Perceptions of Access in the Community

A question on the survey dealt simply and directly with the change in access to acute services for the Nenagh community. 100% of participants agreed that access to care had changed in their local area since 2006. Access to care is difficult to define, especially if one is not familiar with the study around the issue. For the purpose of this study it was crucial to discover what "access" to care really means to the people of Nenagh and whether they perceive it to be at a good or bad level. When asked in the survey, "*define what good access to care means to you*", respondents were encouraged to write their perception of what they deemed fair access to health care was. Many respondents expressed their opinions and were very forward in what they believed good access to care entailed and how their own definition applied to Nenagh Hospital, some of which are documented below.

Participant 1: *"Always available in emergency"*

Participant 26: *"24 hour care locally"*

Participant 158: *"best facilities available locally"*

Participant 171: *"Open all the time and fully staffed"*

These answers are just a sample of the two hundred which were received and the majority pertained to returning twenty-four hour care to Nenagh Hospital. Some participants voiced their opinions on how it was unfair that services were taken away from the community. 72% of participants used the phrases "*24/7*" or "*always available*" in their answers. The words "*emergency*" appeared in 82% of answers and "*local*" or "community" appeared in the 95% of answers suggesting that people believe that good access to care means twenty-four hour care. This also brings about a new type of geography, the geography of fear, where people fear that their health may be in danger due to their location. The idea of a fully capable and staffed hospital available locally also featured in various answers. Other traits of access also appeared in many answers with some respondents suggesting that they should only have to travel within a certain time frame to avail of services, especially those who are in rural areas.

Participant 33: *"Within reasonable distance- no longer than 30 minutes"*

Participant 78: *"Within 20 minutes of my house"*

Participant 121: *"Not having to drive over a half an hour for care"*

In regards to measuring access in the community, a number of participants believed that policy makers should work with the local people to ensure that they are happy with their local health service and that if they are not, then for both parties to work together to try and reach a cost effective compromise that guarantees sufficient access to all care sectors. The Department of Health state in their documents that one of their core values is to:

"encourage and facilitate the open expression of views and to ensure that the views of key stakeholders, and in particular the perspectives of patients and other service users, are at the heart of the decision making process in the design of the health care system." (The Department of Health and Children Website, 2012)

To test this statement, the next question on the survey asked if the public believed that their level of access to health care was sufficient in their local area. This was asked in terms of looking at other forms of access such as ambulance numbers, staff levels and opening times of care centres. Two hundred participants replied that health care is not accessible in their local area and further questions in the survey which were related to the level of access actually available in Nenagh (i.e. ambulances etc), were for the most part answered incorrectly, due to poor knowledge within the community.

5.4.   New Health System Policy

Ireland's newly proposed health system policy, as discussed previously in the literature review (National Task Force, 2003/2006/2008), states that there will be twelve major health centres outside Dublin which will be called centres of excellence. These centres will provide full emergency services for their specific catchments and network with the local hospitals on patient transfers and outpatient clinics. Knowledge of this system on the ground is quite limited especially with clinics interchanging between hospitals on a regular basis i.e. CT Scanner being placed in Nenagh as part of the new regime and then removed due to the hospital having no staff to operate it. As some people may not be familiar with the term "centre of excellence", it was

decided to pose the question to discover how many people know exactly where their nearest centre of excellence is, how efficient it is and the facilities it provides for its patients.

5.4.1. Location of the Centre of Excellence

Results from this particular question showed that 100% of respondents chose Limerick as their centre of excellence suggesting that this sample of the community is fully aware of where their nearest emergency service hospital is.

5.4.2. Analysing efficiency through surveys

When measuring efficiency from a user service point of view, many factors must be taken into account. These include the use of the service itself, as well as the staff expertise, the location, waiting times and so on. For the purpose of this research, it was decided to try and obtain the personal opinion of the respondents who use the service regularly as their opinion would be considered raw honest data and uninfluenced by any other factors. A small number of participants revealed personal information at the time freely, in regards to they themselves being regular patients in both Limerick and Nenagh and these questionnaires were marked with an asterix to be referred to if necessary, at a later time. Safety and equality are linked closely with access, with all three affecting a patient's welfare greatly. The question in this case asked simply if the participant believed that their centre of excellence operated to its full potential offering safe and equal health care.

Table 5.5: Public opinion on the full potential of the centre of excellence

In your opinion, is the centre of excellence running to its full potential, a safe and equal service?	
Yes	24.5%
No	72.5%
Don't Know	3%

As shown above, a considerable amount of respondents decided that in their opinion the centre of excellence was not running to the best of its ability. This fact has been highlighted countless times in the media in regards to patients being left on trolleys for a number of hours in the emergency ward (O Duffy, 2010 and O Regan, 2010). Many of

the participants expressed their concern verbally during the survey process and blamed politicians for not listening to the people in the community before changing services.

> Participant 88: *"It's the last time, I will vote for Labour or Fine Gael. Both parties have let us down. Remember James Reilly being down in Nenagh during the last march and calling this new health system a joke and telling us people would die- where is he now only the head of that same system. I should have voted for Sinn Féin."*

> Participant 155: *"Where is Senator Alan Kelly now? He was the one on the side of the people for so long and once he got in, he forgot the people who put him in there. It's a shame that he used the hospital to get votes and never followed up on anything he promised. I feel hard done by with my vote."*

> Participant 192: *"I think at this stage the people of Nenagh have been truly forgotten when it comes to health care. No hospital, no psychiatric services, no maternity services, nothing. There is nothing for a person living in North Tipperary only an overcrowded hospital an hour away- there is nothing fair about that."*

Some who had travelled by ambulance to the Limerick previously, complained of waiting a huge amount of time in accident and emergency just to be seen by a doctor briefly and then moved on. A few of the participants voiced their opinions stating that the staff members, although overwhelmed, were doing the best they could in Limerick under the present conditions and if circumstances were better or improved, the hospital would be "okay".

The question which followed asked whether or not the participant had ever received care in the centre of excellence or knew of any other person who had. A choice was given as it was believed that many may not wish to disclose personal information of attending the hospitals especially under difficult circumstances. All two hundred participants acknowledged that they had received care in Limerick or had knowledge of someone who had spent time in Limerick Hospital. 77% of participants had received care first hand in Limerick, with 18% of participants stating that a member of their immediate family (i.e. partner, sibling or child) had received care and just 5% having a family member or friend who had attended the hospital for care. Paired to this question was

another, which asked if the participant felt that the patient discussed in the last question would have benefited more from care if it had been received locally.

Table 5.6: Public perception on whether patient would benefit from care locally.

Do you believe that the patient would have benefited from care in a local setting?		
Yes	144	72%
No	46	23%
Don't Know	10	5%

This question related only to if the emergency services which were taken from Nenagh Hospital were reinstated and this was expressed to the participant at the time of the survey. 72% of the participants believed the patient would have benefited more from the same care locally and this could be put down to the patient being in his or her own environment, surrounded by the people he/she knows. This would provide reassurance to the patient who may not like the busy schedules in the larger hospitals. 23% stated that the patient would be better in the centre of excellence which can be attributed to the expertise and technology available in the larger hospitals and the feeling of being safe in a high profile hospital. The remaining 5% were undecided.

5.5. Emergency Room experience

A critical part of emergency care is for staff to try and get the patient to the consultant as soon as is humanly possible. This is the norm in every hospital where there is an emergency room or care unit but it is this factor that often obstructs patients from obtaining necessary care every day. Over the past number of years, the media have focused acutely on waiting times for casualties and patient-consultant time, stating that waiting times in accident and emergency facilities are increasing, while the time a consultant has to spend with a patient is decreasing (Hunter, 2012). During the course of this research and indeed also in the literature review, it was this form of access to care that featured more commonly in discussions rather than measurable access such as distance from a hospital. Policies introduced in Ireland during the last five years which have increased regional hospital catchment areas, have arguably been to blame for the long waits and the stressed and frustrated staff. While some suggest that the media only ever highlights the bad points of the health system quoting that "paper has never refused ink", it is possible to say that the media are also highlighting the facts which need to be dealt with as soon as possible before

something goes very wrong with the system. When beginning this research, one passing objective was to find out how long people from Nenagh have actually waited in Limerick Regional Hospital and compare that to the wait they may have experienced in Nenagh, relating to cases within the Emergency Department only.

5.5.1. Patients waiting in Limerick Regional

Question fifteen on the survey asked the participant if they had ever waited in casualty in Limerick Regional Hospital. This provided details on the amount of people who have actually used the service from the Nenagh community and results gathered showed that 100% of participants had used the service in Limerick. Participants were asked only to choose "yes", if they had waited since Nenagh Hospital was downgraded. This result was not expected but proved to be valuable as the following question on the questionnaire asked the respondent about waiting times and the approximate time he or she had spent waiting to be seen.

5.5.2. Length of time spent in casualty

This question focused on the amount of hours the patient had to wait in casualty in Limerick Regional Hospital to be seen by a consultant. An approximation of hours was asked for as an answer as some participants had said that it may have been quite some time since their treatment there. To address this issue, patients were again asked to fill in an answer, only if they had received care since services were moved to Limerick. From analysing this data, there were some alarming results in regards to how long some people were left waiting. In addition to the waiting time stated on the questionnaire, five participants described their time spent in casualty adding "*on a trolley*" or "*on a chair, receiving treatment*" to their answer. These statements are inexplicable when compared back to the Teamwork Report of 2006/2009, Hanly Report of 2003 and Quality and Fairness Report of 2001 which concluded that this would not be the outcome of the new health service and that reconfiguration would deal effectively with the overflow of patients by employing more staff to be a part of the emergency care team. HIQA, in 2009, deemed the regional hospital in Limerick to be of red light status which means that

the hospital was under performing, in their traffic light system[1] and urged that procedures be put in place to reduce the amount of people waiting to see consultants in accident and emergency units. In May 2012, the HSE upgraded the Limerick Regional to amber status. The average waiting time to be seen by a consultant in the Emergency Room of the centre of excellence for April 2012 was 0-6 hours with over 40% of patients being seen within that time frame. In the same month, 38% of patients waited 6-12 hours to be seen and 20% waited 12-24 hours. However, these statistics refer to just a sample of 349 patients out of a total of 1,771 admissions for that month (HSE, 2012). Healthstat have set a target for Limerick Regional Hospital since obtaining amber status, to try and have all patients seen within six hours, regardless of what area they are coming from. The statistics collected show that the minimum time waited was one hour; the maximum time waited was fourteen hours with the average time waited by participants being five hours. The results gathered from this study do correlate with that of the HSE mentioned above, with many participants waiting up to six hours to be seen by emergency room consultants. There was however a significant amount of patients left waiting over six hours for treatment- an issue which seemed to of lesser importance in the study conducted by the HSE.
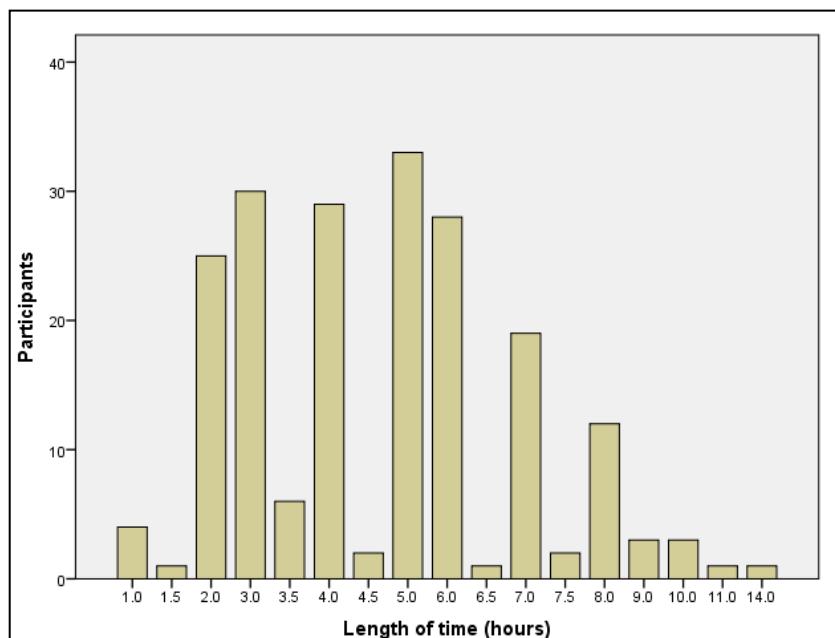
Figure 5.1: Patient waiting times in Limerick Regional Hospital

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[1] The HIQA Traffic Light system was introduced in 2009 by Healthstat where hospitals were rated on their levels of access, integration and resources and then overall performance. Green means good performance, Amber means average performance with room for improvement and red means unsatisfactory requiring attention.

Following this, the participants were asked a question about if he/she considered the length of time spent in the regional hospital in Limerick to have been longer or shorter than time which they may have spent waiting for care, at Nenagh Hospital. The majority considered the wait to be longer in Limerick than in Nenagh, although many participants told of waiting up to 5 hours in Nenagh Hospital at times when patient volumes were high. Longer waiting times in the centre of excellence may be attributed to the fact that Limerick Hospital now has to deal with the influx of patients from North Tipperary and County Clare as well as its own patients even though no plans to upgrade the hospital itself, including increasing bed numbers or hiring staff, have been completed. These changes were amongst those listed in the Teamwork Report but have not yet been implemented fully.

Access barriers previously discussed in the introduction (WHO, 2010) and the literature review (Graves, 2009) can take many forms, with distance being one of the main factors. Travelling thirty-eight kilometres to a centre of excellence (from Nenagh town), only to have to wait a further three to five hours to be seen can be considered unfair access and can jeopardise the health of a patient further.

Long waiting times in an already overcrowded and understaffed hospital can be frustrating for both the patient and the staff who have to deal with increasingly agitated people on a day to day basis. This can be put down to the delay of inpatient consultations, especially if extreme emergency cases are brought through casualty and seen before those already waiting.
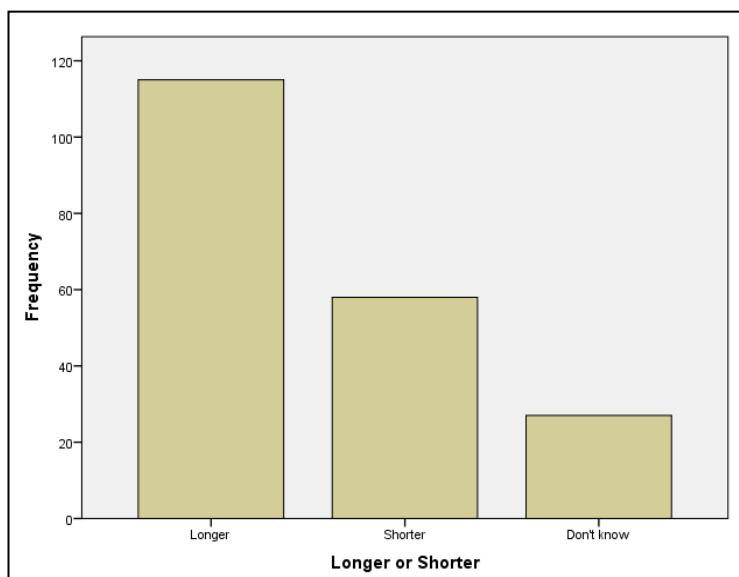
Figure 5.2: Comparison between waiting times at Limerick Regional and Nenagh Hospital

5.6. Who have the health changes affected?

Changes to health care affect everyone but the aim of this question was to determine if there was a certain minority that people believed would be more affected than themselves. It was constructed with the hope of having the participants reflect back into the community as to how health has changed in their area and who may be suffering more as a result. As assumed, the answer "everyone" was the most popular answer, with people also commenting that the elderly would be most affected. Many participants also mentioned that the youth would be affected greatly in the community, which showed how dependent youth clubs such as the GAA and other sporting clubs are on having the accident and emergency close by. There are also other issues to be considered such as alcohol, drugs and road traffic accidents where there is demand for emergency services, particularly from the youth.
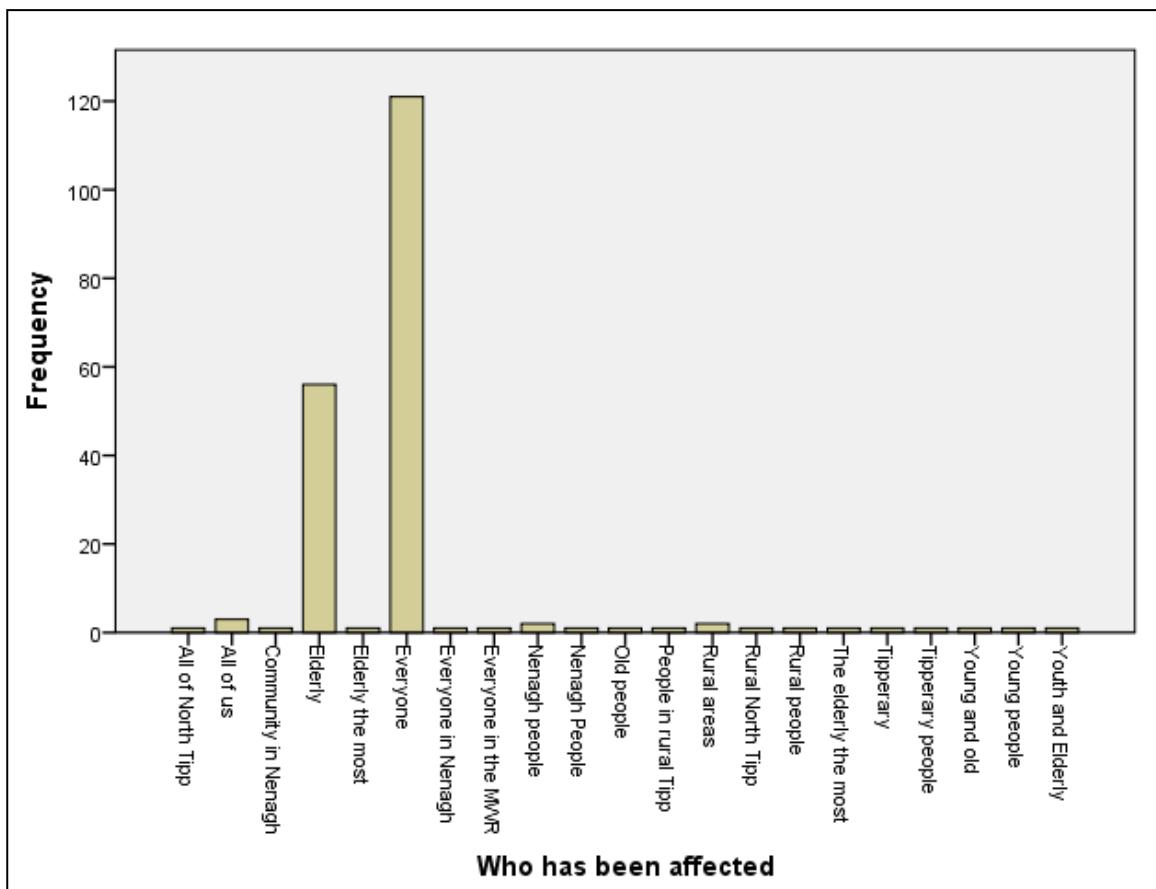
Figure 5.3: Community members who have been affected by health care changes.

5.7. The Patient Scenario

It was decided to add in a very different type of question, so as to give participants a sort of visual account of what access to care really is so that they could relate it to their own situation. This took the form of a scenario where participants read a piece (which was reviewed by local ambulance personnel for authenticity purposes) and decided what hospital they would rather be treated in, using the information provided. Previous research into the area of Redwood, using records from paramedics, show that there have been a number of cases including serious road traffic accidents in Redwood which was once in the catchment of Nenagh hospital's emergency room, a road distance of 38.6 kilometres away. The scenario included a road traffic accident where the patient would have been originally sent to Nenagh Hospital, about 35 minutes away, to be stabilised and then moved on to Limerick Regional Hospital, 1 hour 32 minutes (from Redwood), if required. According to the new changes, patients will be met at the scene by paramedics and advanced paramedics, the latter if available and transferred directly to Limerick to be treated by consultants. The objective of this question is to discover if the participant had a choice and the service change reversed, where would they rather receive care and treatment for their injuries?
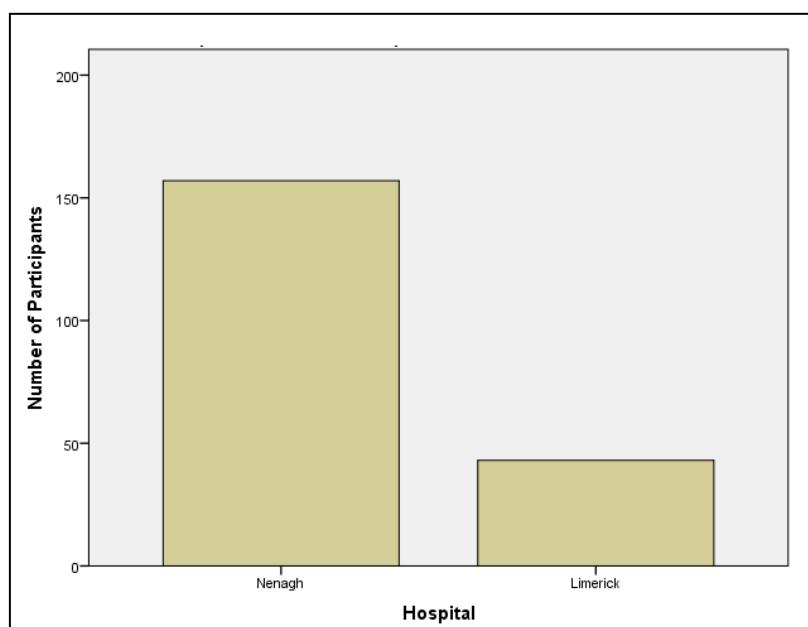
Figure 5.4: Participant's choice of hospitals from Scenario Question.

Results showed that 76.5% of the participants would rather be treated in Nenagh Hospital reasons being that the hospital is closer to not only the scene of the accident but also the patient's home if there were any complications. The remainder, 23.5% chose to be treated straight away in

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Limerick suggesting that patients may feel safer there due to the expertise of consultants and the facilities which are available to them in the regional hospital. This is an understandable circumstance and may have been a difficult question to answer for some. However, it was relevant that this question be asked to acquire a specific set of results concerning a patient's choice when it comes to his/her care.

5.8. Emergency Care in North Tipperary

Paramedics and advanced paramedics are the first care facilitators a patient will meet at an accident or in any other circumstances where an ambulance is called for. They are part of both the primary care sector and the secondary care sector in that each paramedic has undergone continuous training and up-skilling in order to be able to perform certain medical procedures when needed at critical times. Likewise, advanced paramedics have been trained to carry out the more advanced of these procedures which may mean intubation (inserting a tube into organs) of patients at a scene before transferring them to a hospital. Advanced paramedics travel alongside an ambulance in cases of life threatening accidents or illnesses so that they are able to move swiftly after stabilising a patient to another case if needed. It is then the job of the paramedics to administer further care en route to the hospital and ensure the patient arrives safely to the hospital. The Nenagh community has been quite fortunate in that the largest ambulance station in North Tipperary has been housed there for the last twenty years and has provided an excellent on-call service to the community during that time. Two other stations, one in Thurles and one in Roscrea also exist but on a smaller scale, however during times of need, these ambulances and their crew members can be working either in any station in North Tipperary or be redeployed to Limerick for extra cover.

Ambulances can be considered a form of access to care as they are in fact a care facility in their own right. They are often the first to be called in many cases over a general practitioner no matter how minor or major the case may be. For this reason, two questions were put on the survey asking participants if they were aware of how many ambulances were allocated to serve Nenagh hospital both for emergencies and as patient transport to and from the centre of excellence.

Table 5.7: The number of ambulances believed to be in Nenagh Hospital by participants

Number of Ambulances	Participants
1-2	3
3-4	95
6+	102

Communication of the provision of emergency services in North Tipperary has obviously broken down with the general public as the majority of this sample believed that there are more than six ambulances covering Nenagh hospital at any one time. There are in fact only three ambulances ever working in Nenagh during weekdays with one at night and one at weekends.

Table 5.8: Ambulance statistics in North Tipperary (Nenagh Ambulance Station Log)

Station	Number of Ambulances during the week	Number of Ambulances at weekend
Nenagh (3)	2 working on Monday and Tuesday 1 at night (2 ambulances)	1 Saturday and Sunday 24hours (1 day and 1 night- 1 ambulance)
	1 working on Wednesday and Thursday 1 at night (1 ambulance)	
	2 working on Friday 1 at night (2 ambulances)	
Roscrea (1)	1 each day and 1 at night (1 ambulance)	1 Saturday and Sunday 24hours
Thurles (2+1)	2 on Wednesday and Thursday with 1 covering Roscrea on a Tuesday (2 ambulances)	1 Saturday and Sunday 24hours

The table above details the information on the ambulance stations in North Tipperary. In Nenagh there are two ambulances working Monday, Tuesday and on a Friday there is one working from 8pm to 8am the following Monday. There is one ambulance working on a Wednesday and Thursday with one available at night. There are two ambulances working in Thurles on a Wednesday and Thursday with one at the weekend. On a Tuesday one of these ambulances is sent to cover Roscrea, which has no cover. One ambulance works in Thurles at the weekend with one crew. In Roscrea, there is only one ambulance ever on duty during the week and weekend with one ambulance crew. There is supposedly always one ambulance in each station but there have been times when there has been no cover in North Tipperary as all ambulances are away at other hospitals. In contrast, Limerick has three ambulances which are staggered and has two

working ambulances at the weekend. There is a bus for patient transport purposes in Limerick but this does not operate in North Tipperary leaving the ambulances mentioned above to cater to patient transport as well as act as an emergency service.

As part of the reconfiguration process one extra ambulance was provided in Scarriff, Co. Clare to help ease access problems, however the ambulance service in North Tipperary is still overly strained. For the purpose of this question, the Thurles and Roscrea stations were not included, as patients from Thurles are given a choice to attend either Clonmel hospital (which is currently in the process of being downgraded) or Nenagh and Roscrea patients are often taken to Tullamore, Portlaoise or Kilkenny, whereas before Nenagh was the first choice. It is also worth mentioning that the ambulances in North Tipperary have often covered work in Limerick with no support left behind to cover the North Tipperary area.

5.9.   Advanced Paramedics

As a product of the new health service, advanced paramedics have become an integral part of health care provision in today's health society. Due to this, it was considered necessary to include a separate question on their role in society and to find out how much people know about them and their work in the community. The question which was posed was similar to the previous question about the number of ambulances working in Nenagh, but asked instead, about the number of advanced paramedics that the participant believed covered North Tipperary.

Table 5.9: The number of advanced paramedic cars covering North Tipperary

Number of Advanced Paramedic Cars	Participants
1-2	62
3-5	126
6+	12

The majority of participants believed that there were on average three to four advanced paramedic cars covering North Tipperary at any one time. Participants commented on this question believing that there was one per station in North Tipperary but as disclosed earlier, information was not given to respondents on the actual statistics, in case the final results would be compromised. There is in fact only one advanced paramedic car covering North Tipperary at any one time but it is always stationed in Nenagh. In Limerick however, there are no advanced paramedic cars. One car was piloted for the Limerick area but it was decided shortly afterwards

by ambulance personnel, that because of the large catchment area of the hospital in Limerick county and the demand for ambulances, it was more suitable and safer for patients to have advanced paramedics crew ambulances along with paramedics. There have been no plans as of yet to increase the number of advanced paramedic cars in North Tipperary or even allow for more advanced paramedics to join the crews on the ambulances.

Referring to a point made in an earlier chapter, barriers have also increased for patients who may need the assistance of the ambulance service during emergency times. Speaking to paramedics and advanced paramedics during the course of this research, many believed that the old ambulances used in the early 2000s, served the public better as it allowed for two patients to be carried in one vehicle. The new ambulances are equipped with only one stretcher which can prove awkward at times for the crew as they have to lean over the patient to access machines or equipment for treatment. This can delay care in some circumstances and this point was sent in writing to the HSE when the present ambulances were being designed but was subsequently ignored. It meant that double the amount of ambulances and crews had to attend accidents leaving stations and areas of North Tipperary often without cover for many hours.

5.10. Choice of access for patient

The final questions on the survey ask the participants where they would seek treatment if full acute services were returned to Nenagh Hospital, even after reconfiguration has succeeded or failed. This question was considered to be a good choice as the final question as it gives a concrete finish to the survey as well giving a definite answer to where the patient would rather be treated. This also gives evidence of how many people prefer the service the way it is now rather than what was on offer pre-reconfiguration.
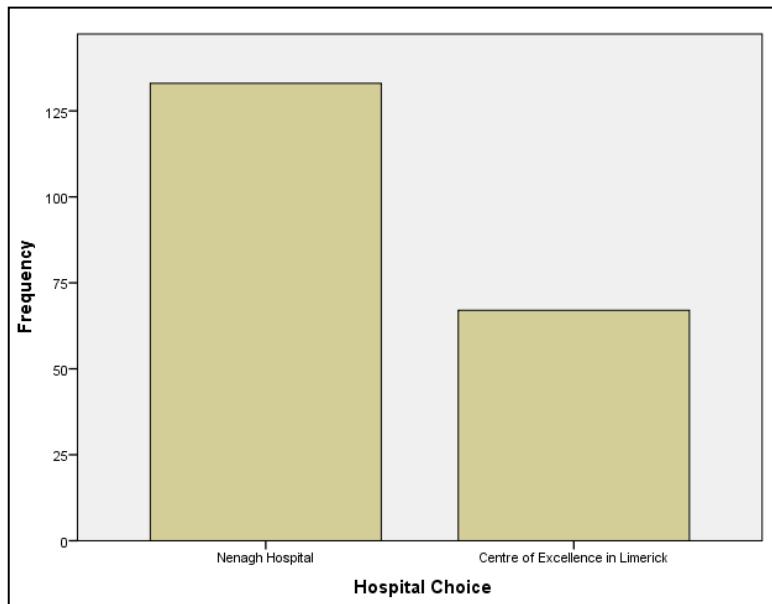
Figure 5.5: Participants preference for care if reconfiguration is reversed.

According to the results 133 participants would still rather attend Nenagh Hospital if acute services were placed back in their local hospital. There was a substantial number of respondents, sixty seven to be exact, who chose to attend the centre of excellence over their local hospital regardless of if services were moved back locally or not. This may be due to people feeling that it is the better option in the long run to go to Limerick Hospital as they may end up being transferred there to be treated from the local hospital in any case. The participants were then asked to explain the answer which they had chosen and give a reason for their choice. Below is a summation of quotes which explain why people chose Nenagh Hospital over Limerick Hospital.

Participant 05: *"The staff in Nenagh is more understanding, I'm not just a number there"*

Participant 14: *"It's a great hospital and services should be put back there"*

Participant 17: *"It's the safest option for patients"*

Participant 22: *"Exceptional services provided at Nenagh- it was always my first choice"*

Participant 59*: "Local is best, especially for the elderly"*

Participant 87: *"There is more time dedicated to the patient"*

Participant 94: *"More personal than a larger hospital"*

Participant 100: *"Closer to my family and friends"*

Participant 154: *"Limerick is under too much pressure so I would choose Nenagh"*

Those who chose Limerick Hospital over Nenagh Hospital have their comments listed below:

Participant 23: *"It's a larger hospital"*

Participant 33: *"More experience in Limerick"*

Participant 91: *"Bigger is best"*

Participant 103: *"Higher standard of care"*

Participant 122: *"They have the newest technology in Limerick"*

Participant 169: *"It's a longer distance but I suppose better care"*

Participant 182: *"More specialised consultants in Limerick"*

From the answers quoted above we can see there is a divide amongst the public but clarifies that people are aware of the advantages and disadvantages of going to either hospital. It also shows that public perceptions of health care are never quite one sided and many opinions can often fall into the grey area. After further analysis, it was found that the some of those who chose Limerick as their answer for the final question, were younger and located on the Limerick side of Nenagh while those who seemed increasingly concerned about access to health care were slightly older and located further away from both Nenagh and Limerick. This assumption is based on the hinterland statistics mentioned previously.

It cannot be denied that there are access problems to health care in North Tipperary and hospital statistics show that patients are outnumbering beds on a regular basis in the centre of excellence (O'Regan, 2012). In terms of looking at the results above as a whole, a conclusion can be reached in that the people of Nenagh are concerned about their welfare and where it stands, now that reconfiguration has removed acute services and the coronary care unit (August 2012). The knowledge on access to facilities is not as definite as was predicted and in hindsight more questions should have been asked in relation to whether a person was benefiting from

private health insurance. This would also have highlighted the socioeconomic stance of participants on whether or not they were also availing of the medical card or simply had no cover.

5.11. Cross tabulations

Access has featured a considerable amount throughout the community questionnaire and the results collected, required further analysis. In order to determine the extent of how access has changed in the community, cross tabulations were conducted through SPSS to link answers together to find a more definitive answer to the research questions posed in the introduction.

Due to all of the participants thinking that access to health care has changed, it was imperative for the results to be explained further to see how access has changed through the public perspective. The first table shows results from three questions which featured access heavily. As all participants believed access to health care had changed in Nenagh and that health care was now not considered as accessible as it once was, before reconfiguration. Results from the question which asked if the centre of excellence was running to its full potential were cross tabulated also with the access change question. 72.5% believed that the centre of excellence is not running to its full potential with 51% of that portion believing that the patient may benefited from care locally in Nenagh thus proving that local access to care can be perceived as being the better option for some depending on the ailment.

Table 5.10: Cross tabulation: Access change

		Is health accessible locally	Total
		No	
Has access changed since 2006	Yes	200	200
Total		200	200

	Is COE running to full potential			Total
	Yes	No	Don't know	
Has access changed since 2006 Yes	49	145	6	200
Total	49	145	6	200

		Benefited more from local care			Total
		Yes	No	Don't know	
Is COE running to full potential	Yes	37	10	2	49
	No	102	35	8	145
	Don't know	5	1	0	6
Total		144	46	10	200

This idea is further reinforced by the previous results which showed that 66.5% of participants decided that they would rather go to their local hospital over the regional hospital, if services were reconfigured back. Analysing further, it seemed that even those who favoured and supported the centre of excellence, which accounted for 71% of the Yes vote, still would have preferred care locally in the long run.

Table 5.11: Cross tabulation: Hospital Preference

| | | Where would you rather go | | Total |
		Local Hospital	Centre of Excellence	
Is COE running to full potential	Yes	35	14	49
	No	93	52	145
	Don't know	5	1	6
Total		133	67	200

Taking the scenario question which also asked participants whether or not they would desire to receive care in the centre of excellence, 75.5% believed that they would still rather be taken to their local hospital than have to travel long distances for the same care in Limerick.

Table 5.12: Cross tabulation: Scenario hospital preference

| | | Scenario | | Total |
		Nenagh	Limerick	
Is COE running to full potential	Yes	37	12	49
	No	116	29	145
	Don't know	4	2	6
Total		157	43	200

It is crucial that the community have knowledge of the health services available to them, in case of emergency. To test the knowledge of the community and in particular those who have worked in the health sector, on access to care, a cross tabulation was conducted amongst health workers, to discover their knowledge on both the primary and secondary care services in Nenagh.

Table 5.13: Cross tabulation: Health Sector workers knowledge on access to services

| | | Primary Care Team | | | |
		Yes	No	Don't know	Total
Health Sector Work	Yes	17	8	7	32
	No	94	17	57	168
Total		111	25	64	200

| | | How many ambulances cover NT | | | |
		1-2	3-5	6+	Total
Health Sector Work	Yes	1	9	22	32
	No	2	86	80	168
Total		3	95	102	200

| | | How many AP cars cover NT | | | |
		1-2	3-5	6+	Total
Health Sector Work	Yes	9	19	4	32
	No	53	107	8	168
Total		62	126	12	200

It was found that although working in the primary care sector themselves, only 53% of health care workers believed there to be a primary care team in Nenagh. 69% of the health workers believed there to be more than six ambulances covering North Tipperary at any one time and 59% believed there to be between three and five advanced paramedic cars working in North Tipperary also. These results compared to the 80% of non health care workers believing there to be six or more ambulances covering North Tipperary and 63% believing that there are also three to five advanced paramedic cars operating in North Tipperary, prove that the information on health care changes is not filtering to the public as clearly as it is made out to be.

The overall opinion of the Nenagh community seems to be that the more local the care, the more accessible it is and the better the outcome for the patient.

5.12. Conclusion

The literature review carried out for this thesis proved invaluable as it provided a foundation on which this research could evolve. Looking at previous research in relation to access and acute services, this research has proved worthy to Irish health geography through obtaining a certain type of data which has not been widely used i.e. collecting accounts from the people who provide the service and those who use the service. Choosing Nenagh for this research has proved to be interesting as the data presents how health service reconfiguration can affect rural communities which were accustomed to having twenty-four hour acute services in their locality. Despite the loss of acute services in the hospital, the ambulance service in Nenagh has filled the void to an extent in regards to acute care by providing an excellent emergency service to the community and must be given recognition for the added responsibilities it has taken on since reconfiguration began.

In spite of this additional service, the general opinion from this sample suggests that the Nenagh community has been denied a stable health service and those who are to blame are the local politicians and Dáil representatives who used the issue as political propaganda. It was not favourable to include a question regarding politics on the questionnaire as it was believed people may follow their politics rather than give a sincere opinion, which is what was needed for this research.

This chapter has provided an insight in the community perspective on health reconfiguration and will be followed by the next chapter which deals with the opinions of the medical professionals who provide the service especially in the primary and secondary care sectors.

Chapter Six: Results from the Medical Community

6.1. Introduction

A second questionnaire was conducted with the intention to accumulate empirical data from the medical community in both Nenagh and Limerick. The series of questions which were asked to medical workers were in relation to their field in the health sector and dealt with issues around access to care and their opinions on health reconfiguration. Both questionnaires contained questions which asked the participants to define what access to care means to them. This second questionnaire is available in the appendix (Appendix C). There were forty of these questionnaires completed from both the primary and secondary care sector which encompasses a variety of posts such as general practitioners, therapists, consultants, nurses, paramedics and advanced paramedics, from both Nenagh and Limerick. The questionnaire was designed like the previous one, to be easily followed and to take no more than ten minutes to complete. Extra care was taken in distributing these questionnaires early, so as to allow for late replies due to work commitments.

6.2. Participants' Profile

Taking part in this questionnaire were 25 Paramedics, 4 Advanced Paramedics, 4 Nurses and 7 General Practitioners. The questions posed were brief and direct to accumulate answers pertaining to access to acute care, health care philosophies and thoughts on health policy.

6.2.1. Gender

The majority of participants who took part during this division of the research were male with a total of 21 males and 19 females. This number accounted for 52.5% of participants with 47.5% being female.

6.2.2. Age group

The question in relation to age group was expected to show few results in the younger categories as many older medical workers would have worked through the various

health system changes in Ireland and could account for the good and bad experiences as policy progressed.

Table 6.1: Age statistics of medical professionals

Age Group	*Number of Participants*
18-29 years	2
30-39 years	13
40-49 years	15
50-59 years	8
60 years and over	2

6.3. Locality

As before, the participants completing this survey were asked to give the location of their local hospital i.e. their nearest local hospital and not the hospital of preference for referring patients.
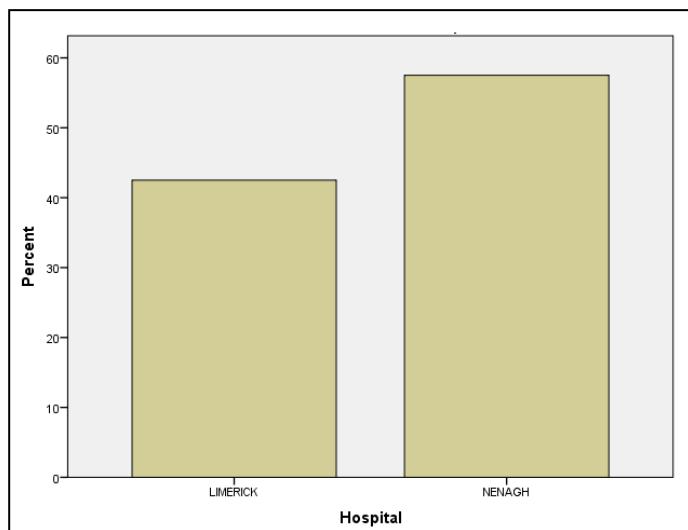
Figure 6.1: Nearest local hospital to participant

As shown, 57.5% of participants indicated Nenagh Hospital as their local hospital and 42.5% indicated Limerick Regional as their local hospital. When revising questionnaires it was found that in fact two Nenagh participants considered Limerick Hospital to now be their local hospital due to the fact that Nenagh Hospital is no longer carrying out any surgical procedures or acute care clinics. One of the above noted that "*because of this it is no longer a fully functioning hospital, in my eyes*".

The following question referred to where medical professionals considered their centre of excellence to be located. This was asked due to previous discussions on this topic with medical professionals in Nenagh, who often referred their patients to hospitals other than Limerick because of shorter waiting times or simply because they felt it was a better hospital with more capabilities, for their patient. This was confusing when first identified because it seemed that even the local medical professionals in Nenagh had little faith in Limerick as a centre of excellence.

Table 6.2: Where is the nearest centre of excellence located

Answers	Where is your nearest centre of excellence?
Limerick	39
Other	1

All participants but one answered Limerick and the one extra answer given concluded that New York's Columbia and Cornell Hospital was their nearest centre of excellence simply because it was a hospital built to serve its large catchment and had enough beds, staff, specialties and technology to cater to a patients every need. The awareness of primary care facilities in both Limerick and in Nenagh proved to be a difficult answer for some, with quite interesting results.

Table 6.3: Limerick perspective on primary care team in their local area

Answer	*Is there a primary care team your local area?*
Yes	2
No	7
Don't Know	9

Table 6.4: Nenagh Perspective on primary care team in their local area

Answer	*Is there a primary care team in your local area?*
Yes	14
No	8
Don't Know	0

There seemed to be slight confusion with these results and an independent consultant from Nenagh, who had not taken part in this research, was asked to look at the data. It was their opinion that general practitioners in the Nenagh area may be acting as a primary care team with each other but because there is no certified premises in which they all work together, there is no official primary care team in Nenagh. Participants in Limerick however, seemed just as confused as to whether or not there are primary care clinics in the city, of which there are six centres. It is justifiable, as 80% of the Limerick participants work as part of the ambulance service and may not be aware of primary care facilities in the city, as they would not be in contact with primary care centres as much as hospitals, when transporting and treating patients.

6.4.   Positions held within the health sectors

Participants were then asked what area of the health care sector they worked in whether it was the primary, secondary or emergency service sector. Figure 6.2 shows that the majority of health care workers who took part in this research belong to the Emergency Service sector which includes the ambulance personnel and the on-call doctor service, Shannondoc. These are the services that operate twenty-four hours a day, seven days a week in North Tipperary. As some were from different areas of North Tipperary, additional information was required as to where they are normally stationed. Those who were working in Roscrea and Thurles at the time of this survey were "on loan" to Nenagh ambulance station at the time so as to cover shifts during the week when the Nenagh crew were absent. This occurs on a regular basis and can often leave Thurles or Roscrea with reduced ambulance cover or with no ambulance cover.
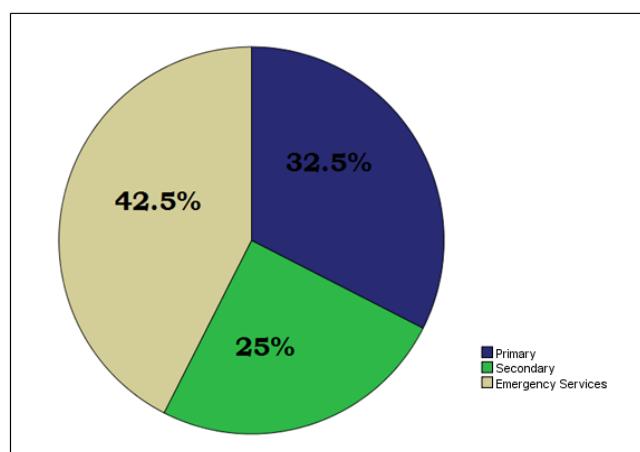
Figure 6.2: Health care sector workers

The remaining percentage of Nenagh participants comprised of G.Ps, one consultant and a group of nurses who are working permanently in Nenagh. Those who participated from Limerick include consultants, nurses and ambulance personnel. This gave this research a wide variety of medical backgrounds working in the new health service and because each of the above experience healthcare differently each day.

6.5. Defining Access

In tune with the previous community questionnaire, it was necessary to ask the health care professionals what "good access to care" also meant to them, the health care provider. It was found that perceptions of access changed according to what part of the health sector the participant actually worked in. Participants who oppose and support the system considered good access to care to mean "an affordable, efficient, equitable and trustworthy system". These same words have appeared throughout literature (Barton 2004, McNamara 2004, Nolan and Nolan 2005, Saltman 2007, Burke 2009, WHO 2010/2011, Hunter 2012) and describe what access to care should be perceived as rather than what it actually is. To focus on the above descriptions at a deeper level, participants were divided into groups based on their specific profession and opinions were analysed according to how many used those descriptions in their answers.

6.5.1. General Practitioners

The group of General Practitioners seemed to have similar opinions of access to care with some suggesting that acute service movement needed to be "*seriously reconsidered*" because of the limited access to these services in North Tipperary. The point was also made in relation to the overcrowding issue in the centre of excellence which was described by another G.P to be a "*death trap*". Some described the move as being "*dangerous*" to the "extremely vulnerable" (youth and elderly) because they have limited access already, due to travel means. Some comments argued that assumptions have been made by the people in power that everyone has some form of access to care:

> "*this is not true- at least 25% of my patients don't have a car and are coming*
> *from rural areas so they are in fact dependent on others to help them access*

care- if you increase the distance, people may not be as willing to help others who have no means of travel to a hospital in the first place."

"... two of my patients come to me from as far as Lorrha, they said it was more convenient because of having the hospital in Nenagh, if they needed to go any further. They chose here even though there is one GP closer to them. I'm sure I'm not the only one with this issue and now I have to send them further for services. It just isn't right for this to happen even at primary care level".

Three other GPs gave a more defined view of access to care stating that their opinion of access was about

"... getting the patient an early diagnosis and immediate medical care if the condition requires it", *"patients being able to get the appropriate care they need for their condition in as local a situation as possible"* and *"obtaining appropriate timely care based on medical need at a close distance".*

Each of these opinions suggested that distance played a key role in access to care which has supported the literature reviewed earlier in the thesis, on this issue (Samplis et al 1993, Jones, 1998, Pederson 2002, Barton, 2004/2006, Burke 2009).

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6.5.2. Paramedics and Advanced Paramedics

Paramedics and advanced paramedics, as stated before, are a form of access to care in their own right and have a considerable breadth of knowledge on how access has changed in both the primary and secondary sector since 2006. In regards to being cared for in the centre of excellence, points on inefficiency of care and lack of quality of the care given now compared to before, were referred to:

"These days, you are only a number especially if you don't have money or don't have any contacts in the hospital itself. After that it is he who shouts the loudest. This is what our health service has been reduced to and it is certainly not the way access to care should be".

Although some are in favour of the service change *"I get to spend more time treating my patient on route to Limerick and using my new skills, than I did before"*, some believe that the service would be greatly improved if Nenagh were allowed to have some acute care facilities back for the benefit of both the ambulance crew and the patient:

> *"I've resuscitated patients in the back of an ambulance and more often than not, it would be easier to pull over and do the job at the side of the road than keep going, but we have to. If Nenagh could provide just patient stabilisation, it would benefit more for the patient and take the pressure off us coming from the rural parts of Tipperary. Any patient can suffer a cardiac arrest, even during routine transport and the crew need the support from local hospitals to be able to keep the patient alive."*

One opinion given from a paramedic shows how the lack of access to acute services can lead to the abuse of emergency services.

> *"There have been cases where we have been called to scenes in houses where the smallest of things could be wrong with a person- severe back pain, migraines, and sprains. We have medication on board to assist with these health problems and other minor problems but these are not issues we should be called out for. We are not GPs and we are not pharmacies but we are being used as these because people don't want to travel to Limerick. It's easier to call 999 for an ambulance to come and give what we call now a "quick fix" treatment from Nenagh, than go to Limerick to wait to deal with the health problem. It's a complete waste of our time, but it is the reality because of the fear people have. Some could call in hysterics down the phone and make a situation seem worse than in really is, just so they can get quick treatment that will hold them over."*

Another paramedic from Limerick who has worked in Nenagh on cover is quoted as saying:

> *"Access is nonexistent now for the people in North Tipperary; I covered there once and hated seeing patients trying to endure the drive"*

A number of the advanced paramedics are of much of the same opinion of the health system being built "*around the patient's needs*" with the realisation that it is now "*more about building it around the consultant's needs and what is convenient for them rather than the person on the trolley*". However there are those that do believe that access has changed for the better:

> "*I would hope that we are providing a better service and bringing access closer to the patient, in a way, but I know that I am not a trained consultant and my car isn't a hospital so I can only give care to some level*"

> "*... sometimes a patient isn't able for the distance no matter what level of care they are receiving from myself or my crew and it can be very distressing to them to have to travel a distance for something that could have been provided locally*".

These are the harsh realities of what is going on in the ambulance service not only in North Tipperary. It also demonstrates that distance can in fact play a huge part in the health outcome of a patient, as was referred to in the literature review (Nichols, Dixon and Hughes 1998, Jones 1998, McKee 2002, IAIM 2003, Barton 2006, Burke 2009, Chou and Deily et al, 2009)

6.5.3. Nurses

It was imperative that those who were part of the research had a direct connection with acute service provision and the nurses in both Emergency Departments in Limerick and Nenagh were chosen due to having acquired a considerable amount of information on access to acute care:

> "*As nurses we have to advocate and fight continuously for a justifiable and equitable service which provides equal access to services which are now in Limerick. Even calling the hospital in Limerick to enquire about a bed for a patient is tedious in comparison to Cork or Dublin*".

In regards to access there were some very honest opinions which were parallel to those of the paramedics:

> *"I would be lying if I said health care was in anyway accessible- it should be about the patient getting care but they aren't getting care in Limerick- the numbers are too great to provide a safe and efficient service- it's so overwhelming for everyone and that's not what access is about. I'm not afraid to say it but patients are to some extent being neglected".*

> *"...we need to re-open the local hospitals either as surplus centres or to provide full acute services for longer times, to give us a chance to get numbers down in here".*

From a Nenagh perspective, nurses believe that they may have been cheated out of being able to provide a quality services to the patient

> *"at one stage it may have been about giving the best care possible for the patient in a local setting, now we are bypassed and reduced to clinics while our patients are treated in another county, in an overcrowded hospital- what's accessible about that?".*

6.5.4. Hospital Consultants

Limerick consultants outnumbered those who could participate from Nenagh, which was effective in a way, resulting in a top heavy response from the centre of excellence. This was hoped to provide further evidence into how either the local hospitals would be welcomed back as a support net or be a classed as a hindrance to the system moving forward.

Two Emergency Department consultants in the centre of excellence described access to care in their hospital as "*chaotic*" and at "*breaking point*". One clearly stated that in the evenings, moving patients swiftly through the system becomes "*quite difficult and tedious*". With extra increased pressure mounting on the centre of excellence with "*at least 10 new patients on our list any given night from Tipperary and Clare when they could have easily have gone to their local A&E before*" reports

of patients on trolleys and waiting long hours are being highlighted both in the media and within the medical community itself.

Future cuts in the service are also instilling fear into consultants who are "... *just waiting for something to go seriously wrong in here some night*". On the other hand, in the local hospitals consultants want to do more to support their colleagues and try and help solve the access issues in the larger hospital:

"I know we are small, but we have halved the waiting list for Limerick's A&E before, why not help by just opening a local 24 hour A&E at weekends, or come to some agreement like that."

"Nenagh provided excellent access to patients- it was within distance and had specialised consultants ready twenty four hours a day. That's what access is- it's the likes of Nenagh and Ennis, not waiting in a room for hours here".

This further supports the statement made in the literature review in regards to consultants from both hospitals forming a support network for each other in times when need is greatest and encouraging professionals to work together for the good of the patient (Ricketts, 2009).

In summation, it can be seen that the GPs are unhappy with the current way the system is operating and are seemingly very negative towards the new system. The consultants' point of view from both hospitals proved to be interesting with professionals wanting traits of the old system to help fix the issues of the new system for the patients' benefit. The paramedics also believe that access has changed and that it is not fair for the patient to be travelling long distances for care. The issue also brought up by paramedics was that of "*fighting for beds*" and having to wait with patients until one is found, again underlining bed issues in Limerick.

6.6. *Local Accessibility*

Figure 6.4 illustrates the question asked on accessibility to health care in Nenagh i.e. if healthcare is deemed accessible in the area by medical professionals. It can be seen that most of the medical community believes that access to acute care is not sufficient in Nenagh or in North Tipperary which supports answers from the previous questionnaire by members of the public.
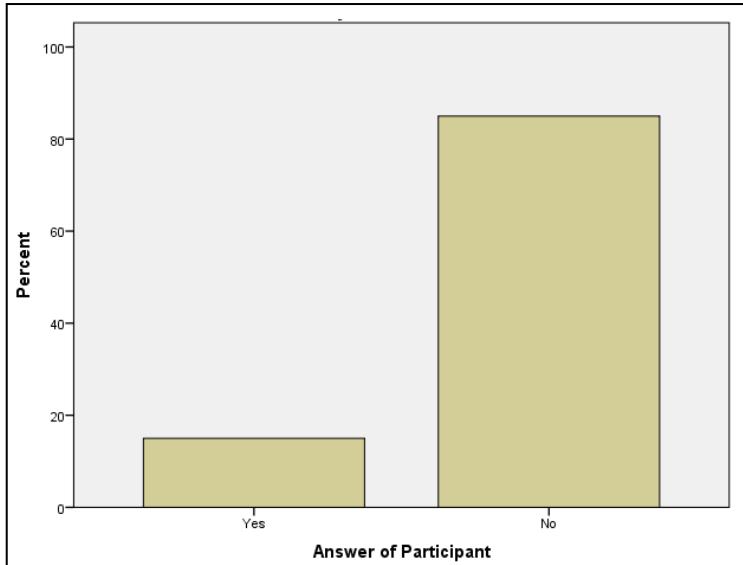
Figure 6.4: Perceptions of accessibility between medical professionals

6.7. Impacts of reconfiguration on the patient

One of the main reasons behind centralising health care in Ireland was to provide better care to patients on a wider scale and decrease waiting times which can be quite traumatic and distressing for an ill person to endure. The concept of time has featured solidly throughout this research and to an extent, has set a dual definition of access in regards to looking at time and geography when considering access inequalities. The key answer which is needed to resolve one of the research questions of this paper is to find out if the level of care the patient receives now, in the centre of excellence, has improved as a result of reconfiguration. From the above answers in regards to access, it can be provisionally concluded that this new health system could be potentially unsafe to the patient and to the staff who have the responsibility of looking after the patient.

The present Minister for Health, Dr. James Reilly, has said on record before obtaining a government seat, that the new health system was *"carelessly planned and did not take the needs of the Irish people into account"* (Nenagh Guardian, 2006) but yet he himself, has progressed the system further into what he once called a "*treacherous system*".

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Table 6.5: Perceptions on the improvement of health care for the patient

Answer	Has care for the patient improved since centralisation of services
Yes	12.5%
No	87.5%
Don't Know	0%

Table 6.5 shows the results of a question which related to whether or not care actually has improved from the medical perspective, for the patient since the reconfiguration of acute services in North Tipperary. A clear majority of the respondents decided that health care for the patient has not improved which causes slight concern about the accountability of the new health service. It would seem that the government has asked for little input from health workers on the ground, in planning this new health policy.

In light of the answers to this question, the next set of answers also tie in with the above, which are related to the amount of emergency vehicles available to patients in North Tipperary. As stated previously there are only a certain number of ambulances and response cars at work at any time in North Tipperary and more often than not, these are also required to work in the Limerick area if cover is needed. Access to emergency vehicles is extremely important, especially in today's circumstances when one vehicle can only transport one patient. It is therefore essential that there be emergency care workers on call at all times, should the need arise and as of yet this is not the case in Ireland.

On the continent, and in the USA, emergency response vehicles have become more important in the everyday lives of a patient. Vehicles are fully equipped to cater to all possibilities and carry emergency transmitters which can summon helicopters in case of delay. Ambulances are built to act as mini emergency rooms and more often than not, many fire engines have also undergone transformations to act as ambulances in a time of need, with staff being trained as EMTs to assist in emergencies. This has doubled the number of emergency vehicles available to patients in other countries but so far in Ireland, this has only been practiced in Dublin. In response to the question on whether or not there are enough vehicles to cover North Tipperary (which includes both ambulances and response cars) the answer given by all forty participants was "*No*" confirming that North Tipperary needs more emergency care cover.

6.8. Death by Geography

The possibility of death by geography has been argued numerous times over by health geographers. It is a national worry now, that two very sick patients in two locations will have two different fates. Fairness needs to be considered in line with the new health service in that there will be more hospitals with acute services, within reach to those living in the capital than to those who live down the country. This is a growing cause for concern. After seeing this issue and how it related to the nature of this research, it was decided to use it as part of a question in this survey. Participants were asked to look at the picture and to write a caption on whether or not they believed that this picture could be related to the effects of Irish health system in North Tipperary. The sub categories below discuss the views given in response to the question.

Figure 6.5: Ambulance versus The Grim Reaper (Source: www.stumbleupon.com)

6.8.1. General Practitioners

The general views given from GPs in regards to this answer were negative towards the new system stating that "*this is what will soon be our reality*" and that "*lives will be lost*". The picture also described what one GP believed to be "*the future of the Irish health service, illustrated for everyone to understand*". There were a few comments linking the picture to local hospitals such as "*this is the reason we need local hospitals to be reopened*" and *"it's a shame that it will be passing a great local service*" with one GP. asking simply "*who will win the race in rural Ireland?"*

6.8.2. Paramedics and Advanced Paramedics

The opinion of the advanced paramedics in regards to the picture was divided with some commenting that the picture was explaining the facts through irony. One Advanced Paramedic commented that they believed it was complete "*sensationalism*"

with others describing it as humorous with the ability to "*play heavily on people's fears*". Those who were in favour of reconfiguration, added that it "*undermined the ambulance service*". Many of the advanced paramedics who supported the local services sympathised that "*the picture speaks the truth and it is sad*" and that "*this is what we try to prevent, every day*". A comment was given which suggest that some confusion may arise in regards to the actual meaning of the picture:

> "*...to me, it's not really about the quality of care but the distance to travel to the care and some could see this as the service itself given on board the ambulance, to be of poor quality, which it isn't*".

The paramedics who this picture directly refers to, had differentiated opinions on the question asked and believed that they were the medical professionals most targeted in the debate of distance and patient outcomes. Some voiced concerns that the patient may be gravely concerned now that they have to travel further "*...when will these people be able to turn up for me, how far from home will they take me and will I survive the journey?*" Many took a view much the same as the Advanced Paramedics saying that the picture "*made a mockery of the ambulance service, as usual*" and "*is really only applicable to very rural locations*" with some also referring to the private ambulance service suggesting it related "*more to the 'privates' who are not trained to the same level...*" as the National Ambulance Service crews because "*with them the patient has very little chances for good outcomes, but it's a perfect choice just for transport*".

Quite a few paramedics took a very pessimistic view to the picture commenting that it portrayed being "*dead by the time you get to you centre of excellence*" and "*help coming too late*". Other comments included it that the picture showed the health service to be a "*complete and utter nightmare*" and a "*sad reality for some*". Another commented that the picture "*makes a joke of me and my job but that's what the health service is all about right now*". In relation to access many suggested that the picture highlighted what access to care in rural Ireland has now become. Paramedics from both North Tipperary and Limerick were quite alarmed that this picture was in existence "*the fact that this picture is out there and has even been published, leaves little hope for any ambulance service going through a change like this*" as it showed the pressure that the ambulance service is under, with another

suggesting that "*it's probably what most patients see me as now when they see me coming*".

A number of workers also added some after thoughts referring to the job at hand "*does the ambulance even know where it is going because sometimes, I don't, when I am covering a shift elsewhere?*" and also referred to specific locations "*looks like what you would see on the far side of Tipperary on any given day*". The plight of the ambulance service has also been highlighted by some, who were able to relate the picture in the question to the current situation in North Tipperary "*on more than one occasion, we haven't even had an ambulance in the race because there has been none available*".

Those who favoured reconfiguration added that "*centralisation would be fine if we had an amazingly resourced ambulance service- which we do not have*". One paramedic critically evaluated the meaning of the picture stating that it showed the "*two health care systems in Ireland for a patient also known as 'delay' or 'death'.*"

6.8.3. Nurses

This question also produced some interesting comments from the nurses. One nurse wrote of the picture displaying access issues stating "*the picture shows that access is insufficient in emergency care*". With one adding slight irony to her answer suggesting that "*patient outcomes will be grim*". Along with this picture showing uncertainty for patients who may have to travel long distances, it also highlights the importance of having close acute emergency care and brings the debate back to the issue of patients being within the "golden hour" for treatment (Barton, 2004). This was supported by one particular nurse who wrote "*at times it can be uncertain whether a patient will receive timely emergency care that could save their life*".

6.8.4. Hospital Consultant

Amongst the consultants there were some who sided with the local hospital in regards to this question explaining that the picture showed "*the split outcome for the patient, who before had a better chance, locally*" and "*this wouldn't be the case if extra support could be given to patients who need emergency acute care at the local*

hospitals". The notion that centralisation has limited access to a large extent also showed with another pointing out that this is "*the reality of health care outside of Dublin*", an idea which was posed in an earlier chapter of this thesis.

Some answers given offer little hope to patients with professionals agreeing with what the picture entails. Others believe it undermines the ambulance service completely, highlighting issues which have always been within the service but which have only become more apparent since reconfiguration.

6.9.   Does distance really reflect on patient outcomes?

During research for the literature review, minor studies (Nichol et al, 2007) appeared which were based in other countries such as the United Kingdom and the United States of America. These studies suggested that distance from a hospital played a key role in a patient's overall health outcome and that mortality increased with longer distances. This proved to be a very interesting component in which to expand further on and it was decided to propose this situation to the medical professionals in North Tipperary and Limerick so as to get their opinion on the outcomes of that particular research. The question asked whether or not it was distance that played a major role in a patient's survival rate or if it was the emergency care received at first contact.

The issue of distance on patient outcomes has been one of much debate with medical professionals clearly divided on the issue. The opinion amongst the G.Ps state that:

"...*distance does matter but it depends on how bad the patient is. In certain circumstances the extra 10km can be crucial to the patient but can be deadly also*" and another commenting that "*Emergency care at the time can only help in a limited number of conditions so distance travelled is a huge factor*".

The majority of older Paramedics agreed with this with two stating that:

"*from what I've seen, distance does affect health outcomes- I've brought patients with serious illnesses or from accidents from rural areas that never came home*" and that "*emergency care becomes more limited the further you are away from a hospital- we can only do so much*".

This is also supported by an advanced paramedic who commented that "*we are not doctors, ambulances are not hospitals- that is what needs to be realised*".

A further comment from a paramedic stated that

> "...*we've come upon accidents where patients would not have made it to Limerick, even if we had a hospital on wheels- it is the travelling that affects the patient and Irish roads are not the best when you have to perform CPR on a dying patient*".

This has also been touched on in literature previously (McKee 2002 and Culliton 2009) which reads that ambulances may be expected to do too much in a short space of time. This has been supported by a Limerick Consultant who wrote "*the greater the distance travelled the more likelihood of complications or deterioration in a patient's condition, despite initial emergency care*". Both groups of nurses from Limerick and Nenagh pointed to fact that patients who have a longer distance to travel can often require extra care from the "*trauma of the journey*". Many participants also believed that the primary sector needed to be further upgraded so that they could play a part also in emergency care for a patient, especially if an ambulance is on route to a hospital:

"*I believe that the level of care needs to be improved at the primary phase to involve G.Ps more. Look at the Melbourne Study at the Royal Alfred Hospital which shows clinical evidence of this in operation and working*".

The idea of distance being a factor more so than emergency care, seems to resonate throughout the group however more so within the emergency services role where they are actually transporting and treating the patient.

6.10. Increased responsibility for emergency care workers.

As part of reconfiguration the majority of health workers involved in the emergency services have undergone new training which has defined new roles for them. This was also discussed briefly in the literature review when documenting facts on both the Hanly and Teamwork Reports. Before, the role of the paramedic was the highest level in the ambulance service with an Emergency Medical Technician or EMT being the most popular post within the service. Many discussed how difficult the paramedic role was at the time, as they were more accountable (due to being more qualified) for the patient's wellbeing and it was not a desired role to take on. Since the reorganisation of services, all workers at EMT level have had to retrain and upgrade to paramedic level with some undergoing more training, to become advanced paramedics. This permits them to administer certain types of medication to a patient. However, along the path of reconfiguration, there have been more up-skilling courses

which have had to be completed by paramedics and advanced paramedics to improve skills even further. Therefore, it was significant that a question about up-skilling be put on the survey especially to discover if other professionals have had to undergo specific training in lieu of the new health system.

Over 55% of participants which included G.Ps and ambulance staff have had to complete courses which would equip them with new skills to treat the patient effectively on first response. This has forced some of these workers to take on an increased responsibility for a patient's wellbeing, which they previously had limited association with. Figure 6.6 also details the answers to the question which asked if increased responsibility had been taken on by those who have undergone new training. According to the results, 62.5% of participants believe that there up-skilling was as a result of having to take on extra responsibility for a patient. For some such as paramedics and advanced paramedics, this means being able to perform a number of procedures on a call out which could include administering medication to a patient, setting a patient up on an I.V. (Intravenous Drip) along with giving certain injections.

However complex a situation may be for a patient, the ambulance crew are only permitted to treat the patient to a certain extent and must do their best to stabilise a patient for their journey to hospital. This can be extremely stressful and frustrating on the patient and also on the ambulance crew who now more than ever, have a life balancing in their hands. Recent classified documents have also suggested that should anything go wrong in an ambulance en route, it is the crew who are held responsible and must be able to account for the care which they gave to a patient in circumstances which may have caused death.

The media have emphasised this issue in the past number of months where there have been many fatalities, one including a recent case in County Roscommon, where a young woman died as a result of her injuries due to being sent on a longer journey to a centre of excellence (Crawford, 2012). The teenager was involved in a car accident which left her with internal bleeding and after a two hour journey in an ambulance she unfortunately did not make it to the centre of excellence on time and died en route due to cardiac arrest. The National Ambulance Service have had to take the responsibility for this unfortunate accident and are being blamed for causing the death of this young girl even though the site of the accident was only a short journey and within minutes from Roscommon General Hospital. This hospital had its acute emergency services taken away only just a short time ago. Had the general hospital been able to give her treatment, she would have had a high chance of survival Crawford, 2012) which reintroduces the notion of death by geography to this

research and access issues. This is unfortunately becoming somewhat of a regular occurrence with similar incidents countrywide. In September 2012, a man from Cloughjordan in Tipperary was alerted by his wife that she needed to go to hospital as she was suffering from chronic stomach pains. There was no ambulance within reasonable distance available and so he took it upon himself to drive her to Limerick as he knew he would be turned away at Nenagh. His wife became unconscious en route and it was found that she had died from appendiceal rupture or burst appendix. She never made it to the centre of excellence. Had Nenagh Hospital been open and providing acute services she might have been saved.

6.11. Is the new health system fair?
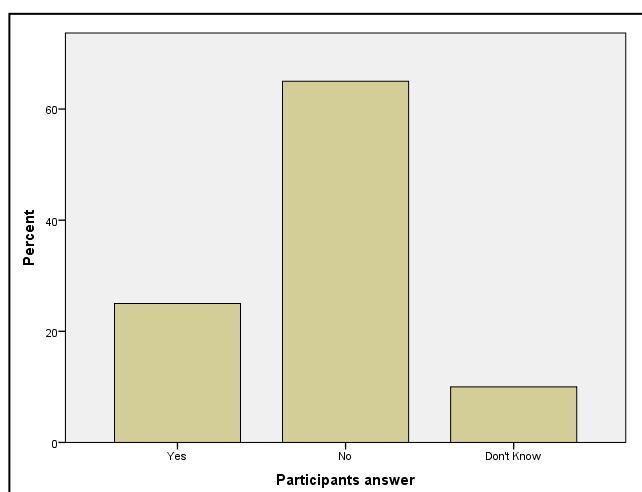
Figure 6.6: Fairness of the new health system

The above circumstances suggest that the new health care system is seemingly not as safe as was promised to be. In light of the recent events, participants were also asked on the survey if they felt that they were now provided with a better and safer service than was available before, to the patient. Those who chose "No" as their answer were health care workers who are based in Nenagh on a permanent basis i.e. all of the GPs and Hospital Staff. A number of paramedics also agreed with the system being less safe, however, this question did leave room for comment in which some suggest that, yes, it is in some ways more safe because patients have the advantage of highly skilled staff such as paramedics and advanced paramedics, but on the other hand events such as that in Roscommon and Tipperary can happen. This shows that not only is distance an issue but also the hospital network system.

Although these are examples of extreme cases of practice in the health sector it must not be forgotten that many patients do arrive on time and are treated exceptionally well by all medical staff.

6.12. Recruitment

Like many areas across the public sector there is now a ban on hiring new staff. The effects of this can be seen especially within the emergency services sector such as the National Fire Brigade and the National Ambulance Service which is in some cases short staffed. When asked if participants would encourage younger members of society to work in the medical field with these new changes to the health system, many were left undecided as the job which they had originally been contracted to do had now changed and had become much more complex.

Due to the economic downturn, public sector workers have had to take substantial cuts to their wages but take increased responsibility in their jobs which as mentioned before, has been the case for those working within the Ambulance Service and in hospitals. Despite this, it did prove to be an interesting question because although the changes to the system have been widely criticised, many people still have interest in the public sector especially for working within the ambulance service with recruitment levels in the ambulance school in Dublin reaching a peak in 2007. The only issue was finding places for the newly trained professionals coming out of the college because of the health system changes and budget cuts. Participants were asked if they would recommend people choose the emergency services as a career:
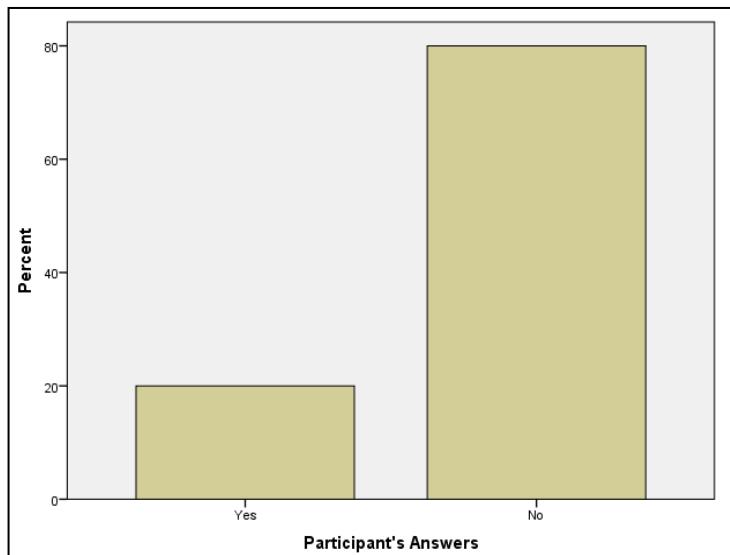
Figure 6.7: Encouragement into the health sector for employment

6.13. Benefits and recommendations of the new health system

Many participants were impressed at the amount of up-skilling needed for their jobs and saw it as an opportunity to gain extra time with their patient. Several of the respondents added that the patient had increased access to trained acute personnel on a base level which was much better for him/her than the previous EMT system. The inclusion of the advanced paramedic system was also praised as it provided an expert level of acute care at first contact with the patient. There were very few negative comments made in relation to this question and most offered recommendations such as increasing the numbers of advanced paramedic cars and ambulances so the new system would function better. It was also recommended that waiting times in the emergency room of the centre of excellence be addressed for the benefit of the patients and the medical staff.

One respondent criticized how careless treatment in the larger hospitals can often lead to the re-admission of patients soon after their discharge, an issue which also needs to be addressed. Another participant also believed that although some services had been improved, services which incorporated work with cardiac patients in the emergency service sector needed to be brought to a higher level so that ambulance crews are equipped with advanced training in all areas of emergency care.

While reviewing some of the literature documented in the literature review, it became apparent that although this new system has been highly praised by both politicians and a number of consultants, it has had some immediate effects on the staff working in the

hospitals, especially the centre of excellence. When asked how the participants felt staff in the centre of excellence would be affected by the changes, their responses were clear and fair stating that realistically if patient volume increase and staff or bed numbers stay the way they are, that the service and staff will be under pressure trying to deal with the patients. Participants reiterated that the impact on staff has been significant in relation to stress levels which can potentially lead to mistakes being made in treatment.

6.14. Choice of hospital if services were ideally located?

To conclude this survey participants were asked to choose the hospital in which they would prefer to either see their patients treated, or be transported to. Participants were given the option of sending their patients to Nenagh General Hospital to be stabilised and transferred if necessary, to the centre of excellence or having their patients directly transported to the centre of excellence, regardless of the distance which needed to be travelled. There was also a comment box linked with this question which allowed respondents to voice further opinions on the matter.

Having services ideally located is an important factor, however it can be argued that although acute emergency services seem a great distance away in Limerick Hospital from Nenagh, they are in fact closer than many services around the country where people are having to travel even longer distances, such as in Donegal or Mayo. Although many chose not to provide a comment to support their answer, those who did choose to leave feedback provided information which both supported the local hospital and the centre of excellence and more importantly the idea of both hospitals working as a network together, to ensure the best possible outcome for the patient.

Many agreed that although the local hospitals were recognised as not being cost effective, they were an essential part to the health care system and were considered a lifeline by so many people in rural Ireland. This being so, the present issues being experienced could be considered as teething problems of a higher order health society emerging in Ireland which in the future may offer an incomparable service to the population, than that which was first expected. The local acute hospitals were an integral part of communities around Ireland and indeed within the medical society itself with larger hospitals often depending on the local hospitals to take the surplus patients. The information provided on the chart below details the responses of all participants who completed the survey.
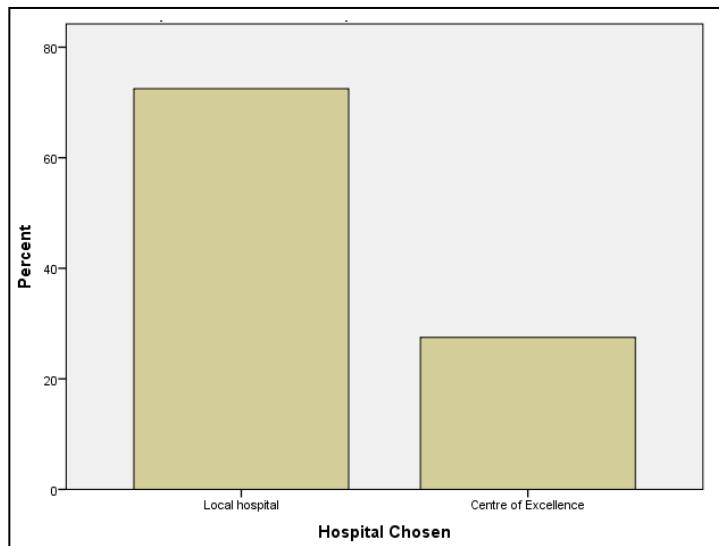
Figure 6.8: Hospital choice if services were ideal.

Professionals who chose the local hospital over the centre of excellence concluded that:

"Nenagh has a brilliant staff and is a waste of a hospital now. It should be open 24 hours a day, 7 days a week. The public are also very annoyed over its slow closure".

The idea of stabilizing a patient before referring them to the centre of excellence also became apparent with a G.P commenting that *"Stabilisation is important in the local hospital so that patients can travel the distance"* with nurses also adding to this point further stating that:

"Prompt access to medical aid is vital and this was provided by the local hospitals in the past and is now a service which is very limited. What happens if there are no ambulances available due to high demand?"

Paramedics and advanced paramedics also favour the local hospital complimenting the work that Nenagh has done in the past:

"...small hospitals have an important role in the assessment diagnosis of patients for example with chest pain and were excellent in the past for cardiac patients".

Paramedics from both Nenagh and Limerick also highlighted the importance of local hospitals in patient care suggesting that the changes made may not be for the best:

"The treat and transfer policy worked for the last 30 years but now we have to take the gamble that the patient's will make the longer journey" and that *"Patients brought to the centre of excellence can often be left for hours on a trolley without treatment, no matter what the condition and would be better off staying local".*

Other comments in favour of the centre of excellence included that:

> "...the expertise in the regional centre cannot be compared with the local hospital in regards to specialty teams and that it should always be the first option for the patient even though it may not be the most desired by the patient".

6.15. Cross tabulations of results

The statistics gathered were examined further to determine which health sector workers believed that access had depleted the most in North Tipperary. The following collection of tables, display information on how many professionals, in each health sector, believe there to be issues with access to acute care.

From the results below, it is clear to see very few health workers believe that the new health system is in anyway accessible to those living in North Tipperary. The group who believe there to be serious issues regarding access to care and quality of care are those in the emergency services but in contrast to this, they are also the group who believe that the service may be the safest option for the patient, once these issues are fixed. Although seemingly contradicting, after further discussion with the group on this topic during research and through interviews, it can be concluded that the paramedics and advanced paramedics believe that their part in administering care to the patient at the scene has improved greatly and in their opinion is much safer than that which was available to the patient prior to reconfiguration. This point is also supported in the literature review (McKee 2002 and Culliton 2009) who state that ambulance care has progressed exceptionally well in Ireland but that there is still more to do to ensure that the paramedics and advanced paramedics can cater to every need of the patient, to some extent, regardless of their situation. Many of the ambulance personnel agreed with this also and there proved to be a significant correlation ($r = 0.384$) between both variables, when matched.

| | | Sufficientlyaccessible | | Total |
		Yes	No	
Healthsectorpart	Primary	2	11	13
	Secondary	2	8	10
	Emergency Services	2	15	17
Total		6	34	40

| | | Hascareimproved | | Total |
		Yes	No	
Healthsectorpart	Primary	3	10	13
	Secondary	1	9	10
	Emergency Services	1	16	17
Total		5	35	40

| | | Nowasafersystem | | | Total |
		Yes	No	Don't Know	
Healthsectorpart	Primary	1	10	2	13
	Secondary	0	8	2	10
	Emergency Services	9	8	0	17
Total		10	26	4	40

Figure 6.6: Cross tabulation of Health Sector workers on access.

There was a significant correlation (r = 0.319) between those working in the health sector and those wanting patients to attend their local hospital. This was in relation to those working in Nenagh only, with the majority of the participants being in the emergency services. This could be justified by the ambulance personnel previously stating that they would rather not bypass the local hospitals, if a patient was in a critical condition and in their opinion, would not make the full journey to Limerick.

6.16. Interviews

In addition to the questionnaires, interviews were also conducted with both medical professionals and public representatives in the community who had a direct relationship with dealing with the health service issues in Nenagh. The questions asked during these interviews were carefully planned to link with both questionnaires and to also delve further into the access issues in North Tipperary. Eight interviews were carried out with medical professionals and four were carried out with public representatives in the community. None of the above had taken part in the previous surveys. The participant was briefed beforehand on the overall study of this thesis and the aims of this research. This entitled participants to decline the invitation to take part, even though during the brief, it was stated that only the job

description of the participant would be given. The full transcripts are available to be viewed in the Appendix (Appendix D).

The first question asked participants whether they believed that the health system which was proposed under the Teamwork Report has provided better care to patients. The general feedback from the medical point of view was that the new system was a good idea but needed to be fitted more specifically for Ireland rather than being worked on theory alone. It is believed that the Irish government reneged on its earlier promises to pump the local hospitals with adequate community care services before the actual transfer of acute services.

Advanced Paramedic B:

"It promised it in theory and couldn't deliver in reality. We see patients all the time that do need to be stabilized rapidly before even entering a centre of excellence and we in the ambulance service were assured that services would be provided to allow the above to happen every hour of every day. Truth is, the service has not been put in place and will never be. One Advanced Paramedic in a response car serving all of North Tipperary cannot and will not replace critical services at a local hospital."

Public Representative B:

"I think that patients do receive better care in Limerick but the care in Nenagh was the same just on a smaller level but it was effective care. There was an accident four years ago on New Year's Eve where four youths barely made it to Nenagh Hospital from the Silvermines- unfortunately three passed away later but they were so critical they would not have lasted to Limerick and were able to be kept alive in Nenagh until their family members arrived. That's how important Nenagh is to our community."

Public Representative D:

"I thought it would be good for the people of Nenagh to promote this system and I still believe in it and that patients will benefit once everything has settled into place."

The following question asked the interviewees directly about access in North Tipperary and how they perceive it to be since health reconfiguration began. It was important to include not only professional opinions but also that of the public representatives who have a duty to the community, to try and safeguard local services.

Nurse B:

"Access has changed very much and especially at night, we still have patients coming to the door at night with basic injuries that we could treat before but we are not allowed to, anymore."

Advanced Paramedic A:

"Yes access has changed but then you have the likes of my job which brings the system to the patient to an extent so patients aren't waiting in local hospitals to be referred- I can make the call for them to go to either during the day and then at night to the centre of excellence- its what's best for the patient."

Public Representative A:

"Access to basic acute care is a disgrace in North Tipperary now, whatever level it was at before, it's ten times worse now. People are being turned away from a hospital who may need urgent care and are told to drive the forty or fifty minutes to Limerick only to wait three to five hours to be seen- if you are even lucky to be there for that short time."

Public Representative D:

"I believe access is better yes, distance may not be suitable but access to facilities, technology and medical teams has improved greatly"

As mentioned before in the introduction, there are many types of health care access, one being functional access which pertains to the services actually available in a hospital. A question was asked for the purpose of looking at how functional the local hospitals are to communities and whether or not acute services should be restored to them.

Paramedic B- Nenagh:

"I believe that they were extremely important and should be given services back. I have worked in this service for twenty five years- I have seen the best of the service and now the worst. This is taking the service away from the people and making our jobs harder. When a patient dies in our care, it is us who are answerable, not a consultant, a doctor anyone- us. And when our support system is gone also- it makes it very hard for us to save people."

Nurse B:

"That is a difficult question because Nenagh was a very good hospital in a very rural area and offered some other services that Limerick did also, so I would suggest only moving back casualty."

Public Representative C:

"I think hours of casualty need to be reconsidered but nothing as drastic as moving back services just yet because the system needs a chance to work."

Acute services remained a central focus throughout the interviews suggesting that even if hours were increased to an extent, it may offer reassurance to the community to know that they have local protection further into the night.

Question four provided an insight into how participants believe North Tipperary as a whole has been affected by the health changes.

Advanced Paramedic A:

"In one word- adversely. One response car trying to serve all of North Tipperary adequately is fantasy. Not only can you not get to every patient you need to in the time frame that they need, but if that patient does need your care then you are out of the picture for two hours or more. Secondly, the skill level of Advanced Paramedics needs to be increased rapidly to that of a Paramedic Practitioner as in the U.K. service. This would allow us to treat and refer most patients at home and not automatically have to tie up A&E services unnecessarily. The huge amount of Geography needed to be covered by one car also increases stress and danger to the Advanced Paramedic and other road users as they are struggling to get to the patient."

Nurse B:

"It has affected everyone, not only the patients but us also, we are left without emergency cases which voids our skills also which decreases quality of care. I know that this is 'the way forward' and they say care will be better elsewhere but I want to be able to do the best for my patient too."

Public Representative A:

"The whole system is a mess- it has affected me and the people I represent which is the Nenagh community by forcing them to travel for basic care and expecting them to

wait for hours for a service that was on their door step already. Consultant led medicine should be abolished- was it not always supposed to be about the patient?"

When asked a question relating to the future of the health service and what changes they would make, if power was put into their hands, some participants gave very detailed answers in regards to what they deemed necessary to be reconsidered, for the sake of the public in rural communities.

Paramedic A- Nenagh:

"The key problem in Ireland is that health care policy is not driven by an evidence base but by the politicians who make changes on what they perceive the electorate will want, while in many cases the public are not adequately educated on health care matters and often see change such as the closure of the acute services at Nenagh as being negative even though it is positive. We also need to now invest on Emergency Medical Retrieval teams such as those in Scotland, these teams are composed of a Doctor with suitable pre-hospital and Anaesthetic education and an Advanced Paramedic and travel to peripheral sites and stabilise and retrieve critically ill patients to central centres of excellence. Take a look at http://www.emrs.scot.nhs.uk/"

Advanced Paramedic B:

"As I said before we need to increase the skills of the current ambulance crews and look into getting helicopters into the skies for critical patients. We shouldn't have to rely on the coast guard because they are a separate emergency service to us and likewise Dublin shouldn't have the advantage over the rest of the country using paramedics trained in the fire brigade. I would eradicate the private ambulance service completely and look then at building the system from the ground up rather than the top down. There are too many managers and not enough frontline staff. I would look at measures to reopen the four wards in Nenagh that were closed and utilise these as patient recover beds for those in Limerick who live in Nenagh and have the consultants that run clinics in Nenagh on a regular basis care for them so as not to block up the centre. A&E would be opened until 12a.m. which was proposed by the emergency services when Hanly and Teamwork were being reviewed so that staff in local hospitals does not lose vital skills. There is a long list of things that I would do but we would be here all day."

Nurse B:

"I would consult people in the community as to how they would like their service and try and give them some relief. I would work with the likes of acute emergency staff in local hospitals- i.e. nurses and consultants and ambulance staff to have their input and would ask emergency staff in the centre of excellence. I would do this as it is only emergency services that need to be changed and then hopefully build a service out of the idea that the patient is the centre and their needs have to be put first."

Public Representative D:

"Re-address the issues but talk to people on the ground and see what their take is. If the providers are happy then the patients should be. The service should be run by what the professionals deem to be safe."

The answers given above give a clear representation of how important the local service is, to both the community and the health workers themselves. Each sample set links directly with the data collected from the surveys and clearly defines how access is perceived in North Tipperary from all perspectives.

6.17. Conclusion

The above information added a significant amount of insight into the workings of the health system both in the public domain and behind the scenes in the hospitals. A noticeable trend which emerged from the above data shows that there is significant internal conflict within the system amongst the planners and providers. Clearly there is no liaison between health planners and health workers and it seems as though government policymakers are ignoring reports from health personnel in the hospitals about the stress health reform is causing, especially in areas like Nenagh. This is also evident throughout the interviews with emerging conflict between medical personnel and the public representatives on what is believed to be best practice for the Nenagh community. This gave further clarification in regards to the issues at hand within the Irish health service and how politics can influence health in a community. It seems as though the triangle of care surrounding the patient which comprises of the health provider, the health service and the health policy has broken down, leaving the patient out of the equation and quite vulnerable.

Chapter Seven: Discussion

7.1.   Introduction

This chapter aims to recap on the research questions which were posed in the literature review in relation to access to care in North Tipperary and determine the extent to which these questions have been answered. Recommendations will be discussed towards the end of this chapter and will relate to what possible changes could be made to increase access to care in North Tipperary. The research questions to be answered during this chapter are as follows:

1. To discover if access to health care in North Tipperary has changed since 2006 and if so, how has it affected the Nenagh community and those in rural areas?
2. To discuss the factors which affect access to care both spatially and economically and determine if those factors apply to the case in hand in North Tipperary and could possibly impact negatively, on patient outcomes.
3. To assess whether the system now in place is supported by medical professionals in the area and if not, what they believe should be done to reduce the inequalities possibly facing Nenagh and North Tipperary.

7.2.   Health and Human rights in North Tipperary

During the course of this research, a significant theme appeared throughout in relation to human rights and access to care. This point was emphasized even more so during the interview process and while conducting questionnaires. The original idea of "the health society", first discussed in the literature review, considered human rights and access to basic health care to be a foundation for which any government should build a health policy. The idea that health policies themselves are inhibiting a person from achieving his/her full health potential is unfair and unjust (Dahlgren and Whitehead, 1995) because of these issues being potentially preventable in the first place. This is also supported by the World Health Organisation (2005), who clearly state that:

> *"the minimum standards under the right to health, oblige states to ensure that public healthcare services are made available to all; are accessible to all, regardless of geographical location or economic status; are acceptable to all cultures, genders and ages and respect the privacy of all individuals; are affordable to all; and of high quality"*

In signing declarations such as the UN International Covenant on Economic, Social and Cultural Rights in which "the right to health" featured prominently, the Irish government promised to promote and protect health (Burke et al, 2004) and increase access to care for those in rural communities as well as to deliver a high quality service to the Irish people. In comparing this fact to the research gathered in this study, it is clear that the government have again reneged on the people of North Tipperary and are in breach of UN law, to some extent.

Interpreting the data gathered, it can be concluded that a high percentage of the people in North Tipperary have an unmet need in relation to health care and access to care facilities. Other research in the literature review supports this finding on a wider scale also in regards to public and private health insurance costs and further inequity in access to care as a result of health reconfiguration. This also offers a solution to the first research question posed. With the loss of acute emergency services, the level of inequity has increased (McKee, 2002) for the people of North Tipperary. Those living in the Nenagh community now have a longer distance to travel for care- a distance which often has to be endured alone without the support of an ambulance. Those living in the more rural communities of North Tipperary have an even longer journey to face and with Nenagh now offering care for only certain injuries, the decisions to face the journey and waiting times are becoming increasingly difficult to make, especially at night. From ambulance station records, there have been instances of people waiting through the night at home ill, to be admitted to Nenagh Hospital when it opens rather than travel to Limerick.

This has not only affected the community's sense of place, but also its sense of security. Many accidents have occurred on the roads in North Tipperary, some of which have been fatal (O'Duffy, 2010). Medical professionals have commented on the fact that people will die on the road to Limerick (Carney, 2006), and that a critical care unit must be returned to Nenagh, if there is any hope for future road fatalities. There has been no sign of the amount of ambulances or response cars being increased to support patients in rural areas and it is becoming more and more apparent that although these services were originally promised, they may never come to be in existence. The public are beginning to believe that they are being subjected to a health service that is inadequate and in some circumstances, dangerous.

7.3.   Access: Proposals and Changes

Spatial access to care in North Tipperary has significantly changed since 2006 with patients travelling on average, sixty kilometres to Limerick from the rural communities used in this research (Chapter Five, Table 5.2). North Tipperary itself has seen a population increase of

almost 6.5% since the last census (CSO, 2011) which was taken just before reconfiguration began in Nenagh. From September 2012, Nenagh can now only cater to soft tissue injuries, and non fatal wounds (see Appendix B) and can only take patients between five and seventy years of age. Unless otherwise referred by their General Practitioner, no patient can attend Nenagh Hospital after 8p.m. The following table shows the changes over a period of six years to the health system in the Mid-West region, in both Limerick and Nenagh.

Table 7.1: Department of Health and Children: Acute hospital statistics 2004-2010

Nenagh General Hospital	2004	2007	2010
Bed Numbers	75	75	52
Hospital Admissions	4,359	4,698	2,599
Bed Occupancy	97.1%	96.3%	95%
Length of stay	5.5 days	5.6 days	6.7 days
Emergency Department Admissions	12,972	15,663	10,646

Limerick Regional Hospital	2004	2007	2010
Bed Numbers	426	425	404
Hospital Admissions	23,531	22,995	24,138
Bed Occupancy	90%	85.8%	93.7
Length of stay	6 days	5.8 days	5.7 days
Emergency Department Admissions	52,295	56,528	60,000

Mid-Western Hospital Group	2004	2007	2010
Bed Numbers	844	835	746
Hospital Admissions	46,611	46,531	44,540
Bed Occupancy	87.5	85.8%	87.5%
Length of stay	5.8 days	5.6 days	5.3 days
Emergency Department Admissions	107,065	110,883	100,348

Since 2004, bed numbers have been decreased in the Mid-West region and have decreased further this year with Nenagh now only having 40 beds available to patients. Hospital admissions in Nenagh have decreased since services have been moved and this is shows with bed occupancy also decreasing and length of stay for patients increasing. Limerick has seen increases also in areas with the emergency department admissions increasing due to patients having to attend the centre of excellence from North Tipperary and County Clare. The length of stay for patients has also decreased slightly probably due to the amount needing beds. What can be seen from the above table is that beds in the centre of excellence have reduced since reconfiguration, even though it was promised that they would be increased to cater to the new patients.

Economically, health is also becoming unsustainable. Health care costs are becoming increasingly high especially within the private sector. Many people are unable to afford the luxury of private health insurance and have to settle for the public system. The Central Statistics Office (2010) reported that private health insurance in the Mid-West has decrease from 55% in 2001, to 52% in 2007, to 49% in 2010. The economic climate is primarily to blame for the inflation on health costs in the private sector but the government more so in not adapting new measures within the public health sector to combat these inequalities. The local hospitals in the Mid-West prior to reconfiguration proved to be cost effective (Carney, 2006) as they spent less on treatment. However new budget cuts in recruitment and service provision suggested otherwise and that in a bid to save money, the local hospitals were to be cut. It was then suggested that if Ennis and Nenagh hospital each received €2.5million a year they would be able to provide safe services on a 24 hour basis which could cater for critical emergencies. With bed costs on the rise in the centre of excellence and a new health budget projecting more cuts of €850 million for 2013, the future of the economic stability of the health service is doubtful as to how a sustainable service can be provided on such strict measures.

The growing cost of health care has blocked many patients in North Tipperary from being able to both afford and access care. This statement has been already supported by medical professionals during the interviews as well as through the community questionnaires where people were fearful of what was to become of their local service, in the future. Care costs can also run high for those who cannot afford private health insurance and are ineligible for the medical card. Not being unable to afford care both in the primary sector (General Practitioners can often charge up to €80) and secondary sector (bed costs range from €850 in Limerick), demonstrate that financial access barriers exist and block patients even further

from availing of care (Citizens Information, 2012). This can cause patients to forgo care until such time as they have no other option but to go to hospital, more than often in a very critical state. The idea of having to travel further for care is also off putting to the patient, as previously mentioned by both communities in the samples. The HSE (2009) still stands by its decisions of implementing reconfiguration and states that the service does in fact provide "*comprehensive 24/7 emergency services and care*" to the patients in the Mid- West. It was also stated in the same report that the policy on reconfiguration was designed to service "an appropriate population catchment". There are, however, examples of where centralisation of services has worked effectively but on a different scale.

A study in Sheffield in the United Kingdom (Simpson et al, 2000) where centralisation has worked very well, shows that despite an increase in patient numbers, waiting times have not increased because an adequate number of beds were transferred to the centre of excellence. The only difficulty that came about as a result of the service change was that there was a decline in the time to see a consultant particularly in the Accident and Emergency Department, thus showing there are flaws in even the most effective cases. In the case of the Mid-West region, the average waiting time drawn from the results of this research was 5 hours in Limerick Regional Hospital which indicates that this average waiting time is close to the Healthstat March (HSE, 2012) record which suggested over 140 patients were seen within a 6 hour period. This accounted for only 7% of the overall target which was set for the hospital by the HSE who expected all cases to be seen within 6 hours. However the HSE reported that 152 people waited up to 12 hours, 70 people waited up to 24 hours and 3 people waited more than 24 hours in March also. These were the only cases documented from 1,802 admissions made that month. This had been mentioned also within the interviews, where paramedics and advanced paramedics were concerned with overcrowding issues and having to wait with patients. They acknowledged also that those who have to wait longer, more often than not, get worse which can be stressful for the patients. Unfortunately, waiting times tend to be long but this differs depending on staffing levels and the number of patients to be seen. These are factors which also control access to care, especially for those coming from rural areas and travelling longer distances.

7.4.   Access: Professional Perspectives

Other studies which have been highlighted by Irish medical professionals in the media include a case published in the Emergency Medical Journal where ambulance services were monitored over a five year period in England. The article concluded that it was safer for the

patient to not bypass the nearest hospital because losing time costs lives (Culliton, 2009) and was also recommended that 98% of patients be located within one hour of care. Professionals also agreed that these changes would affect the elderly significantly. This is because they are relatively immobile and rely heavily on having emergency services closer to them. Paramedics and Advanced Paramedics also called for new changes to be made to their practices which involved re-designing ambulatory vehicles and first response cars so that it is easier on them to give the necessary care to the patient. This also involved putting more vehicles on the road as there was a shortage in ambulances and policies which were previously thought to be introduced have not yet been fulfilled.

While primarily affecting the patient, these changes can also have other impacts which include those on the staff themselves. During the stages of downgrading process in Nenagh, many meetings and public demonstrations were held between 2006 and 2009, where doctors, consultants and ambulance personnel commented on the level of inequity within the health service. One consultant in particular commented on how nurses are often forced to reuse dirty linen (O'Malley, 2009) on a frequent basis in Limerick and hand out towels as blankets, when they run out because of the sheer number of patients attending the emergency department. This has been referred to as being inhumane to both patients and the nurses who have to work in these conditions. In 2010, nurses working in Limerick Regional Hospital staged a work-to-rule protest and stressed that the hospital could not cope with the new patients following the closure of twenty-four hour services and surgery and trauma services in Nenagh and Ennis. This happened again in 2011 when nurses protested about the worsening conditions in the emergency department and were joined by staff members from Galway University Hospital who were in dispute over Roscommon patients having to travel to their hospital for care (RTE, 2011). This outcry shows how concerned health workers are for their patients and themselves and puts emphasis back on to how unsafe care is becoming in the eyes of professionals (Kohn, 2003). Earlier this year, Limerick Regional hit crisis point having nearly thirty people on trolleys waiting for care. A quote from the Irish Nurse and Midwives Association described the scene:

> *"It's chaotic in there. The system is just not working. Staff are doing all they can but every available place is being utilised to fit people in. There is a huge issue with capacity at the Regional Hospital. They have taken over the Acute Medical Assessment Unit and every other possible space to accommodate those who are coming in through the ED. This is not some outbreak of something that is felling people - this is the system not working. You can't take 50 per cent of the acute beds*

out of Ennis and Nenagh without putting additional beds in Limerick, which is where ill people from Clare and Nenagh have to go." (English, 2012)

Although there are those who are in support of the system, the majority of medical professionals believe that the system is currently in turmoil which has been documented countless times in the media. This is also further supported by the research conducted in this study with professionals agreeing that something must be done to tackle the current issues, and fast.

7.5.   Access: Public Awareness

Another issue which has been recognised through this study was the level of public awareness in relation to what services are actually available to the community. When asked in the survey about access, some respondents were quite confused about what exactly they had available to them in their community. The first question on access to services, referred to if a primary care team existed in the local area. The results produced a multitude of opinions as to what a primary care team meant to the public and it was quite difficult to pinpoint an overall answer. In addition to this, the second questionnaire produced equally confusing results as medical professionals from Nenagh were also divided on the existence of a primary care team. A comment left by a General Practitioner on this question clarified that:

> *"... there are primary care services in Nenagh, but we don't all work under the one roof, like in the other primary care centres around Ireland. Our centre on the grounds of the hospital was converted into offices for admin staff. I believe some doctors and nurses just took them over as practices to keep them running before they retired themselves. As far as I know, none of the villages around Nenagh with the units, actually have them operating because I have patients coming to me from those areas."*

The majority of the community participants believed that there was a primary care team in the Nenagh area but high number were still unsure if one existed or not. There are numerous

primary care providers in Nenagh; however they are scattered throughout the town and are not in one designated area as was suggested in the Teamwork Report. This was further explained by a General Practitioner who said he would not be willing to give up his practice to work with the Department of Health in the public system and work as part of a team. Although asked to be part of a primary care team in Nenagh on more than one occasion, he refused to co-locate on one premises at Nenagh Hospital suggesting that he was not conforming to the HSE and wanted to deliver care on his own terms. He also knew of others asked who were willing to do so but it never happened.

Access in terms of ambulatory care was also a question which left many confused. The public were clearly unaware as to how many ambulances cover North Tipperary and to what extent. The same can be said for the amount of response cars. It was found that the majority of people within the Nenagh community believed that there were six response cars available to North Tipperary alone. It has been repeated by politicians that there is ample emergency coverage in North Tipperary and evidence of this is available in chapter six. Interviews held with the paramedics and advanced paramedics have provided insight into why the ambulance service is so under-resourced, even though policy stated it would be otherwise. This has allowed the inequality gap in North Tipperary to widen further, as without acute services there is no meaningful hospital and without enough ambulances or response cars, there is very little emergency coverage.

7.6.   Collective analysis of emerging themes within the data

Emerging themes throughout the collected data included key terms which will be discussed individually below.

7.6.1.   Familiarity of the Service

This knowledge of services within the community was of a relatively poor standard in relation to primary care with the knowledge of the primary care sector within the medical community being quite low also. Despite this, the primary care sector is providing a more stable service to the population than the ever changing secondary care sector and offers some hope to patients who are within reasonable distance of a primary care team or care centre. Even though investment in the primary care sector has increased so as to provide a better foundation for the service as a whole, it is extremely important to regulate services in the secondary sector because of the strong

links between the two sectors and also so that patients are offered a sense of stability, especially those who have to travel long distances.

7.6.2. Lack of development of services at centre of excellence

The promise of support services to be put in place in the centre of excellence to cater for the increase of patients from Tipperary and Clare has not yet been fulfilled by the Department of Health and has caused serious repercussions for both staff and patients. Overcrowding and long waiting times have now become a norm in the Emergency Department which is leaving staff extremely frustrated and under severe pressure. Reconfiguration of services should have been carried out at a slower pace to ensure supports were put in place and also the government should have committed to its earlier promise of working with the community to establish a sustainable service (Health Act, 2004). This would have given credibility to the service which in turn could have changed the perceptions of the service amongst the public and medical workers.

7.6.3. Fixed versus mobile services

The idea of more responsibility being put on mobile health services seems daunting to some even though it is seen as the way forward for the health service. Those working within the ambulance service are happy to be able to offer more services to the patient at first contact but are more concerned that they cannot be given more support themselves. The ambulance service can be seen as an independent health provider which aims to ensure the patient has safe passage from the scene to the hospital. From the interviews and questionnaires with medical professionals, there is growing concern that policy makers are relying heavily on the ambulance service to be a buttress to the new health system. Although this may offer some reassurance to the general public and offer a cover for other underlying issues within the service, government health officials have to be constantly reminded that the services provided on an ambulance cannot compare to those which can be offered even in a local hospital. In addition to this, the distance which has to be travelled by patients is a worrying concern to medical personnel who believe that a fixed service can offer more to a patient than a mobile service. The data gathered from the ambulance

personnel on this issue proved to be extremely important to this study and is an area which should be considered for further study in the future.

7.6.4. Stabilisation of patient and reliability on the service

Care of the patient must be at the core of any health service and this includes stabilisation of the patients in their time of need. It is vital that there are support services available to the ambulance personnel who work hard to ensure that the patient arrives safely at their destination. The importance of having such as service to stabilise a patient has been taken into effect at the most basic levels in communities where members of the public have been trained to work an AED in case of emergency. Many communities which are considered to be located in rural areas have fundraised to purchase AED units and are prepared should the need ever arise to use them. These basic community services have often increased a patient's survival rate but it is astonishing that even though patients may be stable leaving a community, they cannot rely on the health service to provide stabilisation services locally should an emergency situation arise en route to the centre of excellence. Calls from paramedics and advanced paramedics to have an on call stabilisation service made available at Nenagh Hospital and in Ennis have been left unanswered putting sole responsibility on them to save a patient's life, in a crisis. This shows that both the general public and medical workers are unable to rely on the local health service to determine what is best for the patient in an emergency.

7.7.   Further Analysis of medical literature

There have been quite a few studies conducted in countries where centralisation of services is in operation with many being based on the health systems in the United Kingdom and Canada. In 2000, a review of literature in the Journal of Trauma, showed that patients who were in critical conditions were 2.6 times more likely to die if given advanced paramedic care, as compared to those given basic care (Culliton, 2009), before being brought to hospital. This concept has been discussed by consultants in other research (McKee, 2002) which claims that often advanced paramedics can take a significant amount of time to stabilize a patient at the scene and this can cause further delays. Many believe that the older "*treat and transfer*" system carried out by emergency medical technicians was a quicker option for patients as they were on the road quicker and being attended to fully, on board the

ambulance. The above study concluded that patients in fact do a lot better, the closer they are to a basic life support ambulance and the quicker they are brought to an emergency department to receive treatment.

The Teamwork Report can be quoted in saying that the advanced paramedic system is "*international best practice*" and is based on solid foreign policies. However, it is clear that although it may seem a good plan in theory, the Teamwork proposals seem to be based solely on catchment demographics rather than the actual location of the population. With studies such as the above in existence, it is difficult to determine whether or not "*international best practice*", is what is best for Ireland with so many opposing it. This has left the Irish people feeling very much left out in regards to their right to healthcare. It also can be quite irritating, when Irish people become ill abroad and experience what they believe to be better care, much more quickly than is possible at home in Ireland proving that Ireland has not yet reached the health goals that the World Health Organisation have set out.

7.8.   What does the future hold for a health conscious Ireland?

The universal health insurance scheme which has been designed for Ireland by the current Minister for Health and based on the Dutch system is already receiving criticism from Irish professionals. It is believed that a system like this would benefit the population more so than the current public/private system because inequalities would be reduced and people would be able to purchase additional private packages if needs be, but the level of cover one receives will depend solely on the ability to pay and will not be tested by any other means. One issue with this system working in Ireland is that, in the current climate, health expenditure would have to be increased and as it stands, Ireland is currently cutting funding in the sector wherever possible. Ironically, the government wishes to have this new health service in situ by 2016. This would mean that the government will have to fund new primary care units as well as lift the staff moratorium as these new units will have to be fully staffed, if they are to operate in the same way as their template. Consultants fear that this new system may jeopardise health care in Ireland further, as insurance led systems, will mean trying to sustain a competitive market and could mean compromises to the quality of care for financial gain (Wilkinson and Brennan, 2012). Whatever the case may be, the term "universal" will have to be defined more clearly, to ensure that it means the same level of care for everyone regardless of geography and that the barriers talked about in the introduction to this thesis would become a thing of the past.

7.9.   Recommendations

There are many recommendations which could be made to try and improve the Irish health service and make it more accessible and efficient for the patient and the following are based on the results gathered in this thesis.

7.9.1.   Re-claiming acute care locally

To give the current system the benefit of the doubt, re-introducing full acute care services to local hospitals may be a quick solution to the problem at hand but could have long term effects in the future. Currently, a change such as this would be a high price to the already over-burdened tax payer but there are other options which may not be as taxing.

It was made particularly clear during the interview phase of this research that local hospitals were seen to be a great support system to an already pressurised

service. As the support services which were originally promised in the Teamwork are nowhere to be seen, it would be possible to create a new support system which would not breach Teamwork proposals but would offer comfort to patients and ease to staff in the centre of excellence. The proposition would be to extend the opening hours of the current minor injury clinic in Nenagh to midnight. This would ensure that North Tipperary patients would not be a burden to the centre of excellence and that only the critical patients would be filtered through for further consultation. The reason for this change is as follows. During the interview process, it was noticed that many of the emergency service personnel were agitated and angry that they were being called upon for injuries which could be dealt with locally. Due to Nenagh being essentially closed after 8p.m., ambulances were being sent to Limerick with patients who had sustained very minor injuries- as one paramedic described it "*999 calls for everything from headaches to heart attacks and it cannot continue*". Opening for just four extra hours could see a decrease in as many as fifteen patients a week being dealt with locally which could free up the emergency department in Limerick and prevent overcrowding.

This change would obviously incur a cost but for a worthy cause and would ensure patients received quality care for their injury. The effect of this would also filter down into the ambulance service and would make more vehicles available in case of critical emergencies. A motion could also be put forward for a doctor led emergency service which could include one casualty consultant or nurse to assist alongside them. All major cases would bypass the hospital unless a patient is in serious danger of dying. In this case there would be a CT scanner in place (which is already available in Nenagh) and a telecommunication link could be set up where both advanced paramedics and the care team at the hospital would work towards making a patient stable with the help of Limerick consultants, before beginning the journey to the centre of excellence.

If the patient was still at risk, an air ambulance could be made available (the coast guard helicopter in this case) to transport the patient directly into consultant care in the centre of excellence. This could also be made the case for Ennis, Roscommon, Wexford and other areas where local hospitals have lost acute services. In geographical terms, the local hospitals are well placed in order to secure patient safety and although distance by road may be considered short by some, more distance can be covered by air much quicker than any ambulance. The paramedics and advanced

paramedics have already undergone helicopter care training as part of their up-skilling and this change would see their skills being used for a greater good, rather than being wasted.

With all options, there are difficulties but when a person's life is at risk, medical personnel must ensure they do everything that is possible to save lives. The above concept would eradicate geographical access issues but again, this system would cost money to run, money which the government cannot afford to release in the current climate.

7.9.2. Developing a non profit hospital system.

Non profit acute hospitals are very popular in the United States of America, many working as acute service hospitals on a twenty-four hour basis and are run by charitable organisations and/or religious orders. This system would work in a similar way to how Ireland's first health system worked in that a board would be set up which would oversee all financial costs and provide a service on a need and demand basis. For the case of Nenagh this could include the community taking charge of the hospital and setting up a foundation from which the cost of running a small but effective twenty four hour service could be justified. Such a system is already running in the Hokianga region in New Zealand where the hospitals are owned by the community and governed by a Health Enterprise Trust and has proved to be extremely successful especially in the delivery of care to rural patients (Ministry of Health New Zealand, 2012).

7.9.3. Changing the way a patient travels

Another area which would benefit from change is the National Ambulance Service, allowing paramedics and advanced paramedics to have an active role along with consultants in the planning of the health service. This could possibly help reduce access inequalities as it is the ambulance personnel who are the first to the patient before any secondary care is decided upon. Access inequalities could be reduced by a significant amount if ambulance crews were allowed to have a say in the design of their vehicle which would make treating the patient a lot easier on both parties and could improve patient outcomes to some extent. As mentioned by the ambulance personnel in the interviews, further training for those who require it may also be suggested so that patients who are from those more rural areas are given the highest

standard of care on first response and are not left waiting until they reach a centre of excellence.

Above all else, to make the system more accessible more vehicles would have to be put on the roads as well as the introduction of a specific patient transport system. This system was piloted before in Limerick and North Tipperary but was abandoned shortly afterwards in Tipperary as there was a greater need in Limerick for the service. However with on average ten to fifteen new patients a night being brought from North Tipperary to the centre of excellence for minor but difficult injuries, it may be an idea to pilot this service again and see if it would release the ambulances currently being used for just transport. Obviously the above would cost a great deal to implement but those suggestions aim to increase accessibility and results would be seen almost instantly in some cases.

These recommendations along with the functionality of the system in its current state could achieve great results in regards to access and may provide a better foundation on which to build Ireland's future health society.

7.10. Conclusion

Health care needs to become more defined in Ireland. People need to be more aware of the health issues around them and have to want to be involved in creating a change for the future. From its conception, the HSE has determined that it would provide a service that the patient would be proud to use and that staff would be proud to provide but in the space of ten years, and all those promises, this has still not happened. If the Irish government are committed to providing the health service which they refer to constantly, they must work with the people on the ground and the people in the communities. Only then will access and inequity be overcome.

Chapter Eight: Conclusion

8.1.   Facing the facts: Reviewing the issue

Following the discussion it is hoped that the research questions which were set out at the beginning of this thesis have been answered to a satisfactory level. This thesis aimed to bring new approaches for researching health policies to the study of health geography, and set out to do what the Irish government has promised for so long to do- consult with the public and professionals to try and solve issues with access. During the course of this research it was discovered that the public are willing to become involved with the health planning process and so are the medical professionals, in order to put an end to the chaos. The conclusions drawn from the discussion chapter show that access is inhibited in North Tipperary but can be fixed to suit the needs quite easily, if the health policymakers would listen. Although many GPs wish to remain working in their private practices, they are willing to make a compromise for the good of the patient, depending on how much it will impact their business and influence the outcomes of their patients. The evolution of a new geography of fear, also been previously discussed, is becoming a reality for those living in Nenagh as people are increasingly worried about their health and the unreliable services in the community.

What we do know is that health care has been reconfigured for a good reason- to get as much care for the patient as is possible, for a better health outcome but has come at an awful cost. However running local hospitals didn't break the health budget; it was the new centres of excellence. This year alone, Limerick Regional is reported to have overspent by €14.6 million (Dwane, 2012, Limerick Leader) and reports issued recently confirm Limerick hospital to be in crisis yet again with 14,263 patients still waiting over a year, to receive care as outpatients. In contrast to this, the local hospitals in the Mid-West have come in under budget the past number of years, even before reconfiguration making savings this year of €73,000. (Healthstat, 2012). Referring to Table 6.12 in the discussion chapter, it is clear that significant changes have been made physically in both Nenagh and Limerick as a result of health policy, which has affected patients. These changes have also occurred in South Tipperary and around Ireland but at a much slower pace. Politicians in South Tipperary worked hard to secure acute services for as long as possible but it seems as though Nenagh was used as political propaganda by North Tipperary politicians. This has brought up a series of questions for debate about health geography, in regards to what makes the people in South Tipperary more deserving than the people in North Tipperary.

8.2. Facing the Facts: Access Concerns

The major concerns involving access to care in North Tipperary currently revolve around distance and access to acute care. As mentioned many times before, these are two of the most important factors which can decide whether a patient may live or die.

Distance will continue to be a factor where access is concerned and one which cannot be changed. In the hope of reducing distance times, the completion of the M7 motorway was a welcomed gift to the Nenagh community; however it too proved to have significant flaws as there are currently no emergency access routes constructed on the motorway, for emergency vehicles to access patients on the opposite road side, safely. This has caused growing concern not just from the ambulance service but also the fire service, which often have to manoeuvre on the road to attend to an accident. The issue of the hard shoulder being practically nonexistent in some areas has also been highlighted by both services as this often makes it difficult to park emergency vehicles safely away from moving traffic while also offering the patient some dignity in their moment of need. This was another area which was disregarded during the planning of the new health system and public infrastructure.

People's level of satisfaction for the new health system is low with many believing that the previous system no matter the cost, worked better as patients nominally had equal access to care. In addition to the options listed in the discussion chapter, innovations have been made in the health sector in regards to community care which has seen new opportunities being opened for private companies to take over community hospitals. Although an option, this could lead to the development of a new health market which could privatise acute care and may widen the inequality gap further.

8.3. The value of hindsight for future studies

After completing this thesis, there are some changes which could be considered if the study was to be restarted. These changes would include collecting a larger sample of surveys and conducing focus groups on the issue in the more rural parts of North Tipperary. It could also be an option to conduct interviews with those involved in health planning and health geography to add more perspective to the issue.

Another point of interest to consider would be that of conducting surveys in a similar area, such as Ennis or Roscommon, where services have also been lost and comparing the effects in those areas to information gathered from Nenagh. This would help create a wider

scope on the issue and would aid in constructing a more solid hypothesis on the idea that health reconfiguration has not only decreased access in North Tipperary, but in other areas also. An opportunity which could arise from this would be being able to map spatial inequity across a variety of geographical areas which would also strengthen the hypothesis. Patient perspectives on a more personal level could also be explored through interviews which would give firsthand accounts of the system working from a patient's point of view. Although the majority of participants who took part in this research were patients themselves at one point or another, a more recent patient perspective i.e. a long term patient may be considered a valuable input also. There are many more ideas which could be put into place to collect qualitative results but permission would have to be sought from hospital authorities to conduct them.

8.4. Planning for the future

Health systems must balance two purposes. They must respond to the demands of the population for access to existing services and also try to improve the health of the whole population by reducing waiting lists and hours spent waiting for care. Health care in Ireland has not yet reached a satisfactory level for the population and the reality that geography now plays a huge role in health planning and policy making is becoming clearer as time goes on. This creates scope for the emergence of new dynamic approaches to health care planning which must be considered to ensure a reliable and effective service and a lasting service for the future.

At this point in time, the Irish government cannot afford to make a mistake with health care especially when the system is already stretched to full capacity. Careful planning in the health sector needs to be considered so that Irish people, especially those in North Tipperary, will have a system that they can be proud of and put their trust in. From the results of this research, especially those in relation to the general public, it seems as though community members may know more about a local restaurant or the workings of a car they plan to buy, than of the health care services available to them in their local hospital.

The confusion within the health sector itself must also be weeded out to reaffirm the confidence that Irish medical workers have in the system that they are providing, thus, the government must allow the Irish healthcare workers on the ground to own the delivery of care and make recommendations to hammer out the faults in the Irish health maze, for the good of the patient. It will be feasible then, that the notion of an actual Irish solution to an Irish problem may very well come to light for the first time in Ireland's health history.

Appendices

Appendix A

Questionnaire distributed amongst the general public for the purpose of this research.

Health Reconfiguration in North Tipperary- Comm

This survey is part of on-going research into health reconfiguration in Ireland and the effects it has on rural areas. Answers will be used as data for a Research Masters (MLitt) in NUI Maynooth. You will remain anonymous.

1. What is your gender?

   ◯ Male
   ◯ Female

2. What age group are you included in?

   ◯ 18-30
   ◯ 30-40
   ◯ 40-50
   ◯ 50-60
   ◯ 60+

3. What is your local town/village?

   _____

4. Do you work in health care or have you ever worked in this sector?

   ◯ Yes
   ◯ No

5. Where is the nearest hospital to you located with full 24-hour emergency services?

   _____

6. Is there a primary care team in your local area?

   ◯ Yes
   ◯ No
   ◯ Don't know

7.   Where is your nearest emergency room?

_____

8.   In your opinion has access to health care changed since 2006?

◯ Yes
◯ No
◯ Don't know

9.   Define good access to care in your own words:

_____
_____
_____
_____
_____
_____

10. Do you believe that healthcare in your local area is sufficiently accessible (i.e. opening hours of casualty, enough ambulances, doctors, nurses etc)

◯ Yes
◯ No
◯ Don't know

11.   Where is the nearest centre of excellence to you?

_____

12.   In your opinion is this centre running to its full potential, providing a safe and equal service?

◯ Yes
◯ No
◯ Don't know

13.   Have you or any of your family members or friends experienced healthcare in your centre of excellence?

○ Yes
○ No

14.   Do you believe that the above would have benefited more had that care been received in their local hospital?

○ Yes
○ No
○ Don't know

15.   Have you or your family ever had to wait in the emergency room at your nearest centre of excellence?

○ Yes
○ No
○ Don't know

16.   For approximately how long was the length of time spent waiting there?

_____

17.   In your experience how did this compare to a wait time you may have encountered at your local hospital?

○ Longer
○ Shorter
○ Don't know

18.   Who do you believe has been most affected by the change in health services?

_____

19. You are in a bad car accident in Redwood, Co. Tipperary. It takes 35 minutes to get from Redwood to Nenagh Hospital and 1hr 32 minutes to get from Redwood to Limerick Regional (AA Road Watch route planner statistics). Which hospital would you rather be treated in ideally, given the choice?

◯ Nenagh Hospital
◯ Limerick Hospital
◯ Don't know

20. Taking a guess, how many ambulances do you think are allocated to Nenagh Hospital (for patient transport and for emergencies)?

◯ 1-2
◯ 3-5
◯ 6+

21. How many advanced paramedic cars, do you think are allocated to the North Tipperary area alone?

◯ 1-2
◯ 3-5
◯ 6+

22. Where would you rather receive 24 hour acute care, if services were made available?

◯ Local Hospital i.e. Nenagh Hospital
◯ Centre of Excellence i.e. Limerick Hospital

23. Please give a reason for your answer:

_____
_____
_____
_____
_____

Appendix B

Reference material from the HSE which was distributed to local sports and youth clubs in Nenagh.

Mid Western Regional Hospital
Nenagh
Co. Tipperary

Tel: (067) 31491
Fax: (067) 33440

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Memorandum

To : GAA Clubs; Nenagh Youth Club; Nenagh Swimming Pool; NT Soccer Board; Athletics Club; NT Sports Arena; Rugby Club; Boxing Clubs; New Institute; Canoe Club; Basketball Clubs; Taekwondo Clubs; Tennis Clubs; Golf Club; Pitch & Putt Club; Cricket Club; McDonalds Riding School;

CC:

RE: Opening Hours of Accident & Emergency Department, Nenagh General Hospital

To Whom It May Concern,

It has come to our attention here at the Mid West Regional Hospital, Nenagh that the general public may not be aware of the opening times of the Local Injuries Unit (formally known at the Accident & Emergency Department) here in Nenagh Hospital.

In order to provide the best service possible for the people who require our service we have attached a memo outlining the opening hours of the Local Injuries Unit and the services that we provide. We would be grateful in your capacity as Secretary if you would bring this memo to the attention of all of the various local clubs under your remit. Perhaps they could read out the memo at their local meetings.

Yours Sincerely,

John Doyle,
Hospital Manager,
Nenagh General Hospital

Margaret Gleeson,
A/Director of Nursing,
Nenagh General Hospital
28th June 2012

Outside of our opening hours please contact SHANNONDOC 1850 212 999 for assistance

HSE

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Local Injuries Unit

Mid-Western Regional Hospital, Nenagh

Opening Hours: 8am - 8pm, 7 days

Injury Types:
Soft Tissue Injuries

Head injury (fully conscious only)

Fractures of upper and lower limbs

Wounds to limbs, face, scalp

Services:
X-ray

Laboratory

Plaster application

Appointments made for fracture clinic in Limerick

Wound closure (suturing under local anaesthetic/glue)

Splintage of soft tissue injury

Consultant review clinic weekly

Follow up physiotherapy

Dr. Damian Ryan, Consultant in Emergency Medicine & Bridget Hoctor CNM2

Outside of our opening hours please contact

SHANNONDOC 1850 212 999 for assistance

Appendix C

Questionnaire distributed amongst medical professionals in Nenagh and Limerick for the purpose of this research.

Health Reconfiguration in North Tipperary

This survey is part of on-going research into health reconfiguration in Ireland and the effects it has on rural areas. Answers will be used as data for a Research Masters (MLitt) in NUI Maynooth. You will remain anonymous.

24. Are you?

◯ Male   ◯ Female

25. Age Group?

◯ 18-30   ◯ 30-40   ◯ 40-50   ◯ 50-60   ◯ 60+

26. Where is your local hospital?

_____

27. Where is the nearest centre of excellence to you?

_____

28. Is there a primary care team in your local area?

◯ Yes
◯ No
◯ Don't know

29.   Which area of the health sector do you currently work in?

◯ Primary
◯ Secondary
◯ Emergency Services

30. Which area of North Tipperary are you stationed in?

◯ Nenagh   ◯ Thurles   ◯ Roscrea

Other: Please Specify: _____

31. **Define good access to care in your own words:**

_____
_____
_____
_____
_____
_____

32. **Do you believe that healthcare in your local area is sufficiently accessible (i.e. opening hours of casualty, enough ambulances, doctors, nurses etc)**

◯ Yes   ◯ No   ◯ Don't know

33. **Since centralisation, has the level of patient care improved?**

◯ Yes   ◯ No   ◯ Don't know

34. **Do you believe that there are enough emergency vehicles currently in the system**

◯ Yes   ◯ No   ◯ Don't know

35. **Look at the picture. This was used to describe access to care under a centralised system. What comes to mind when you see this?**

_____
_____
_____
_____
_____
_____
_____
_____

_____
_____
_____
_____

36. **Do you believe distance travelled plays a big factor on a patients survival rate or is it down to the emergency care received at the time.**

_____

_____

_____

_____

37. **Have you undergone up-skilling or extra training as a result of new policies**

◯ Yes
◯ No

38. **If Yes, has this resulted in you having to take on more responsibilities?**

◯ Yes
◯ No

Comment:_____

_____

_____

39. **Do you feel that you are providing a better, safer service as part of the new health system.**

◯ Yes
◯ No
◯ Don't know

40. **Do you believe that the new health system is a fair system and provides equal and accessible care to all, as was promised?**

◯ Yes
◯ No
◯ Don't know

41. **Would you encourage others into your area of healthcare?**

◯ Yes
◯ No
◯ Don't know

42. **What have been the benefits of the new system in your opinion, including the introduction of the AP response car system.**

◯ Yes
◯ No
◯ Don't know

43. **How do you feel staff in the centre of excellence will be affected by the large numbers of patients how attending from Co. Tipperary and Co. Clare**

_____

_____

_____

_____

_____

44. Which would you rather for your patient, if services were ideal?

◯ Patients brought to the nearest hospital to be stabilised and then referred if necessary to the centre of excellence.
◯ Patients brought straight to the centre of excellence no matter what condition they are in or the distance needed to be travelled.

Please give a reason for your answer:

_____

_____

_____

_____

_____

_____

_____

Appendix D

Transcripts from the interviews conducted with medical personnel which have been listed according to question.

1. **Do you believe that the new health system which was proposed in 2004/2006 under the Teamwork Report provides better care to patients than the previous system?**

Paramedic A- Nenagh: "Yes."

Paramedic B- Nenagh: "No, I have never supported the movement of acute services to Limerick from Nenagh. The previous system brought care into the community which is needed in a large area like Nenagh. Tipperary is essentially without an acute hospital after Clonmel is downgraded and it will be in the near future."

Consultant- Nenagh: "The care received in the centre of excellence by the patient is excellent treatment but the hospitals should all be linked more closely to provide a better system."

Advanced Paramedic A: "It was a good system in theory but it still has to prove itself."

Advanced Paramedic B: "It promised it in theory and couldn't deliver in reality. We see patients all the time that do need to be stabilized rapidly before even entering a centre of excellence and we in the ambulance service were assured that services would be provided to allow the above to happen every hour of every day. Truth is, the service has not been put in place and will never be. One Advanced Paramedic in a response car serving all of North Tipperary cannot and will not replace critical services at a local hospital. What we need to provide adequate care now is minimum one response car with an Advanced Paramedic on board and local access to an air service with a physician and Advanced Paramedic on board for true time critical patients. The ambulance service in North Tipperary has undergone helicopter care training but we were never given the helicopter and trained pilot which was promised to the area to help."

Nurse A: "No I don't, and the sooner this is realised on a wider scale the better."

Nurse B: "It's a ridiculous system, thought up by people who have never worked in a hospital in their lives- care has decreased on so many levels."

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Nurse C: "I believe the intentions of the new system were good but we had so many problems beforehand that were shoved under the carpet and now we're back to square one again. I do believe that overall care has improved but access to it is more difficult now."

Public Representative A: "I think it was a shocking move for the people of North Tipperary to lose their acute emergency services so no, care has not improved, because we are losing out on basic services."

Public Representative B: "I was in support of the new system and publicly praised it- now I'm not so sure, it may have been better to keep more services in Nenagh so that people wouldn't have to go as far for care- not that Limerick is that far away- but if you don't have a car and have to rely on the ambulance system, with the way it is, it doesn't look good for some."

Public Representative C: "I think that patients do receive better care in Limerick but the care in Nenagh was the same just on a smaller level but it was effective care. There was an accident four years ago on New Year's Eve where four youths barely made it to Nenagh Hospital from the Silvermines- unfortunately three passed away later but they were so critical they would not have lasted to Limerick and were able to be kept alive in Nenagh until their family members arrived. That's how important Nenagh is to our community."

Public Representative D: "I thought it would be good for the people of Nenagh to promote this system and I still believe in it and that patients will benefit once everything has settled into place."

2. **Do you believe access to care has changed significantly in the Mid-West region since implementation?**

*Paramedic A- Nenagh: "*Yes it has, acute care access has changed. Access to more appropriate care for acutely injured or ill patients has improved."

Paramedic B- Nenagh: "Yes I do believe this and believe that it has changed for the worst for all parties involved. Access to care should be easy and little to ask for tax payers. I work for the public emergency services and I cannot guarantee that I can get to you in time. I can treat you and transport you but I can't promise you that you will survive the journey to Limerick."

Consultant: "Of course it has, it was always going to because acute services were being changed, but some services are still the same- I think access to services in Nenagh haven't changed on a wide scale, only those to acute services and this is what has been highlighted over and over again. When acute services were there they were underused and were wasted and now they have gone, there is a higher demand for them."

Advanced Paramedic A: "Yes access has changed but then you have the likes of my job which brings the system to the patient to an extent so patients aren't waiting in local hospitals to be referred- I can make the call for them to go to either during the day and then at night to the centre of excellence- its what's best for the patient."

Advanced Paramedic B: "Yes, patients have to be within an hour's distance maximum from a hospital where there is a team of consultants. In North Tipperary, only a minority of the people are within the distance i.e. people in Nenagh. What about the rest?"

Nurse A: "Yes demand is high for the basic acute services and Limerick can't keep up with the demand and we are left twiddling our thumbs in Nenagh, it isn't fair on us or the patient, especially if they want to be treated locally."

Nurse B: "Access has changed very much and especially at night, we still have patients coming to the door at night with basic injuries that we could treat before but we are not allowed to, anymore."

Nurse C: "It has changed, but possibly for the better- patients have better access to facilities now and a team of medical experts whereas before they had to settle for individual consultants in Nenagh."

Public Representative A: "Access to basic acute care is a disgrace in North Tipperary now, whatever level it was at before, it's ten times worse now. People are being turned away from a hospital who may need urgent care and are told to drive the forty or fifty minutes to Limerick only to wait three to five hours to be seen- if you are even lucky to be there for that short time."

Public Representative B: "Yes it has changed a substantial amount but I am hopeful that the new service may still have some good traits left that patients will eventually see. For the amount of time that was invested in this project, I would hope to see some sort of benefit from it in regards to access, especially for those in Nenagh."

Public Representative C: "Access hasn't changed that much for the people in Nenagh Town or on the Limerick side of Nenagh but has for those on the far side of Nenagh, the extremely rural parts that some ambulances have had difficulty finding in the past. We always get complaints from the emergency services about bettering road signage especially because those often working in North Tipperary or Nenagh, aren't from the area."

Public Representative D: "I believe access is better yes, distance may not be suitable but access to facilities, technology and medical teams has improved greatly"

3. **What is your opinion on the functionality of a local hospital such as Nenagh/Ennis/Clonmel- do you believe that the likes of Nenagh Hospital should have its acute services returned?**

Paramedic A- Nenagh: "No, these hospitals did not manage enough acutely ill/injured patients to be 'safe' for patients in the provision of this role. With the current road network it is very difficult to justify for example providing acute surgical services/anaesthetic services in Nenagh when Limerick is so close."

Paramedic B- Nenagh: "I believe that they were extremely important and should be given services back. I have worked in this service for twenty five years- I have seen the best of the service and now the worst. This is taking the service away from the people and making our jobs harder. When a patient dies in our care, it is us who are answerable, not a consultant, a doctor anyone- Us. And when our support system is gone also- it makes it very hard for us to save people."

Consultant: "It is hard to say really, the services were there and people were using them but just not as much as needed to keep them. It would be nice to see Nenagh functioning again as a local acute hospital but I sincerely doubt it will ever happen."

Advanced Paramedic A: "It was a great hospital and still is, it has just been tweaked to match Limerick. Maybe someday services might be brought back slowly but I can't see it happening if the new system fits better. People just need time to adjust."

Advanced Paramedic B: "I was transferred to Nenagh after reconfiguration was implemented and had never been involved with the hospital before but all I heard was good things about it. It is a shame but maybe implementing a standby team for very critical patients would be the way to go."

Nurse A: "Yes all services should be returned to Nenagh so that pressure is taken off Limerick."

Nurse B: "That is a difficult question because Nenagh was a very good hospital in a very rural areas and offered some services that Limerick did also, so I would suggest only moving back casualty."

Nurse C: *"Maybe longer opening hours in the evening would suffice."*

Public Representative A: "The local hospitals were great hospitals in my opinion and catered to the communities well with the likes of the GAA and other clubs depending heavily on the acute services. The Elderly also depended on it and that is why the services should be reconfigured back."

Public Representative B: "I believe some acute services should be reinstated may be casualty for longer hours until about 10pm so that people feel safer that much more into the evening, but there were lots of acute services in Nenagh which were going to waste and are being well used now in Limerick so those services should stay put."

Public Representative C: "I think hours of casualty need to be reconsidered but nothing as drastic as moving back services just yet because the system needs a chance to work."

Public Representative D: "No, I think that we should try and work with this new system to see what it can offer us before thinking of reversing the situation. This was supposed to be a step forward for the community."

4. **How do you feel changes in the health sector have affected the people of North Tipperary?**

Paramedic A- Nenagh: "They now have a safer system for the provision of trauma care from the pre-hospital to critical care phase of their management."

Paramedic B- Nenagh: "It's a longer distance for a longer wait with just a hope that you will be seen within five hours. I have to wait for a patient to be signed off and given a bed if they are brought in on an ambulance stretcher- if there is no bed, I cannot leave the patient so I cannot cover North Tipperary and that leaves that area with one less ambulance. The point people forget is that there are only three ambulances ever on in North Tipperary at one time. When all those three are taken up with patient transport and waiting at night in Limerick casualty- what happens then for the people who have just been in an accident the far side of Nenagh? Advanced Paramedic Cars cannot carry patients."

Consultant: "Greatly. The distance to be travelled has been off putting for some with people requesting that they would rather go home than go to Limerick. A colleague of mine, working between Nenagh and Limerick, often refers to it as 'to hell or to Limerick'. It's ironic that most patients would probably choose hell. But patients need to realise that there are many services there under one roof, so it takes away the travelling between hospitals for them."

Advanced Paramedic A: "In one word- adversely. One response car trying to serve all of North Tipperary adequately is fantasy. Not only can you not get to every patient you need to in the time frame that they need, but if that patient does need your care then you are out of the picture for two hours or more. Secondly, the skill level of Advanced Paramedics needs to be increased rapidly to that of a Paramedic Practitioner as in the U.K. service. This would allow us to treat and refer most patients at home and not automatically have to tie up A&E services unnecessarily. The huge amount of Geography needed to be covered by one car also increases stress and danger to the Advanced Paramedic and other road users as they are struggling to get to the patient."

Advanced Paramedic B: "I think it is more of an inconvenience for the members of the public rather than the realisation that once centre of excellence is way more beneficial."

Nurse A: "I think this new service has instilled a fear into people- people are afraid now that if they get sick they will have to travel for basic care. Shannondoc is run by General Practitioners in the area after 8pm and is a consolation to some but G.Ps are not consultants and their choice is to refer on even minor cases. I think it's a disgrace that in this day and age in a first world country we have a third world health service."

Nurse B: "It has affected everyone, not only the patients but us also, we are left without emergency cases which voids our skills also which decreases quality of care. I know that this is 'the way forward' and they say care will be better elsewhere but I want to be able to do the best for my patient too."

Nurse C: "Having no acute services and a further distance to travel."

Public Representative A: "The whole system is a mess- it has affected me and the people I represent which is the Nenagh community by forcing them to travel for basic care and expecting them to wait for hours for a service that was on their door step already. Consultant led medicine should be abolished- was it not always supposed to be about the patient?"

Public Representative B: "Yes okay access has changed but for the better- I believe that 99% of the community are actually in favour of this honestly because they are offered more services now in one centre. What is so bad about that?"

Public Representative C: "Access to care is supposed to have become better and I believe that it has in some ways, but they are dealing and coping with this system elsewhere and if it doesn't work down the road, I'm sure the future government will try and fix the system to fit needs then."

Public Representative D: "There have been many changes, some good, some bad but if care is best this way for the patient, is this not the path we should be on- the patient

is the centre of this service like they have always been and people need to be reminded that this system is in place to help the ill, not cause them anymore pain."

5. **If you were able to design a new health service for Ireland, what changes would you make?**

Paramedic A- Nenagh: "The key problem in Ireland is that health care policy is not driven by an evidence base but by the politicians who make changes on what they perceive the electorate will want, while in many cases the public are not adequately educated on health care matters and often see change such as the closure of the acute services at Nenagh as being negative even though it is positive. We also need to now invest on Emergency Medical Retrieval teams such as those in Scotland, these teams are composed on a Doctor with suitable pre-hospital and Anaesthetic education and an Advanced Paramedic and travel to peripheral sites and stabilise and retrieve critically ill patients to central centres of excellence. Take a look at http://www.emrs.scot.nhs.uk/"

Paramedic B- Nenagh: "If we have to stay on the line of this service, I would at least have a consultant working in Nenagh 24/7 in case of critical patients and increase casualty opening hours until about 12am. This would give Limerick the chance to clear its emergency room for all cases after 12am from North Tipperary and Clare. I would put more ambulances on the road with more response cars and train Advanced Paramedics further to be able to stabilise patients at the scene, rather than sedating them and rushing them to the nearest hospital. I would also redesign the ambulances to carry two patients if necessary i.e. have a pull down stretcher, this would allow us to free up extra ambulances for cover."

Consultant: "I would look at providing a few more services at a local level but major research into utilisation would have to be done to assess what we could put in place that wouldn't be at a loss to the system."

Advanced Paramedic A: "I would increase response cars and ambulances on the road and look at seeing could emergency cover be put into local hospitals up until a certain time or have consultants in the local hospital work on an on call system like we do."

Advanced Paramedic B: "As I said before we need to increase the skills of the current ambulance crews and look into getting helicopters into the skies for critical patients. We shouldn't have to rely on the coast guard because they are a separate emergency service to us and likewise Dublin shouldn't have the advantage over the rest of the

country using paramedics trained in the fire brigade. I would eradicate the private ambulance service completely and look then at building the system from the ground up rather than the top down. There are too many managers and not enough frontline staff. I would look at measures to reopen the four wards in Nenagh that were closed and utilise these as patient recover beds for those in Limerick who live in Nenagh and have the consultants that run clinics in Nenagh on a regular basis care for them so as not to block up the centre. A&E would be opened until 12am which was proposed by the emergency services when Hanly and Teamwork were being reviewed so that staff in local hospitals does not lose vital skills. There is a long list of things that I would do but we would be here all day."

Nurse A: "I would put a person from the pit face as the minister for health, who would build the service according to needs which should have been done in the first place. Acute services back to the local hospitals and a separate patient transport system so ambulances are not blocked up."

Nurse B: "I would consult people in the community as to how they would like their service and try give them some relief. I would work with the likes of acute emergency staff in local hospitals- i.e. nurses and consultants and ambulance staff to have their input and would ask emergency staff in the centre of excellence. I would do this as it is only emergency services that need to be changed and then hopefully build a service out of the idea that the patient is the centre and their needs have to be put first."

Nurse C: "I believe the current system is ok but I would increase ambulance staff and vehicles on the road."

Public Representative A: "One thing I would do- bring acute services back to the local hospitals."

Public Representative B: "I would give this system a chance, what we should be doing. There has been too much money spent on it to let it go to waste."

Public Representative C: "Maybe bring some acute services back to try alleviate overcrowding issues in Limerick."

Public Representative D: "Re-address the issues but talk to people on the ground and see what their take is. If the providers are happy then the patients should be. The service should be run by what the professionals deem to be safe."

Appendix E

Location Map

Health Policy History

Nenagh Case Study

Site Location Map featuring Nenagh Hospital (Local hospital) and Limerick Regional Hospital (Centre of Excellence)
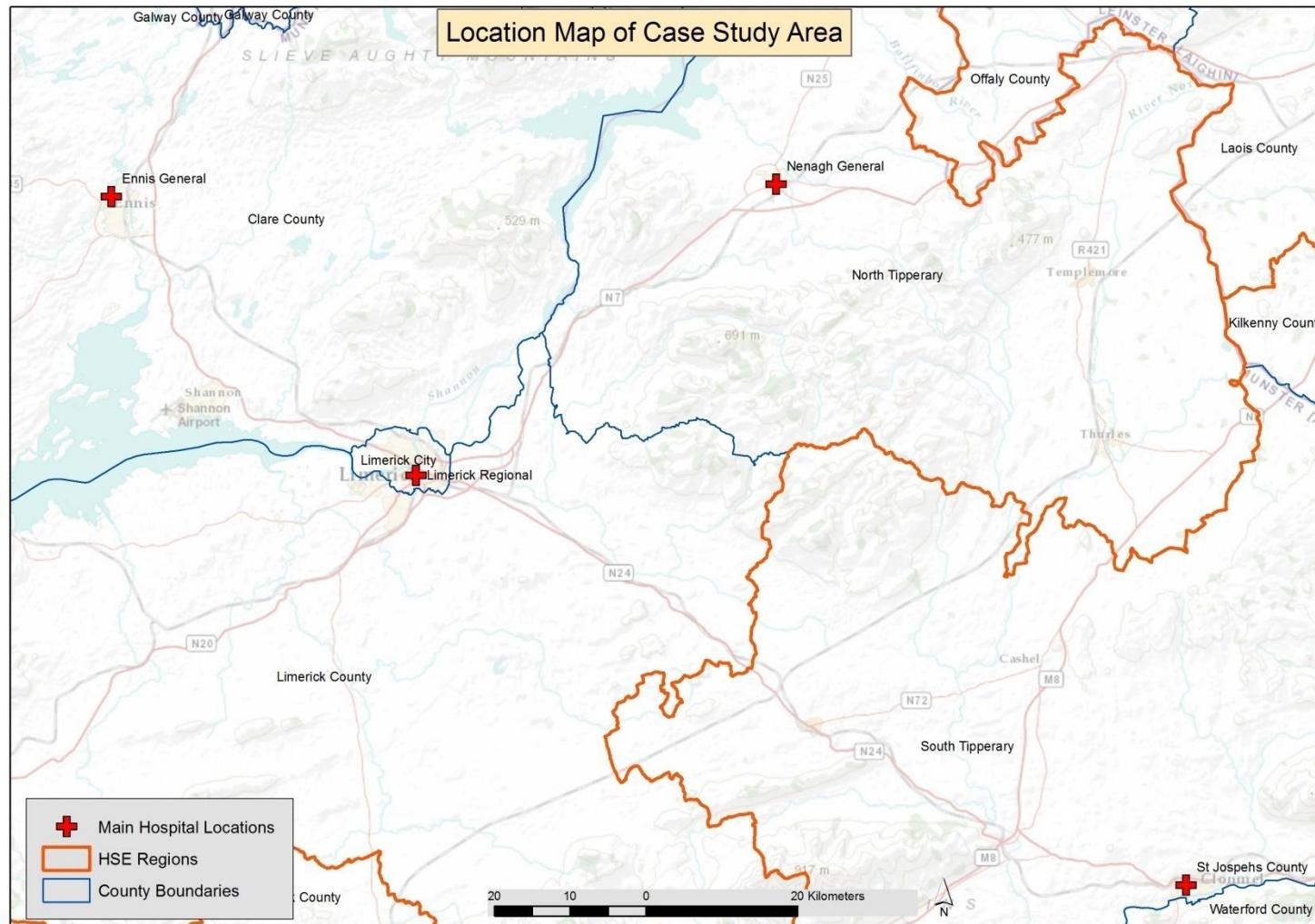
Year	Policy	Geography (System/Service Change)	Local Headlines (Nenagh Guardian 1940-2012)
1940	-		"Nenagh welcomes new County Hospital" (88 beds, 4 surgical wards)
1947	*Proposals for the improvement of Health Services*	Ireland Department of Health becomes an independent body and health system is built on the same grounds as the health system in the United Kingdom.	"New Ministry for Health welcomed to advance health"
1949	*White Paper on Health*	Proposals for a Universal Social Insurance Scheme.	"Dr. Browne says public entitled to best health services"
1953	*Health Act*	County Councils have authority over all hospital services except mental health.	"Hospital Committees necessary"
1957	*Voluntary Health Insurance Act*	Private Health Insurance introduced to Ireland.	"Minister explains new health operation"
1960	*Health Authorities Act*	County Councils are given authority over mental health services.	"Psychiatric Unit a possibility for Nenagh"
1966	*White Paper on Health*	Local Authorities surrender control thus reducing links between local government and health.	"Changes coming in Health Services" "Improvement and Extension in Health Services" "Health Services and their further development"
1968	*Fitzgerald Report*	First reorganisation of services and the development of Regional and General Hospitals.	"Will County Tipperary be without a hospital?"
1969	*The Devlin Report*	Department of Health to take over health policy planning.	"Losing grip on rural hospitals"
1970	*Health Act*	Regional Health Boards established as well as Comhairle na nOspidéal.	"Tánaiste addresses first meeting of Mid Western Health Board"
1972	*General Medical Scheme*	Introduction of Medical Card Scheme and Fee for Service Scheme.	"Fitzgerald will not close Nenagh Hospital as proposed"
1977	*Public Health Care*	Health care standardised throughout all regions.	"Locals demand services be kept in small hospitals" "Outpatients unit extended at a cost of £20,000" "Extra Consultants needed for Nenagh Hospital" "Obstetrical Unit proposed for Nenagh Hospital" "Nothing left for North Tipperary"
1979	*Health Act*	Family Planning Developed.	"Nenagh Hospital Action Committee may be recalled"
1986	*Health- the wider dimensions*	Government proposes to reduce hospital based care. Hospitals closed and beds decommissioned as a result.	"Wards to close soon" "No ward closures for Nenagh Hospital" "Roscrea Hospital to close in June"
1994	*Shaping a healthier future*	Modern approach to monitoring health, Public Health groups established in health boards.	"£1.2 million new acute psychiatric unit for Nenagh Hospital"
2001	*Primary Care- A new direction* *Quality and Fairness*	Proposals for Primary Care Teams to be established. New proposals for the development of quality services in hospitals.	"Acute Hospital- What's in a name?" "The way forward for acute services" "North Tipperary Health Services to get major boost" "Nenagh Hospital Expansion lauded" "Calls to clarify status of Nenagh Hospital"

2002	*Acute Hospital Bed Capacity*	Proposals for increased care in the community and a review of acute bed facilities.	"Six new beds for Nenagh Hospital"
2003	*Health Service Reform*	Creation of the Health Service Executive.	"Hospital faces its biggest threat" "Fears for future of Nenagh Hospital"
2003	*Prospectus Report* *Brennan Report* *Hanly Report*	Proposals for one governing health body for Ireland. Financial management of the Irish health system reviewed. Proposals for new health reconfiguration and centralisation of services in line with EWTD.	"Nenagh Hospital fears" "Hospital gets €150,000 despite imminent closure"
2004	*Health Act*	Governance and Accountability strengthened in the health system.	-
2005	*Health Service Executive*	Transition of health services to one governing health body.	"Go ahead for extension to A&E services" "Hospital Action Group launch new campaign" "Nenagh Hospital under renewed threat"
2006	*Teamwork (First Draft)*	Proposals to reorganise acute care services from small hospitals to regional centres.	"Further bed losses for North Tipp" (Thurles) "Urge for investment in Nenagh Hospital" "€45m spending boost for Tipperary" "Update on Nenagh Hospital Extension for new A&E Unit" "Nenagh Hospital Action Group launch Report"
2007	*Health Act* *Health Information and Quality Authority*	Focus put on elderly care. HIQA established to monitor standards and quality of care.	"Petition launched to stop hospital cuts" "Mixed views on Nenagh Hospital's future" "Concern over bed losses at Nenagh General" "HSE must come clean on hospital plans"
2009	*Teamwork (Second Draft)*	Implementation of proposals begins.	"Local G.Ps to fight for Nenagh Hospital" "Rallying cry for Nenagh Hospital" "Night Vigil for Nenagh Hospital" "Black Monday for Nenagh Hospital" "Reservations about Ambulance Service" "Nenagh loses A&E" "Nenagh Hospital Scanner finally operational"
2010	-	Intensive Care Unit in Nenagh is slowly disbanded.	"Twenty-five beds to go at Nenagh General Hospital" "Hospital Group claims lives now at risk" "No new beds or ambulances for Nenagh"
2011	-	Coronary Care Unit in Nenagh Closed.	"Future of Nenagh Hospital sees no more closures" "Tipp Patients stretch city hospitals to the limit" "Nenagh ICU to close"

Case Study: Nenagh General Hospital before and after health reconfiguration

Hospital	Nenagh General Hospital
	 Source: Google Images 2012
Year Built	1940
Number of beds before reconfiguration	88
Number of wards before reconfiguration	4 [2 Male (One surgical, One Medical) and 2 Female- (One surgical, One Medical)]
Number of Staff before reconfiguration	285 across all disciplines (20 doctors, 130 Nurses) Remainder Support Staff
Services provided before reconfiguration	24/7 Acute Care Clinic (Accident and Emergency) - General Internal Medicine - General surgery - Cardiology - Diabetes/Endocrinology - Gastroenterology - Geriatrics - Urology - Injury - X-ray and Laboratory Sessions from Limerick Consultants: Gynaecology ENT Orthopaedics Paediatrics Ante Natal Rheumatology STD Clinic
Other Services	Ambulance Centre on site, Outpatient Clinic

Reconfiguration Period 2006-Present	
Number of beds 2012	40
Number of wards after reconfiguration	2 Wards (One Male Medical, One Female Medical)
Number of Staff after reconfiguration	120 across all disciplines (10 doctors, 40 Nurses) Remainder Support Staff

Services provided after reconfiguration	*Injuries which can now be treated*: Soft Tissue Injuries only
	   Head injury- fully conscious only
	   Fractures of upper and lower limbs
	   Wounds to limbs, face and scalp
	
	Services: X-ray
	   Laboratory
	   Plaster Application
	   Appointments made for fracture clinic in Limerick
	   Wound closure (stitches/glue)
	   Splintage of soft tissue injury
	   Consultant review clinic weekly
	   Follow up Physiotherapy
	
	Sessions from Limerick Consultants: STD Clinic
	
	*Endoscopy Clinic built in Nenagh but all patients are taken to Limerick for appointments.

Other Services available	Outpatient Clinic and Shannondoc

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