Deloitte & Touche

Value for Money Audit of the Irish Health System

Main Report

DELOITTE & TOUCHE

IN CONJUNCTION WITH
THE YORK HEALTH ECONOMICS CONSORTIUM

VALUE FOR MONEY AUDIT OF THE IRISH HEALTH SYSTEM

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THE DEPARTMENT OF HEALTH & CHILDREN

Deloitte & Touche

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SECTION 1: INTRODUCTION

1.1 BACKGROUND TO STUDY

Value for Money is an essential element of public reporting and accountability. In health, Value for Money not only raises questions about the economy of expenditures and efficiency of activities, but also more fundamental questions as to whether patient outcomes improve over time. Despite the fact that considerable improvements have occurred over the past 50 years in the health status of the Irish population, population health indicators in Ireland continue to compare poorly with our European counterparts.

Recent years have seen considerable increases in the allocation of public funds to the health sector. The 2001 Estimate at £5.4bn compares with the £2.9bn provided in 1997, a mere four years earlier. With the significant increase in investment in health, it is reasonable to ask whether the Irish system delivers good value for money.

The Department of Health & Children ("the Department") as the body with overall responsibility for Irish Health Care services, faces a range of challenges to ensure that the best standards of care are provided and that the objectives of equity, quality and accountability are met. These include:

(i) A reduction in waiting times/lists for services.

(ii) The development of appropriate skills within the sector at Department, Health Board and health agency level.

(iii) Management of medical inflation, particularly that due to new technologies such as new drug regimes, innovations in the diagnosis and treatment of disease, for example advances in transplant surgery and expensive imaging techniques etc. Managing health inflation is particularly complex as it not only requires management of price inflation but also of the impact of the growth in intensity of treatments and changes in demographics.

(iv) The achievement of improvements in management information throughout the health system, through improved data systems and analysis, and the development of performance management systems.

(v) Managing ongoing pressure for expansion in the range of services particularly in relation to personal social services and acute hospital care.

(vi) Ensuring ongoing inter-sectoral co-operation and the appropriate integration of services to achieve health and social gain.

(vii) Management of a growing health service within the finite resources available to the Department.

The Department, as part of the Irish Government's commitments outlined in the Action Programme for the Millennium, signalled its intention to retain consultants to carry out a comprehensive Value for Money Audit of the Health Services in order to determine:

- The trend in resource inputs versus the trend in service outputs to clients over the past ten years;
- The trend in demand for health services over the past ten years;
- The difference, if any, between the trend and the level of contribution to the cost of public and private patients vis-à-vis service levels to each category;
- Differentials in output costs across Health Boards and hospitals including specialties;

1.2 TERMS OF REFERENCE

In April 2000, Deloitte & Touche in conjunction with the York Health Economics Consortium were chosen by The Department of Health & Children to carry out an examination of the health services over the past ten years under the following headings:

(a) Input/finance/comparisons
- Review of financial and staff inputs against the programmes delivered.
- Comparisons between delivery of Health Care in Ireland and in other countries including demographic issues.

(b) Evaluation issues - outcomes
- Review of outcomes against objectives.
- Examine and comment on whether the health services are being delivered in the most economic, efficient and effective way from a customer perspective in terms of health and social gain.
- The effectiveness in delivery of Health Care programmes.
- Comment on the investment in health services and state whether value for money has been achieved against objectives set.

(c) Policy Background
- The policy background set against the political, economic and social environment.
- The changing face of Health Care including the impact of new Health Care technology on delivery of Health Care.

(d) Service Integration
- Identify barriers to the delivery of a quality health service.
- Identify gaps in the delivery of health services.
- Carry out a critical examination of the interaction of all the health services including general practitioner, acute hospitals, primary and community health services.
- Point out likely future strategic direction for Health Care in the light of research carried out.

(e) Individual Policy Issues
- Examine and comment on issues arising such as waiting lists, Accident & Emergency services and OPD services provided in acute hospitals.

(f) IT issues
- examine whether the current management information systems are sufficiently developed to provide ongoing accurate and timely information and if not state how this objective is to be achieved.

1.3 ACKNOWLEDGEMENTS

We would like to acknowledge the considerable assistance given to us by those interviewed during the wide ranging consultation process undertaken as part of this study, details of whom are set out in Appendix I.

SECTION 2: BACKGROUND TO THE IRISH HEALTH CARE SYSTEM

2.1 INTRODUCTION

Any examination of Value For Money in the provision of Irish health services in the 1990s requires an understanding both of state of the services at the start of the decade and of the factors which had a significant bearing on costs in Health Care during the ten years.

2.2 THE IRISH HEALTH CARE SYSTEM IN THE 1980S

Whilst the period from 1990 to 1999 is the principal focus of this report, any assessment of development in the Irish Health Care system during the 1990s needs to be set in the context of the significant and often traumatic change that occurred in the system during the 1980s.

Irish Governments during the 1980s were faced with a series of difficult economic conditions. Unemployment levels were consistently high throughout the decade peaking at 17% of the labour force in 1987. The National Debt to GNP ratio reached 131% during the period and Governments were forced to borrow to meet day-to-day current expenditure. GNP growth averaged a minimal 0.2% per annum during the period 1980 to 1986.

In the late 1980s governments adopted policies of fiscal rectitude and made significant cuts in public expenditure to restore order to the public finances. From 1986 to 1989, current expenditure fell by 10% of GNP. The reductions in public expenditure had the effect of reducing the Exchequer Borrowing Requirement towards the end of the decade and creating an environment of modest economic growth in the period 1987 to 1989.

The health sector, as a large public spending department, was one of the hardest affected by the severe cutbacks in expenditure during this decade. By 1986, it is estimated that health spending was some 8.5% lower than in 1981 taking into account inflation, the impact of demographic change and advances in medical technology. Net non-capital public expenditure on health in the 1986 to 1989 period remained virtually static at c.£1.2bn per annum.

Significant rationalisation of the Irish hospital system also took place at this time, with the closure of a number of voluntary and Health Board controlled hospitals. The most significant impact of these closures can be seen in the reduction in bed capacity in the Irish Health Care system in the period 1983 to 1990. During this decade, acute inpatient bed numbers in public hospitals dropped from some 15,163 at the end of 1983 to 11,766 by the end of 1989, a reduction of 3397 beds or 22%; this number remained virtually unchanged throughout the whole of the 1990s. Approximately 2000 of the reduction in bed numbers occurred in the Eastern region, representing 29% of the beds in the region. The biggest part of this reduction occurred between 1986 and 1988 at the time of the stringent budgetary cutbacks, when 2200 beds were taken out of the system in a short period. These bed reductions took place against a background of Ireland having an already low ratio of beds/1,000 population. By 1990, Ireland had an average of 3.9 inpatient beds per 1000 population, less than half the EU average at that time of 8.2. Within the EU, only the UK had a lower ratio at 2.3 per 1000 population in 1990. Significant reductions in numbers employed in the system arose in the latter part of the 1980s – 57,275 people were employed in the health service in 1989 compared to 64,889 eight years earlier.

In retrospect, it can be seen that the health sector found it difficult to adjust to the significant reductions in capacity and expenditure constraints. Boards began accumulating significant levels of debt to fund the provision of services.

By 1988 accumulated overruns had risen to in excess of £85m. By 1994, a once off cash injection of £100m was required to pay off all outstanding debt, a residue of funding difficulties in the late 1980s.

Table 2.1 sets out in summary form Gross Public Expenditure on health for each of the years 1980 to 1990. The following points are of note:

- Health expenditure in 1980, valued at 1989 prices, was some 4% higher than the health budget in 1989, representing a real decrease in funding for the service.
- From 1984 to 1990, the average increase in annual expenditure was a mere 3.5%, a situation that prevailed into the early part of the 1990s. Against this background, it is clear why the system had difficulties in operating within the resources made available to it.
- 1988 represented a real decrease on the previous year. The situation was exacerbated by the fact that the health system in 1988 was expected year on year to recoup some £20m from its Estimate to deal with outstanding funding deficits from prior years.

Table 2.1

YEAR	GROSS EXPENDITURE	% INCREASE IN ESTIMATE ON PRIOR YEAR	% OF GNP
	£m	%	
1980	767	38.8%	8.4
1981	895	16.7	8.2
1982	1,048	17.1	8.3
1983	1,144	9.2	8.3
1984	1,211	5.9	8.1
1985	1,302	7.5	7.8
1986	1,361	4.5	7.7
1987	1,382	1.5	7.2
1988	1,380	(0.1)	6.8
1989	1,470	6.5	6.6
1990	1,491	1.4	6.3

During the 1980s Gross Public Health Expenditure fell from 8.4% of GNP to 6.6% in 1989, a reduction of one fifth. This reduction took place when other developed countries were significantly increasing their expenditure on health; indeed the OECD found that accumulated spending on public and private Health Care in Ireland over the period 1980-1993 dropped by some 23% compared to an average increase of 24% in thirteen other OECD countries during the same period.

The experience in health funding in Ireland in the latter part of the 1990s is markedly different to that prevailing in the 1980s. Significant advances have been made in providing funding for a wide range of developments in all service areas, with specific funding made available in respect of national health strategies such as cardiovascular, cancer, waiting lists, cardiac, and mental handicap.

During the 1980s no such funding arose; indeed the health system had to rely on a significant build up of debt to simply maintain an acceptable level of service in a highly resource constrained environment.

No examination of value for money in the Irish health system in 1990s would be complete without an understanding of the circumstances and context in which the system found itself in the latter part of the 1980s.

The stringent economic cutbacks and significant constraints on health expenditure spawned an era of minimal service development and significant reductions in bed capacity, a factor (as we point out later in this report) which continues to impact on the effectiveness of the acute hospital services to the current day.

2.3 CHRONOLOGY OF KEY DEVELOPMENTS IN THE 1990S

A number of key developments took place in the Irish Health Care sector in the 1990s:

1993: Comptroller & Auditor General (Amendment) Act (No. 8, Section 6), which imposes responsibilities on the C&AG for the audit of Health Boards and certain voluntary hospitals. The C&AG is entitled under the legislation to carry out such examinations as he considers appropriate to ascertain whether and to what extent the resources have been used economically and efficiently. The C&AG is also required to assess the effectiveness of the systems, procedures and practices employed by participants in the health sector.

1994: Publication of "Shaping a Healthier Future" a comprehensive strategy for the Irish Health Care sector for the 1990s.

1994: Refinancing of Health Agency debt of £100m to clear deficits built up in Health Boards over a period of years.

1994: Health Insurance Act, opening up the health insurance market to competition.

1996: Health Amendment Act (No 3) , introducing accountability for service delivery and funding for Health Boards, and introducing requirement to prepare annual service plans.

1996: "Cancer Services in Ireland", the national cancer strategy published.

1998: "Working for Well Being" published.

1999: "Building Healthier Hearts", the national cardiovascular disease strategy published.

1999: Health (Eastern Regional Authority) Act passed, establishing the Eastern Regional Authority ("ERHA").

1999: Publication of White Paper on Private Health Insurance

1999: Publication of Mental Health Bill

2000: Publication of National Children's' Strategy

During the decade, the health sector was impacted by the Strategic Management Initiative process, the passing of the Public Services Management Act 1997, and the impact of partnership structures under various agreements between government and the social partners, the latest of which, the "Programme for Prosperity and Fairness" established further elements of a changed programme for the health sector.

2.4 FACTORS IMPACTING ON COST ESCALATION IN HEALTH

During the 1990s, public health expenditure in Ireland increased year on year, from a starting position of £1.5bn to £3.8bn by 1999. By the time of the 2001 Estimate, public health expenditure had risen to £5.4bn. Between 1994 and 1999 the annual average increase in public health expenditure was 11%. This compares to an average general inflation rate of c.2% in the period. Some of the increase in expenditure is attributable to service developments, but a significant part of the increase is due to factors driving up the costs of Health Care without increasing the levels of service provision.

The experience, globally, in the 1990s was that health inflation significantly outstripped general inflation. Because health is a complex and rapidly changing environment, health inflation is not simply a measure of the difference between purchasing a similar set of goods or services over time. A wide range of factors influence Health Care costs, the principal of which are as outlined below:

2.4.1 Price Inflation

Medical goods and services are subject to price inflation in common with the wider goods and services available in the economy. Statistics from the CSO indicate that, in general, the prices for private medical goods and services have increased annually by c.3% over and above economy wide consumer price inflation in the 1990s. Medical price inflation thus explains part of the increasing costs in the provision of Health Care.

2.4.2 Impact of Technology

Health Care, arguably more than any other sector, has been impacted by significant advances in technology. Generally, advances in technology bring with them significant increases in the costs of equipment and the treatment costs of patients. New drug therapies, which offer the prospect of significant improvements for patient outcomes, place increased budgetary pressures on hospitals and on general medical services in the community. Furthermore, technology improves the diagnosis and treatment of illness. More complex surgery and expensive imaging techniques add to the costs of meeting the resultant increased patient expectations in Health Care.

2.4.3 Demographics

Changing demographics represent a significant influence on demand for Health Care. The impact of medical technology means that people now live longer, while the incidence of illness still remains the same. The increasing number of elderly in the population as a whole places increasing demands on Health Care systems. Medicine also prolongs life with the result that Health Care systems must provide for increasing numbers of chronic sick requiring intensive treatment. As the proportion of elderly grows in Ireland in the years ahead, a direct consequence of our somewhat unique demographic profile, cost pressures on Health Care systems are likely to increase.

Further demographic influences on the costs of providing Health Care include an increase in the birth rate, (in evidence in the latter part of the 1990s) and an increase in the total population. A reduction in historical levels of emigration, together with the significant increase in non-nationals resident in Ireland in recent years, has added to the increasing population.

The change in demographics in the 1990s has placed further cost pressures on the Irish Health Care system.

2.4.4 Patient Expectations

Patients increasingly demand the highest possible standards and quality of care from health service providers. This influences both their demands for the most technologically advanced methods of treatment and also the quality of the physical surroundings in which care is provided. Further cost pressures arise in meeting these increased patient expectations. In future, the costs of implementing quality programmes in hospitals through accreditation, clinical audit and clinical governance will place further cost pressures on the system.

2.4.5 Legislative Change

The health services are being increasingly affected by the increased costs of meeting new legislative requirements, for example in relation to health and safety, changes in employment practices, minimum wage legislation etc. The introduction of the 48-hour week for NCHDs will result in increased costs to the health service over time. The increase in medical litigation is also increasing costs. These cost pressures have been further accentuated by the need for the health services to compete for staff in a buoyant economy.

The above factors result in increasing upward pressures on costs in Health Care provision. The factors identified are not unique to Ireland. Some or all of the above factors face governments internationally in providing for the Health Care needs of their population.

A recognition of these factors, and an acceptance of the fact that their influences on costs are difficult to control, is important in any value for money assessment of health systems. What is clear is that in improving value for money in any health system, it is necessary to gain a more in-depth understanding of the impact of each of the cost drivers identified above. Such an understanding is fundamental to being able to plan future service delivery, particularly (as this report advocates) in the context of a multi annual planning framework.

PART 2
FUNDING OF HEALTH CARE SYSTEMS

SECTION 3: HEALTH CARE FINANCING

3.1 OVERVIEW

This Section examines the funding of Health Care internationally, the method of raising revenue and the effect on different parts of the Health Care system. The report uses information gathered from published sources along with academic and consulting experts from the countries concerned to provide a more detailed picture of the current state of their health systems. The report compares the experiences of Ireland in relation to funding mechanisms to those in a selected group of OECD countries.

Australia
Belgium
Canada
France
Germany
The Netherlands
New Zealand
Sweden
Switzerland
The United Kingdom
The United States

Section 3.2 provides an overview of the factors that underpin Health Care finance and expenditure in developed countries. In this outline, a number of issues are explored which have led to particular models of both Health Care finance and payments for health services being adopted in individual countries

Section 3.3 compares different methods of raising revenue to finance the Health Care system: tax based financing; social based insurance mechanisms; voluntary subscriptions to private insurance schemes; out of pocket payments; life time savings accounts in the different countries. In addition it compares the overall level of financing in the different countries. Social insurance-based schemes are considered including those in France, Belgium, the Netherlands and Germany. The similarities and differences between these schemes are discussed as well as recent trends in health policy.

In Section 3.4, we summarise the different types of user charges on first contact, for referral services and for pharmaceuticals for each country. Private health insurance is also discussed as a predominant method of financing Health Care. The equity and access problems of using private insurance as the main funding mechanism are discussed.

Section 3.5 considers different institutional structures in Health Care delivery. Five different models are considered.

- Direct payment to providers by government;
- Two tier government models;
- Decentralisation to regional health authorities/Boards;
- Social Insurance models;
- Private health insurance.

The aim of the section is to consider the effect that different institutional structures can have on different aspects of the system. Four key features are considered for each institutional model:

- Cost containment;
- Service planning;
- Service integration;
- Responsiveness.

Appendix II takes each comparator country individually. The financing of Health Care in 1997 is given, as are indicators for the level of health, the equity of the system, the responsiveness of the system, the cost of the system and an overall ranking for the health system. In addition, for each country there is a brief description of the reforms that have taken place in the 1990s and the current policy situation.

Appendix III compares the levels of Health Care employment across the different comparator countries.

3.2 THE FACTORS THAT IMPACT HEALTH CARE FINANCE

This Section provides an overview of the factors that underpin Health Care finance and expenditure in developed countries.

3.2.1 Health Care and Markets

In most developed countries governments have significant involvement in both the financing and delivery of Health Care. Unlike most markets where only those people able to afford a product, can buy it, with Health Care, most governments have intervened to ensure that Health Care is available for everybody. In addition, with many products consumers can shop around to find the best value for them. With Health Care, consumers only have limited information about which product they need. By intervening in the market through both regulation and public ownership, governments are able to achieve social policy goals such as fairness and consumer protection.

In this outline of the issues, we examine a number of factors which have led to particular models of:

- Health Care finance;
- Payments for Health Care services.

Subsequent sections of this report provide more detailed data and analysis on finance in the countries targeted by the study.

Money to fund Health Care is raised by taxes, social insurance and private insurance. Payments out-of-pocket also occur but typically make up a small part of total spending. Health Care is paid for under a range of models including:

- Public and charitable hospitals and services providing free or subsidised services through employed or fee-earning clinical staff;
- Private sector organisations including hospitals and pharmacies;
- Clinical professionals working independently, either full or part time, usually for salaries and fees.

Most provision is not paid for directly by the consumer.

The providers may be paid:

- By fees per patient or other unit of activity (for example day in hospital, test given) paid to hospitals and individual clinicians, including fees set prospectively rather than for expenditure incurred;
- By capitation funding, based on the population to be served rather than the level of service;
- By block grants (and broad contracts which are not very sensitive to the volume of services) covering a range of services and service levels;
- By payment individually to clinical providers as salaries or fees.

Individual clinicians may work in a corporate environment and receive a salary or they may receive fees per item of service or via a capitation system linked to patients covered for services. The latter model is particularly common in primary care.

Although elements of fund raising and payment tend to go together, it is possible to find examples of different combinations within the same country. For example, US health maintenance organisations use annual capitation and block grants to pay for services while other US insurers pay prospective fees.

Health Care finance has developed outside simple markets for several reasons:

- Good health is seen as an important social goal, encouraging government intervention.
- Illness is unpredictable, leading to insurance as a preferred method of funding uncertain, expensive Health Care for more complex problems (for example workers' friendly societies, insurance funds, commercial insurers);
- Commercial insurance leads to risk selection, which increases premiums charged to the sick. This tends to make Health Care less affordable for the sick, if there is no alternative to commercial insurance. Hence governments tend to provide alternatives though they may have limited eligibility or coverage;
- Patients as consumers have less knowledge than providers of Health Care so regulation of providers is required to prevent exploitation and over-payment by vulnerable patients;
- Suppliers of health services have the capacity to increase use of services, recommending additional treatments in their role as the patient's agents. Financial arrangements, including capitation payments and provider monitoring of various kinds, have developed to meet this imbalance between suppliers and consumers;
- Once insured, consumers have an incentive to use services even when they offer little benefit. User charges to offset this can have the counter-effect of reducing the demand for beneficial treatment.

The current pattern of provision reflects a number of historic factors. For example, European social insurance schemes developed during the 20th Century from schemes to protect workers from ill health. Such social insurance schemes consequently retain many features linked to employment.

Payment systems have similarly developed along non-market lines:

- In much of Europe, but also in the US, Australia and Canada, the expansion in medical knowledge in the 18th and 19th centuries led to the charitable founding of many "voluntary" hospitals, where doctors provided free care for the poor (some charged medical students for studying with them). In some countries, these have been more easily shifted to a mix of public and charitable funding than to purely commercial operation;
- Public hospitals developed in some countries to house the indigent poor, as part of welfare plans. These hospitals were likely to be less technically advanced and have fewer medical staff;
- General practice outside hospital has developed at different rates in different countries, partly because it was seen by hospital-based medicine as a source of competition. Direct access to specialist, rather than GPs, is now typically linked to the finance and payment system. Direct access is usually linked to a fee per consultation.

Internationally, Health Care systems exhibit features of piece-meal reform. The UK is the best example of a major overhaul at one time, with the creation of the NHS in 1948. Even this radical change programme was forced to compromise on private practice and the independent status for GPs, a last minute change to secure the commitment of British doctors. As a result, a staunchly public Health Care system has many of its staff also carrying out private practice. There are about 20,000 privately practising specialists in the UK, nearly all of whom also have NHS consultant contracts (Laing, 1999).

In Australia, a substantial private insurance system has had to respond to the introduction of universal public access to Health Care under Medibank and then Medicare since the 1970s. Together with controls on insurance against fees above a pre-set schedule, this led to a significant decline in private insurance in the recent past. This is now being offset by:

- Substantial subsidies for those taking out insurance;
- Tax penalties for higher income groups without adequate private health insurance;
- Moves from simple community rating to age-adjusted community rating, with younger joiners enjoying discounts on premiums throughout their membership.

In Australia, the reforms are addressing individual parts of the system, rather than being part of a comprehensive overhaul.

In Europe, a range of measures have been introduced during the past twenty years, in an effort to contain the rising costs of predominantly fee-for-service medicine, without engaging in wholesale reform of the social insurance systems.

In the USA, the development of Health Maintenance Organisations, initially by employers aiming to control the costs of health insurance, changed the US Health Care market but did not displace older insurance models.

(Health Maintenance Organisations (HMOs) are effectively comprehensive health service organisations in miniature, providing directly or via contracts with other providers for all their members' health needs, in return for an annual membership fee. HMOs typically manage patients' care and their access to services in order to balance quality of care with cost. The success of this balancing act is the subject of continuing debate in the US.)

The Irish health services are funded primarily from general taxation and the entire population is entitled to a core publicly funded service, including public hospital in-patient services. There is, however, a mix of public and private care in the Irish health services which is reflected in the fact that voluntary private health insurance is an established part of arrangements used to meet the costs of hospitals services. While approximately 45% of the population is covered by private health insurance, the total annual expenditure under such plans is small relative to public spending on health services. Approximately three quarters of health spending is financed by the state and one quarter comes from private sources. This private expenditure mainly comprises of household expenditure on GP visits and pharmaceuticals, and health insurance companies' spending on private hospital care (Nolan, 2000).

3.2.2 Principles of Health Care Finance

Health financing models vary from country to country and reflect different characteristics:

- A desire by society/government to protect the poor from illness by subsidising their care is a universally accepted principle.

  Countries differ in their stance on the protection of other groups from the consequences of ill health and in the way the cost of Health Care is spread across different groups.

- Some countries, for example UK, Australia, Canada provide universal access to tax-funded public Health Care at little or no direct charge;

- Some countries have schemes for specific groups, such as those for the elderly and long term care in the Netherlands, or to target child health;

- All countries (except Canada) have some private insurance linked to medical risks. However, in several countries this is regulated so that those at high risk of illness do not pay more;

- In the USA, private insurance is the only alternative offered to those not covered by directly subsidised schemes for the old and poor.

The observable social/governmental principles that underpin these different models are:

- A desire to give all citizens reasonable access to Health Care;

- A desire to protect better off people from becoming poor, due to Health Care costs;

- A continuing preference in many countries to do this outside the direct public sector, by the use of insurance of some kind;

- A desire to reduce, or at least avoid increasing, the levels of taxation.

A related principle is that citizens should, where they have the means, make provision for their own care and not rely on the state. However, while this may be an appropriate principle for say education, it overlooks the point that any insurance-based system involves relying on others, rather than on one-self. Insurance and tax-funded public services are two ways of doing this.

Protection is achieved by sharing the cost of care for the sick between the sick and the healthy. Conventional private insurance does this to some degree. However, the sick may face rising insurance premiums as their condition deteriorates. They will certainly find it difficult to change their insurer.

Protection against risk discrimination can be achieved in several ways:

- Using constant premiums, or at least premiums not linked to risk of ill-health (for example community rating, risk adjustment financial transfers between insurers);
- Income-related tax payments;
- A mix of the two, for example when sick funds receive public subsidies.

Health Care finance in many countries reflects their history. Multiple sick funds, which derive from employee schemes in the early 19th Century, may simply duplicate their services and their bureaucracy. They may offer some benefits through the need to compete for members though standardisation of plans, to prevent adverse risk selection, reduces this. Some observers have argued strongly that competing insurers offer significant benefits (for example Hoffmeyer and McCarthy, 1994). Critics argue that the inefficiencies of multiple funds cannot be wholly avoided (Culyer, 1995). Sickness funds or insurers have the advantage of separating (or appearing to separate) government from Health Care finance. In practice, governments often subsidise social insurance in such countries, either through tax relief or direct payments to support sickness funds. Governments are also likely to find it difficult not to help sickness funds facing bankruptcy. More generally, the importance of Health Care for the public at large makes it difficult for governments to avoid becoming involved.

Health insurance has the advantage that it is not seen as a part of general taxation, which appears only to take from citizens. Rather, it is an earmarked payment for a service that citizens are likely to value. This may reinforce public solidarity more than a tax-financed system. But it is possible that this solidarity will be in support of a lower cost insurance system serving mainly the better-off, the younger (that is, the work force) and those in continuing employment. The risk is that it will erode solidarity and commitment to tax-financed care for older, sicker and unemployed groups.

It is interesting to note the diversity of mechanisms and principles that are found in each country. For example, US policy is widely seen as flawed, outside and inside the US. It fails to prevent high Health Care costs falling on those who are near-poor and those who lose their insurance due to their health state and associated loss of their jobs. But in the UK, elderly people are in a similar situation when needing long term care. They must effectively join the near-poor, by spending their own money on long term care until only £16,000 remains. Only then do they qualify for the safety net service (though their partners are now protected while alive from forced house sales). There has been public discontent with the funding arrangements for long term care. In July 2000, the British government announced reforms to long-term care for elderly people as part of "The NHS Plan". Subject to a decision from parliament, nursing care provided in nursing homes will be free from October 2001. From April 2001, for the first three months from admission to residential and nursing home care, the value of a person's home is being disregarded from the means testing rules.

Community rated insurance, which does not discriminate against the sick, has the potential to achieve principles of social support and also reduce the demands on public services. Risk-rated insurance can also reduce demands on public services but may discriminate against the sick. But insurance has drawbacks when it is linked to employment, as it often is. Employment provides the money to pay premiums and may lead to membership of specific occupational funds. The drawbacks are:

- Employment is a test of health to some extent, in that the very sick may be unable to find work. This means that some risk discrimination is taking place;
- Serious illness can often lead to loss of employment. This in turn may lead to loss of health insurance and subsequent reliance by the sick on public services.

Community rating also protects the relative level of premiums, not the absolute level. As Health Care costs rise, changes in membership may make health insurance less sustainable, even with community rating.

3.2.3 Paying for Services

The key factor controlling cost inflation is the payment mechanism. Insurance payment is generally linked to fee-for-service and multiple payers. Tax funding is more often linked to fewer payers, capitation for primary care and block grants or cost and volume controls for other services. Some models, for example US Health Maintenance Organisations come closer to the public sector model of payment, using control of payments and employment of salaried clinical professionals to control total expenditure.

Table 3.1 summarises the mix of Health Care financing and payments for services delivered in different systems. It has two axes, for finance and payment:

- The Private/Public Finance scale shows the variation from private market insurance through to tax funding, via social insurance;
- The Payment scale shows the variation from fees for services provided, which may be set by the market or controlled by payers, through to public spending methods such as capitation, block grants and lump sum payments.

Table 3.1 Private and Public Health Care Finance and Payment – International Examples

	Paying for Services		
	Fees per item		**Block Grants + Capitation**
Source of Funds	**Market fee**	**Controlled Fee**	
Market Insurance	US Private Insurance	VHI Australian Private Insurance	US HMO
Social Insurance		France Germany	Dutch Primary Care
Taxation		Australian Medicare	UK NHS

US private health insurance occupies one extreme position. Community rated private insurance, including VHI and Australian systems, is less like wholly private finance because of the adjustment for premiums to prevent discrimination against sicker citizens. VHI also has some caps on its' payments to hospitals, again moving from a pure private market approach of wholly fee-for-service.

Employment-related schemes with, in some cases, earnings related contributions, are a further move towards public financing. European schemes therefore come closer to publicly financed schemes though they have a substantial element of fee-for-service.

Each method of payment has advantages and drawbacks. Fee-for-service is likely to increase total spending because it gives an incentive to providers to do more, for example to treat more patients, or to keep patients in hospital longer. Where there are multiple payers, they may also have less power over providers. Alternatively, if they fear losing members, competing insurance plans may prefer to settle inflated claims rather than dispute them.

In contrast, a tax-financed health service with capitation and block grant funding of providers has strong control of staff costs and total spending. Critics argue that it puts too much emphasis on cost control, due to the need for fiscal control of what is a major item of public expenditure.

Fee-for-service typically goes with insurance finance. Insurance gives the individual a sense of personal protection and rights to treatment as required, for those services for which insurance cover is provided. Fees are increasingly set prospectively, so that the insurer has a clear idea of the cost of services rather than having to reimburse the costs actually incurred by providers. This gives efficiency incentives to providers.

US Health Maintenance Organisations have moved US Health Care to a managed care approach, which limits the patient's freedom of choice. This has attracted considerable criticism though they retain large numbers of members. But in general, health insurers pay out fees for individual services provided. This is likely to put up expenditures, for example because newer, more expensive investigations and treatments are introduced faster.

Payment for primary care providers may differ from those for secondary care. This is because primary care is less likely to require a very high level of medical time spent with patients. Patients needing complex care are referred to hospital. Demands for frequent visits can be largely managed and controlled by GPs. Capitation funding, with simple adjustments for age group and gender, can therefore provide a relatively stable basis for funding primary care.

While some patients may use much more of the GPs time than the average patient, the variance in cost-per-patient is much larger in secondary care. Capitation funding can only cope with this if there is a more sophisticated risk adjustment built into the capitation approach for secondary care. Otherwise, hospitals in higher risk areas would either go bankrupt or fail to meet local needs. This is used in for example the UK to provide funds to health authorities. They pay out through capitation to GPs and a mixture of block contracts and variable contracts to secondary care that shift only a limited part of the risk of higher utilisation onto suppliers.

In the sections that follow, we present comparative information on Health Care financing, payment systems and the flow of funds in each of the countries examined.

3.3 HEALTH CARE FINANCING

3.3.1 Methods of Raising Revenue

There are five main mechanisms for raising revenue to finance Health Care. In Table 3.2 each country has been shown under the main financing mechanisms. However, no country relies solely on one method of raising revenue, and many use a variety of methods. For example, in Ireland there is both tax based funding and controlled market insurance. Table 3.2 also lists the main and supplementary payment method for each country. The different types of revenue raising mechanisms can be described as follows:

Tax based financing: Health Care funds are raised through general taxes or "ear-marked" payroll taxes. Funds are transferred to regional authorities that act as third party payers by financing health service providers.

Social insurance based mechanisms: Membership of social insurance programmes, (often called sickness funds) independent non-profit organisations, which are compulsory for certain groups of the population.

Controlled market Insurance: Private companies provide insurance through a market but with regulated premiums, for example using community rating.

Private insurance based: Competing private insurance companies raise Health Care finance using risk-rated premiums.

Out of pocket payments: Payments made by individuals directly.

Table 3.2: The Mechanisms of Raising Revenue for Health Care

Financing mechanism	Main revenue raising mechanism	Supplementary revenue raising mechanism
Tax based financing	Ireland, UK Canada Australia Sweden New Zealand	The United States (elderly/children) Belgium Germany France
Social insurance based mechanisms.	Belgium Germany France The Netherlands	-
Controlled market insurance	Switzerland (previously risk related private insurance now community rated)	Ireland (VHI) Australia The Netherlands (wealthier citizens are not covered by social insurance)
Private insurance Free Market	The United States	UK New Zealand Canada (Mainly Pharmaceuticals)
Out of pocket payments	-	All

Table 3.3: Comparison of Total Health Expenditure Per Capita $US Purchasing Power Parities (PPP)

Country	Total expenditure per capita on health in 1990 in $US PPP	Total expenditure per capita on health in 1997 in $US PPP	Average annual % growth between 1990-1997	Total expenditure per capita on health in 1998 in $US PPP	Average annual % growth between 1997-1998
Australia	1320	1909	6	2043	7
Belgium	1247	1768	6	2081	18
Canada	1695	2175	4	2312	6
France	1539	2047	5	2077	1
Germany	1602	2364	7	2424	3
Ireland	759	1293	10	1436	11
Netherlands	1326	1933	7	2070	7
New Zealand	937	1357	6	1424	5
Sweden	1492	1762	3	1746	-1
Switzerland	1760	2611	7	2794	7
United Kingdom	955	1391	7	1461	5
United States	2798	4095	7	4178	2

Source OECD 2000

When comparing total Health Care spending there are a number of factors that have to be taken into consideration in order to make a fair comparison. Firstly, as different countries have different population sizes, it is useful to divide total Health Care spending by the number of people in the population; this gives the total Health Care spending per capita. (A further refinement, not carried out here, would be to adjust for demographic profile. Ireland's comparatively young population is a contributory factor in explaining differentials between countries.)

The second is that each country uses a different currency. Therefore, in order to compare between countries one needs to use the same currency unit: in this case we have used US dollars. However, by simply comparing expenditure in $US dollars we would not reflect what could be bought in the various countries. $100US in Australia, for example, can buy more than $100US in the UK. Secondly, exchange rates are often used as an economic policy tool to influence capital movements. (The Euro has changed this but the data here pre date the Euro).

Due to the problems of using straight exchange rates we have used purchasing power parities instead to compare Health Care expenditure per capita in table 3.3. The conceptual framework for this method is to make comparisons based on real volume measures of what one could actually buy comparing a similar basket of good across countries.

Table 3.3 shows that in Ireland in 1990, compared to other comparator countries, less money was spent on health per person than in other countries. However, between 1990-1997 the average annual increase in expenditure on health was 10%, higher than any other comparison country over that time period. Between 1997 and 1998 again the annual increase in expenditure was high at 11% growth. Therefore, although at the beginning of the decade Ireland was behind the other countries in health spending, throughout the decade health spending has increased and Ireland now spends similar amounts to other countries such as the United Kingdom and New Zealand. Given that health spending has doubled over the past five years, comparative information for 2001, when available, can be expected to show a change in Ireland's relative position in the league table.

One can also compare health expenditure between countries as a percentage of Gross Domestic Product (GDP). However, there are certain limitations in this method. There are differences between countries in the way that they measure GDP, and routine data may exclude the informal sector. In Ireland, as GDP has also been increasing rapidly over the last decade compared to other countries, it is more relevant to compare expenditure per capita in terms of purchasing power parities as opposed to percentage of GDP. Furthermore, GDP in an Irish context is significantly influenced by the multinational sector; GNP is a more appropriate measure.

Recent work at the University of York by Nixon (1999) shows considerable convergence in European health spending. Nixon shows that convergence has been greater in countries with a predominantly public Health Care system. Social insurance countries show less convergence in the 1990s. The lower income countries of Europe have shown more rapid growth in expenditure on predominantly public health systems as their economies have developed in the EU.

3.3.2 General Taxation and Tax-Finance Countries

The UK, Australia, Canada and Ireland can all be classified as predominantly tax based health systems. In Ireland expenditure on public health services comes directly from general taxation, together with health contributions, often known as the 'health levy', charged at a percentage of income.

There are a number of key features, which distinguish the taxation-based countries from the social insurance group, Belgium, France, The Netherlands and Germany.

- Health Care funding bodies do not have a separate identity and independence from the state;
- Provision of Health Care is largely the responsibility of the public sector;

- Coverage is universal so that contributions to an insurance fund do not determine eligibility for Health Care.

Ireland differs from other countries using tax funding, as it is the only one where benefits covered by the publicly funded system have varied with income. Since 1991, there have been two categories of eligibility for public health services in Ireland:

- Category I: Those who, on the basis of a means test, are considered unable without due hardship to arrange services for themselves and their dependents. They are issued with a card from their Health Board and have full eligibility to all health services free of charge;
- Category II: The remainder of the population is entitled to free hospital treatment at a statutory levy. Fees for general practice services are met by the individual. However, expenditure on approved prescribed drugs by an individual and his or her dependants over a certain monthly threshold, currently £42, is met by the State through a scheme of re-imbursement to the pharmacist.

In relation to public funding it has previously been argued by some observers that Ireland should move to a system of ear-marked taxation, whereby money is allocated to a dedicated fund for Health Care, perhaps even moving towards a system more similar to the social insurance schemes in Europe.

The Commission of Health Funding in 1989 considered the case for and against ear-marked system of funding in some detail. It reached the conclusion that the arguments for having a separate health fund were not persuasive. The Commission pointed out that the existing health contribution was already essentially part of income tax, as it did not determine eligibility for health services. Ear-marked taxes also grow in line with the tax base on which they are levied. They may therefore grow slower or faster than demands for Health Care.

In Canada, Australia and UK, the main source of funding for health services is general taxation. In Canada and Australia funding for Health Care is mainly through taxes such as income tax, collected by the Federal government. In Canada, this money is then redistributed between the different States. In Australia, some of this money is redistributed to the States in order to fund the public hospitals but General Practice is financed by the national government through Medicare.

In all three countries there have been discussions about the role of private health insurance. Canadian patients are prohibited from being treated privately by doctors in public hospitals. In the UK there has been little growth in the private insurance sector. This may reflect the fact that many of the perceived problems in the NHS particularly affect the elderly, who are less likely to have private health insurance after retirement. There is also a large group of healthy, better off workers who receive health insurance from employers but have little call on it. Direct payment for private care by those on hospital waiting lists has grown, however.

In Canada the exceptionally stringent regulation of private provision of publicly provided services has become a growing issue. A 1996 national poll asked "if it would be okay if Canada developed two levels of Health Care service: a basic one that the government funded for everyone, and another under which those who could afford it paid the full amount and received whatever kind of services they wanted". Almost 60% of Canadians rejected the concept, whereas 70% of doctors supported it. In the same year Gallup found that 44% of Canadians favoured a two-tier system (described as government insuring basic services, with private insurance or direct payment options available for further coverage). The change in support for universal health insurance has largely been attributed to a perception that the Health Care system is deteriorating (Naylor, 1999).

In Australia, the tension between private health insurance and universal health coverage has been a continuing theme in the health policy arena over the last thirty years. Private insurance also helps to fund ancillary services such as dentistry and physiotherapy. Private treatment in a public hospital means treatment by a doctor of the patient's choice and payment for a single room. Until 1998 preferential access to public hospitals was ruled out. Between 1985 and 1996 the proportion of the public covered by public health insurance declined from 48% to 33%.

Insurance in Australia has fallen partly because successive Labour governments limited the fees that could be covered by insurance. Privately insured patients faced big "gap" payments and multiple bills from, for example, pathologists and radiologists. Recent Liberal governments have attempted to introduce single bills. They are also encouraging private insurance. In 1999, the government introduced a rebate of 30% on all insurance premiums, with no means testing. There are also tax penalties for higher income groups without health insurance.

3.3.3 Social Insurance Based Financing Mechanisms

In Belgium, Germany, France and The Netherlands social insurance is the main mechanism for financing Health Care. Social insurance evolved from the risk spreading between groups of individuals for example workers' friendly societies, and organised protection for workers' health and pensions at the turn of the 19th Century.

There are variations in the organisation of social insurance schemes and their performance depending on their particular characteristics. The main arguments in favour of social insurance schemes are the potential to provide universal access to Health Care, the acceptability to the public, the transparency of financial flows, the potential to allow diversity and choice in provision.

However, it should be noted that higher satisfaction may also be associated with higher levels of spending and it is difficult to differentiate as to whether a social insurance based scheme provides more satisfaction due to the method of raising revenue or simply that more money is spent on Health Care compared to tax based schemes.

There are also potential problems with social insurance mechanisms with a risk of cost escalation, potentially high management and transaction costs (especially when patients have free choice of provider) and the need for good accountability. In a tax based system the public can make a collective decision about the trade off between the levels of Health Care spending versus the provision of health service with electoral accountability. Under social insurance the extent that citizens can input into the cost of services is dependent on the level of competition between funds. With little competition between funds, sickness funds may allow costs to rise and simply pass these costs onto consumers. Where there is competition there are problems of ensuring that sickness funds are not simply targeting the healthiest citizens and excluding the sick. With many competitors there may also be a loss of market power to control wages and prices, making it harder to control costs.

In France and Belgium, statutory insurance is compulsory for virtually the entire population. In Germany, people above a certain income level can choose to be insured within the statutory system or with a private insurer. In the Netherlands, there is compulsory insurance for catastrophic risks under the AWBZ scheme. For non-catastrophic risks, insurance is only compulsory for those under a certain income level and for the over 65s. Social insurance systems in Europe have been successful in providing near universal access to Health Care, in contrast to the system in the United States where over 40 million citizens remain uninsured.

The number of sickness funds and the level of competition varies between the different systems:

- Traditionally in Germany, the majority of uninsured people had no choice over their sickness fund and were assigned a fund based on geographical/or job characteristics. Since 1996, almost every insured person has had the right to choose a sickness fund freely. All general regional funds and substitute funds have to contract with all applicants. Company based funds and guild funds may remain closed, although, if they do open up they have to contract with all applicants.

  Even before free choice for insurees, there have been a number of mergers. There still remained 453 funds in 1999. Members have been transferring from the regional based funds to the company based funds, with lower contribution rates cited as the prime motive. The government has a risk compensation formula to redistribute risks across the funds. The members' characteristics are diverging between funds, increasing the need for a risk compensation mechanism.

- In France, membership of funds is based on employment and occupation. The schemes also offer cover to spouses and dependents. The funds do not compete as they are organised along strictly occupational lines. The funds do not have reserves to prevent deficits, but compensation exists between funds (risk sharing). In effect, one large fund, the 'Regime General' that covers 80% of the population, supports the other smaller funds. France's relatively uniform system is partly a reflection of systems introduced during wartime occupation.

- In the Netherlands the catastrophic risk scheme (long term institutional care) is directly regulated by the government.

In France, Belgium and Germany health insurance law is part of the social security code that covers other items such as pensions and work disability. In the Netherlands, health insurance law is separate from other social security items.

In all four countries, health insurance funds are independent bodies, with their own management, budgets and legal status. This gives them a degree of autonomy from government. However, they are all subject to close regulation from government.

In all the countries, contributions to sickness funds are related to income and shared between employers and employees. In Germany and the Netherlands these are paid on a 50:50 basis, whereas in France and Belgium employers pay a higher contribution than employees. The link to employment and income makes these systems more equitable than market-based insurance with constant premiums for all income groups. But there is a risk that social insurance is too dependent on the payroll contributions at a time when the proportion of people with permanent jobs is falling. For example, in Germany, increasing unemployment has caused shrinking financial flows to the social insurance system. There are also implications for foreign investors and trade due to the costs of employees' insurance. Insurance premiums paid by employers may be seen as an extra tax on companies through the effective cost depends on wages and other employer taxes.

In France since 1995 reforms have been introduced to cover social security deficits and longer term reforms. There has been a progressive widening of financing sources from payroll contributions (social health insurance) towards general tax revenue. However, the French public is strongly attached to the notion of an independent social security system with ear marked payroll deductions being perceived as contributions rather than taxes.

For several years there has been a trend in these countries towards increasing government regulation and control of health insurance financing.

This reflects the weaker cost containment in systems, which pay out fees for care provided. Health insurance is subject to increasing legislation, regulation, and decisions by national governments. Factors behind these trends include:

- Increasing government pre-occupation with cost-containment issues;
- To a lesser extent, issues of equity and solidarity.

With the increase in government control, the autonomy of health insurance companies becomes increasingly restricted.

A number of recent reforms in insurance systems are noted below:

German Reforms

A risk adjustment formula was introduced in 1994 including income, age and sex of those insured and whether they received invalidity pensions. Risk adjustment rules ensure that the healthy must pay some of their contribution to those sickness funds with bad risk structures. As a result, differences in contribution rates between funds have fallen considerably.

In addition, in 1996 regulations were altered so that 95% of the insured could choose freely between different forms of insurance companies. The major political reason for this reform was a concern for equity and solidarity.

Dutch Reforms

The Dutch reforms were first articulated in the Decker report in 1987. There were three main components of the envisaged reform:

- All existing finance channelled through a single system with sickness funds and private insurance companies competing for enrolees;
- A shift in government regulation to managed competition as a means to increasing efficiency with appropriate incentives offered to users/consumers, insurers and providers of Health Care;
- Government regulation used to ensure an acceptable quality of care and to meet various equity objectives (Robinson, 1999).

Belgium Reforms

Belgian Health Care reforms have been applied both to the supply side and demand side.

Firstly, they have aimed at devolving responsibility for Belgian Health Care to various stakeholders. This has been implemented incrementally through the shift from a retrospective financial system to a prospective system focused on needs, risk and performance indicators.

Secondly, the reforms have also been focused on limiting the supply of medical services. The reforms offer incentives to Health Care providers to reduce unnecessary in-patient days, consultations and prescriptions (Cranich and Closon, 1999)

French Reforms

In 1996, the French government introduced a wide range of Health Care reforms aimed at containing Health Care expenditure and levelling off income. Changes sought to improve quality whilst strengthening professional practice.

The tools involved include the creation of new regional hospital agencies, the introduction of cash limited budgets, launching of a new contracting procedure between health authorities and hospitals and a new Health Care accreditation agency (Segouin and Thayer, 1999). There have also been moves to introduce gate-keeping by GPs and to control referrals and prescribing through incentives for GPs.

3.4 PATIENT COST SHARING

3.4.1 Cost Sharing in Principle

Cost sharing with patients offers two potential ways of containing cost in Health Care systems:

- It is expected to reduce demand for Health Care;
- It is expected to achieve direct savings by cutting the government's share of the cost and make patients take some responsibility for their Health Care.

There is a moral hazard problem associated with all forms of insurance. If health is free at the point of use:

- People have less incentive to take care of themselves than if they have to pay out of their own pocket;
- People have an incentive to over-consume Health Care. As long as they perceive some benefit from the care they are receiving they will continue to consume even if the real cost exceeds the benefit;
- Patients may accept all treatments offered by suppliers due to the absence of payment and lack of knowledge.

In fee-for-service systems, this means that there may be no limit on activity except provider capacity. In practice, patients will not use unlimited health services but they may accept all recommended treatments.

However, introducing more charges may not be the answer.

- "Charges are a blunt instrument; they are as likely to reduce 'appropriate' or necessary care as they are to reduce 'excessive or unnecessary care" (Dawson 1999).

Patient cost sharing is also sometimes seen as a way to help contain public expenditure on Health Care, as it is an extra source of revenue. But it cannot raise large amounts of revenue if the sick are to be protected from the cost of care.

In the majority of health systems in Western Europe, direct out-of-pocket payments at the point of delivery make up a limited portion of overall Health Care funding. Out-of-pocket payments can be used as a broader cost containment measure to relieve pressure for unnecessary demand for Health Care by patients. However, out-of-pocket payments are the most regressive form of raising taxes, since the payments constitute a greater share of income for the poor and fall only on the sick.

In Ireland there is exemption from co-payments for lower income groups and as a consequence the implications for equity are less severe. Internationally, in spite of their regressive nature, they are widely used and appear to be growing, at least for those who are not the poorest. Table 3.4 summarises the use of co-payments internationally.

Table 3.4: Use of Co-payments Internationally

	First Contact	Referral Services (mainly hospital-based)	Pharmaceuticals
Ireland	Category 1: None Others (category 2): Full charges unless they have private health insurance Persons with private health insurance face an annual deductible, which also serves as an out of pocket maximum. VHI also offers options with different premiums linked to different deductibles.	Category 1: None Category 2: None for out-patient referrals. Co-payment for first visit per episode to Accident & Emergency Dept. (Unless referred by GP in which case there is no charge). Per diem co-payment up to a maximum equivalent of ten days care. Private health insurance buys free private care in public hospitals and, depending on the level of insurance cover purchased, it also buys care in private hospitals.	Category 1: None Category 2: Monthly deductible, which also serves as an out of pocket maximum for the month. This applies only for approved prescribed drugs, medicines and appliances.
Belgium	Narrow range of co-payments (less for low-income persons). Extra billing allowed.	Variable co-payments according to fee schedule; benefit reduced after 90 days (lower co-payment for those on low income).	Co-payment or co-insurance with rates ranging from 0% to 85%; drugs on the positive list are excluded from coverage.
France	Co-insurance; extra billing allowed for defined categories of physician	Co-insurance per diem rate plus co-insurance to cover meals. No out of pocket liability after 30 days.	Most subject to co-insurance; no cover for items not on national list for of approved drugs.
Germany	None	Flat co-payment up to 14 days per year: thereafter no out of pocket liability	Variable co-payment; reference pricing; no coverage for items on negative list.
Netherlands	None for the publicly insured; varies for privately insured	None for the publicly insured; varies for privately insured	Reference price system; no coverage for excluded items
Sweden	Co-payment with annual out of pocket maximum for all services except in patient care	Co-payment per diem for hospital care. Co-payment for therapeutic referrals	Co-payment for first item prescribed; greatly reduced co-payments for additional items
United Kingdom	None	None, except for amenity hospital beds	Co-payments, but 83% of prescriptions are exempt. Items on negative list are excluded from NHS coverage.

3.4.2 Trends in Cost Sharing

The general trend internationally has been to increase the level of patient cost sharing:

"There is a clear tendency in the European Union to increase the share of out-of–pocket payments in Health Care financing"(Van der Made, 1997).

Belgium

During the 1990s three changes in patient cost sharing have been introduced in Belgium:

- Conversion of "acute" and chronic hospital beds into nursing homes and psychiatric care homes. This produces savings for health insurance companies. The reason for these savings is that health insurance in general pays most of the costs for acute and chronic hospital care. However in nursing homes and psychiatric care consumers bear a greater proportion of the costs.
- Downgrading of medicines from higher to lower categories which are eligible for a lower subsidy;
- Increases in co-payments for home visits, laboratory testing, medico–technical treatments;
- Increases in co-insurance rates for hospitals.

The increases in co-payments were followed by the introduction of fiscal and social exemption mechanisms designed to protect poorer patients from excessive charges (Cranich and Closon, 1999).

Netherlands

In the 1980s, Government attempts to introduce user charges for specialist care failed after a short time, due to social resistance. Nevertheless, user charges for 'hotel costs' in mental health and nursing homes are considerable.

The government has signalled its intention to introduce user charges in the form of a percentage (5-10%) of the cost of treatment for all publicly insured people, up to a maximum level. The association of GPs is strongly opposed to this move, due to the financial barrier to accessing services (Van der Made, 1997).

Germany

Cost sharing has been a long tradition in Germany. However, since 1997 there has been a marked increase in co-payment contributions. Co-payments have increased in the following areas:

- Hospital inpatient treatment;
- Devices and non-physician care;
- Preventative, spa and rehabilitation;
- Pharmaceuticals;
- Ambulance transportation;
- Crown and Denture Treatment. (Busse and Howorth, 1999)

3.4.3 Private Insurance

The United States is the only major industrialised nation which does not provide universal health insurance coverage or the equivalent through public services. Elderly and poor citizens are covered by Medicare and Medicaid but eligibility is limited. The growing number of Americans without health insurance is the dominant concern in the discussion of Health Care access across the country. A recent survey found that lack of coverage was systematically related to access problems, including difficulty in obtaining needed care, postponing care, and not receiving high quality care.

In the US, there are moves to try and increase the amount of health insurance coverage such as the recently enacted State Children's' Health Insurance Program. The 1998 Commonwealth Fund international health policy survey found a high level of dissatisfaction with the American system, linked to high medical bills (Donelan, 1999).

If the social goals of equity and access to Health Care for all groups of the population and equity in service provision are considered important, then the US approach to Health Care financing should not be emulated (Kirkman-Liff 1997).

The American experience shows the problem of achieving equity when non-poor groups face considerable financial costs for Health Care. Private insurance may only offer limited protection against the cost of serious illness due to rising premiums, inability to move to cheaper plans and loss of employment. Once out of work, the sick may lose employer-financed insurance. In addition, the US system is the most costly system in the world with over 14% of GDP dedicated to Health Care expenditure. A significant proportion of this is spent on administration of health insurance schemes and competitive Health Care markets.

"Any nation that contemplates relying on private health insurance to finance basic Health Care would be well advised to study the history and experience of the USA, Chile and the Philippines. Their unforeseen long-term negative experiences were much greater than any short term relief that private health insurance may have provided" (Hsaoi, 1994).

Ham (1997) reviewed the experiences of the United States, United Kingdom, Sweden, the Netherlands and Germany. He argues that, although there are advantages of the US system at the micro level, such as clinical innovation and quality, at the macro level there are significant drawbacks to this system. In particular, there are millions of Americans who are uninsured or underinsured. In addition, the United States is also the most costly system in the world and about 3.5% of GDP is spent on administrative overheads alone. From a European perspective, funding Health Care mainly from public finances is the correct approach due to the weakness of private insurance as the main way of paying for Health Care, which is not to say there is no place for private health insurance as a minor part of a publicly financed system (Ham, 1997).

This view has been re-iterated by others over time (such as Evans et al, 1994). They argue that better health is the major objective of heath care systems.

Although market forces can be used in moderation where it is safe to do so, Western countries that use health insurance to finance their health sectors do so either mainly through public insurance or very tightly regulated non-commercial social insurance. The only exception is the United States, which they argue is "desperately trying to escape the negative consequences of commercial insurance".

In Australia, the role of private health insurance has remained ambiguous:

- Private insurance is an optional extra within a universal system. It can be bought by those who can afford it and therefore can be left to the market without too much concern about equity but is covered by community rating;
- Under current pressures for less public spending, a publicly funded system is argued to be unsustainable by proponents of private insurance. Widespread private insurance coverage is seen as an essential means of ensuring sufficient finance in the Health Care sector.

Private insurance was high historically in Australia in the absence of universal public services. It may rise again now that the insured do not face such large gap payments between actual fees and government-set fees. But part of the increase in finance may then be absorbed in higher fees, not more services.

In Western Europe, private insurance serves two purposes:

- Voluntary supplementary cover for certain sections of populations covered by a national health services;
- Voluntary cover for certain parts of the population in countries with statutory insurance who have no cover (mainly those from high income groups).

Since 1945, the UK electorate has been promised universal access to free Health Care and this has become a "norm" in society. In Ireland, the coverage of public Health Care has developed in a more piecemeal manner. From the late 1950s all but about 15% of the Irish population were entitled to state care in public hospitals. The VHI was set up in the 1950s as a state backed insurer offering community rating and income tax relief on premia. In addition, when public provision of General Practice services was introduced this was only for one third of the population. This has led to a historical tendency for many Irish citizens not entitled to free General Practitioner and Pharmacy services to take out health insurance (Nolan, 2000).

Queues and rationing encourage the demand for supplementary private health insurance, for benefits such as shorter waiting times, choice of time and treatment, a wider choice of physicians or hospital, and greater comfort. While private insurance may be a solution for the individual to tight expenditure control by public systems, it may not be the most efficient response by the system as a whole. This is due to the higher transaction costs of competing funds. Private insurance may also push up clinical fees payable by private and public sectors.

3.4.4 Medical Savings Accounts

Medical Savings Accounts (MSAs) are an attempt to get health insurance at a personal level and extending over the individual's lifetime. In Singapore the 'Medisave' scheme is a compulsory tax-exempt interest yielding savings scheme that only covers hospital costs. Those who use up all their savings or who are unemployed receive care from the state.

However, this care is of a lower quality. The scheme allows people to use their savings for other purposes, such as to pass onto their families.

MSAs give individuals a clear incentive to manage their own use of Health Care. The link between personal payment and benefits is also likely to encourage people to pay more for Health Care. But critics point out that the scheme does not help the poor and the very sick as they may run out of funds to pay for good quality Health Care. (Saltman 1998, Harrison and Dixon, 2000).

3.4.5 Conclusions

Governments considering changing their Health Care financing system face a number of choices. These revolve around:

- The total level of Health Care that is sought;
- The associated cost of these services;
- The distribution of the cost between individuals or families;
- The distribution of health services and health gains;
- The incentives to providers of Health Care and to patients;
- The accessibility of services to patients.

The choice of system is linked to the choice of the main policy variables:

- Finance by taxation, social insurance, market insurance, or out-of-pocket payments;
- Payments to providers by block grants, capitation or fee-for-service.

The choice elements above can be rated against the main policy principles.

Table 3.5: Finance and Fairness

Revenue raising mechanism	Fairness to Sick	Fairness to Poor
Tax	High	High
Social Insurance	High	Medium/Low
Private Insurance	Low	Low
Out-of-pocket	Low	Low

In a tax-based system, fairness is high. Other systems are less fair though social insurance can be fair on the poor if they are enrolled at public expense into sick funds.

Payments to providers may be of several kinds. Primary care lends itself to capitation in any funding system because, excluding medicines, the cost per patient is likely to fall in a relatively narrow range. For example, few patients will have a weekly GP contact and most patients 2-3 contacts per year. By comparison, hospital care for the very sick may cost thousands of times more than hospital care for the relatively healthy.

Capitation weakens incentives to respond to patients so access may be lower. This is also true for block grants.

Table 3.6: Payment, Access and Cost Containment

Payment mechanism	Access	Cost Containment
Capitation	Lower	Higher
Block grant	Lower	Higher
Prospective fees	Higher	Lower
Reimbursement fees	Higher	Lower

Fees encourage providers to get services to patients rapidly. Fixed, prospective fees may reduce this as some patients may be relatively expensive compared to the average for their fee category. Reimbursement of all costs is likely to make providers respond most flexibly but cost will then be difficult to control.

Tax funding linked to block grants is therefore fair and gives good cost control at the expense of response/access. This is reinforced by the need to review the fiscal support for Health Care regularly, where it is funded from general taxation.

Social insurance funding is more likely to be linked to other economic factors such as income. This may also be the case for private insurance. Funding can rise more easily but if it is paid out in fees, total spending may increase more rapidly. Also, in the absence of a strong public sector, more spending may be absorbed by higher staff earnings.

A further key consideration is the transfer between generations in health funding. Much more Health Care is used by the old. Therefore, individuals have to contribute to taxes or insurance when young and rely on others' contributions when old. One alternative, in which individuals build up a personal health account, has been tried out in Singapore. Long-term feasibility is not clear but in the shorter term it may not be beneficial for poorer or sicker individuals. Taxes make it easiest at any time to balance income and expenditure for the health system.

Any insurance system is at risk from changes in age structure. Where insurance is not compulsory, premium rises due to ageing may drive out younger members in voluntary insurance with community rating. This has been a part of recent Australian experience. In social insurance, any rise in premiums can be enforced but may be regressive, falling more heavily on lower income groups, unless premiums are linked to earnings.

On the other hand, tax-funded systems may lack incentives for efficiency. If these are introduced, they weaken cost containment. Tax systems may also constrain health spending for non-health reasons, for example the wider state of the economy. In this situation, access to health services may suffer. Waiting lists are a consequence of this restraint but may also reflect either inefficiency due to block grants or diversion of clinical effort into private practice.

Overall, health systems spend their funds based on three factors:

- The number of the "sick";
- The preferred treatments;
- The cost of treatments given to patients.

The first factor is subject to uncertainty due to population change, emergence of new diseases, and changes in the threshold defining "sick".

The second factor depends on the available technology. Preferred treatments may change when new medicines or techniques become available.

The cost of inputs may change due to price rises, new treatments or market power of providers. Each of these factors, and the combination of all three, causes uncertainty in health spending. This uncertainty can be managed by:

- Fixing total spending, so that:
  - thresholds are not expanded;
  - new therapies are held back;
  - new therapies and existing inputs prices/wages are held down.

- Allowing expenditure to rise with the three pressures, so that:
  - thresholds for treatment expand and more patients are treated;
  - new therapies penetrate at a pace driven by clinician innovation rather than funding (though innovation may itself be slow where it involves major changes in technique);
  - new and existing input prices and wages rise to reflect the volume of care, over which providers have some discretion.

Allowing expenditure to rise will reduce limits on access but will lead to either rising insurance premiums, taxes or tax subsidies to insurers or providers. Neither is likely to be popular.

Governments therefore face a trade-off in systems (unless they are relaxed about regular tax increases).

Table 3.7: Trade-off between Health Funding Systems

Insurance	Taxes
Better access likely Worse cost containment likely Higher input prices and clinical staff wages/fees	Worse access likely Better cost containment likely Lower input prices and clinical staff wages

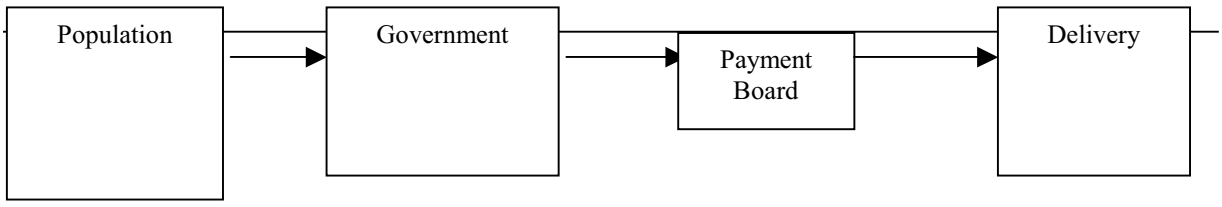
While complex mechanisms can be developed to balance these effects, overall the choice remains between cost and access. Insurance gives higher potential spending but part of this spending is captured in higher prices and wages/fees. Tax funding gives lower spending, typically, but also greater power to keep prices, wages and fees down.

3.5 INSTITUTIONAL STRUCTURES

In this Section, we review the institutional structures that are linked to each financing method.

3.5.1 Tax Based Financing

Direct Payment - Government to Providers



Examples

- GMS payment Boards in Ireland for medical card holders
- Payments to voluntary hospitals in Ireland
- Australia General Practitioners and specialists
- Australia PBS mechanism

Cost Containment

Cost containment is higher under tax based financing structures. It is possible to control costs through budgets but this depends on whether prospective or retrospective reimbursement is used. Ireland has moved to capitation payment mechanism for primary care, for example. In the Australian prescribing reimbursement scheme, government has close control on what drugs are reimbursed.

Service Planning

Government has direct control over providers and therefore can impose planning. However, it may not have sufficient local information. Effectiveness depends very much on the size of population and relationship between government and providers

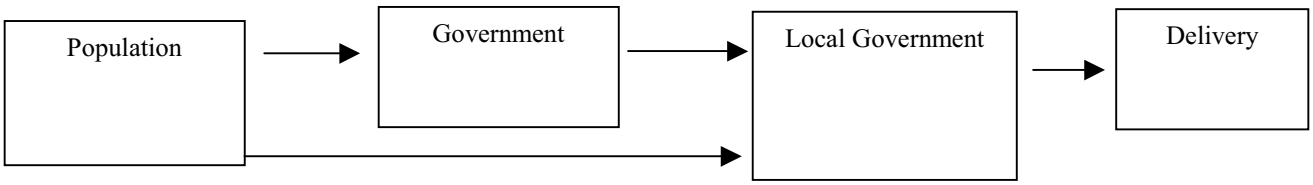
Service Integration

This model can frustrate service integration at the local level as providers have different financial incentives and budgets. In Australia, they have been experimenting with co-ordinated care trials where payments for prescribing, general practice and specialists have been pooled in one budget. UK primary care trusts may also increase integration but much depends on the future separation of funding for social services.

Responsiveness

Fee-for-service with retrospective re-imbursement in a competitive market such as general practice can lead to a demand-led service accommodating patient demands. In Australia, there have been developments in for example 24 hour general practice. For funding hospitals, the effectiveness depends on how much information the government has to match funding to either demands or need and the mechanisms it uses for doing this.

3.5.2 Two Tier Government Model



- Federal/state system
- Australia - Public hospitals are funded by the state
- Canada - most Health Care provision is jointly financed by Provinces and central government
- Sweden - county councils raise tax locally for Health Care

Cost Containment

In Australia the financing mechanism gives the federal government significant power over the state level government as to how money is spent. Money from central government tends to be given according to specific funding streams. For example, money is aimed at specific policy objectives such as improving aboriginal health.

In Canada there is currently conflict between Provincial and Federal level over the amount of funding that is available. The Provincial governments have contained costs through cutting hospital budgets. However, doctors are still paid on a retrospective fee-for-service mechanism.

In Sweden the government has imposed limits on the amount of tax to be raised locally.

Service Planning

In Australia, negotiations take place every five years between the State and the Commonwealth, under Health Care Agreements. These include planning of service developments and targets. In addition planning takes place at local level.

In Sweden the national government has increased the amount of policy directives and increased national monitoring and supervision over the last decade. Sweden developed health service planning in the 60s and 70s aiming at planning in the broad social context. In the early 1990s the Swedish implemented a purchaser provider split. This policy move was similar to that of the UK where a separation was made at the local level between purchasers and providers of health services. At the time the theory behind such a move was based on the idea of market forces to improve health services. The idea of planning services over a period of time became less popular.

In both countries although the purchaser provider split has remained, the move has been away from competition towards co-operation. Negotiations have moved from short-term contracts to comprehensive long-term agreements, based on a mutual commitment to improve activities. Purchasers are planners of a new kind, concentrating on needs, priorities and strategies. For example in the UK, at the local level national service frameworks are being implemented for issues such as cancer and mental health. There is a focus on needs assessment and identifying local priorities.

Service Integration

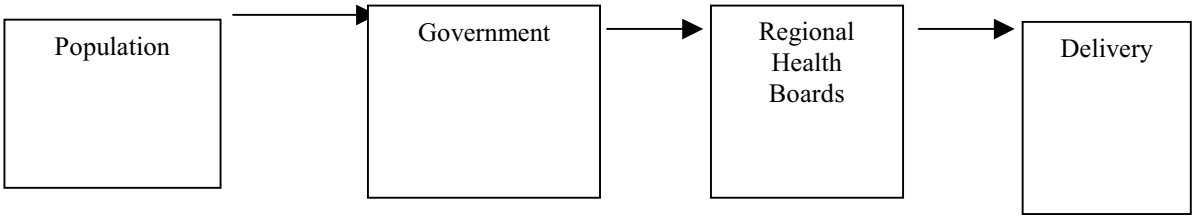
In Australia, national government funds general practice and States fund hospitals, which is often cited as a barrier to service integration with fears of cost shifting on both sides. In Canada, there has been little drive for integration between primary and secondary care; again this is partly caused by the local incentives to general practitioners. In Sweden planning for service integration has been a key part of policy and is helped by local authority involvement. Local councils are able to co-ordinate initiatives to increase co-operation between the primary and secondary care level and with other groups such as social services.

Responsiveness

In Canada, waiting lists are reported as a problem although at an average of around twelve weeks they are comparatively short compared to UK and Ireland. In both Australia and Canada GPs are reimbursed on a fee-for-service basis, with retrospective reimbursement leading customer orientated general practice. In the hospital field, both countries have slashed hospital budgets but waiting lists are not as much of a problem as in European tax based systems. In Sweden, there have also been waiting list problems. Although waiting lists shortened when national guaranteed waiting times were introduced, they subsequently lengthened again.

3.5.3 Decentralisation to Regional Health Authorities/Boards

Decentralisation to Regional Level



- Ireland Regional Health Boards
- UK Health Authorities
- Australia (some states have separate health authorities)

Cost Containment

Health Authorities can be given fixed prospective global budgets from which to purchase a range of services. These budgets may be based on a resource allocation formula as in Australia (New South Wales) and in the UK in order to distribute money according to population need. Fixed budgets allow significant control of costs.

Service Planning

Despite turning away from planning in the early 1990s, there has been a revival in both the UK and Sweden in Health Care in recent years. However, it should be stressed that this type of planning is focused on strategies to increase public health and prioritising to use resources more effectively.

In Ireland the Eastern Regional Health Authority has been established, allowing co-ordinated planning in the region at a local level. This marks a shift away from the model of direct financing to voluntary hospitals towards a more decentralised approach. In Ireland, additions to the budget can be made for specific planning interventions to improve services and population health. By planning at a level closer to the population, this can help to match needs with resources.

Service Integration

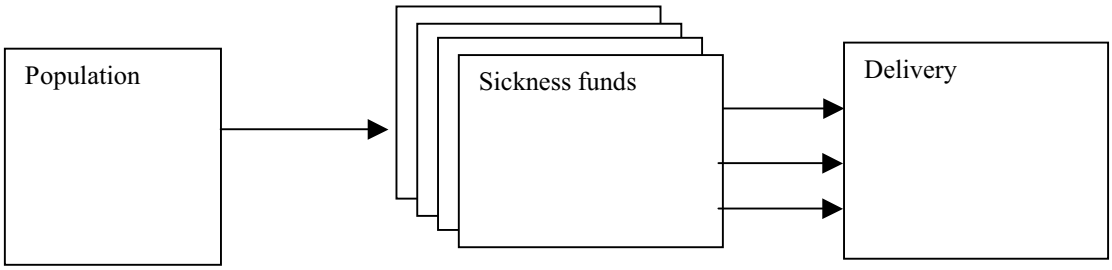
In the UK there has been a move to making health authorities more strategic, which has included devolving budgets to primary care level. There are plans to move to primary care trusts whereby groups of general practitioners and community nurses would hold a global budget including prescribing, general medical services and some funds for purchasing of secondary care.

Responsiveness

The disadvantage of this system is the potential lack of responsiveness to patient demands with resulting long waiting lists as a method of rationing care. There is no competition for public provision of services, therefore patients have little input into what services are provided. The advantage of such a system on the other hand is the potential to respond to the needs of the population at the local level. There is a need to establish dynamic planning mechanisms with input from all levels to provide a service more in tune with patient demands. In addition, there

need to be mechanisms to ensure that there are incentives at the local level for providers to respond to patients needs and demands.

3.5.4 Social Insurance Model



- France
- Germany
- Belgium
- Netherlands

Cost Containment

In the social insurance model, Government has to rely on regulations to control costs. It is a feature of all countries that cost containment has been on the agenda for the last decade. The traditional model of a sickness funds with retrospective reimbursement on a fee-for-service basis can lead to cost inflation. There has been a tendency in the past for sickness funds to simply absorb costs and pass them back to their members. The relationships vary with the different countries depending on the extent of independence of the sickness funds.

This type of model gives the government less flexibility in controlling costs and relies on negotiation and regulation of sickness funds and fees for clinicians. However, some governments for example in the Netherlands and Germany have tried to introduce competition to make sickness funds more responsive to costs.

Service Planning

Service planning is more complex under social insurance arrangements than in the tax-based models. There are more stakeholders involved with more independence and a greater diversity of interests. In countries such as Ireland, planning can be strategically led to match population health needs on the basis of electoral accountability to provide core health services for the population. Organisations such as sickness funds are more likely to be concerned with the demands of their customers rather than the health of all groups in the population. Services are more likely to develop in response to patient demand as opposed to using resources to maximise population health. This said, there is a planning process in all four countries in areas such as public health and capital investment, which is partly tax funded.

For example in Belgium, the French Community priorities include AIDS, drug abuse, elderly people, mental illness, immigrants and the disadvantaged. The Flemish Community has developed a comprehensive health promotion and prevention strategy based on the following premises: co-ordination of local and regional initiatives; increasing inter-sector collaboration; ensuring adequate resources for specific preventive actions; and surveillance of trends in data related to public health.

Service Integration

In France, policy has moved towards trying to integrate the public and private sector with an emphasis on co-operation rather than competition. At the secondary care level, regional hospital agencies have been set up. It is too early to assess the impact of these changes in services. In Germany there has traditionally been a great deal of community doctor input into acute provision. In part this may be due to the lack of general doctors and the tendency to have specialists who practice in the community.

In the Netherlands, there has been a long history of medical centres where doctors, nurses and social workers all work in the same place. In Belgium such a move is currently popular with the establishment of large polyclinics within primary care. It should be noted that the benefits of such a move partly depend on the geographical location, for example it may of less benefit in rural areas.

Responsiveness

In Germany, France and Belgium there are very few waiting lists and people are seen quickly with a customer-orientated service. In Holland, recently there has been a perception of high waiting lists.

Historically there has been a tradition whereby patients are treated instantly and the bill is sent to the sickness fund to reimburse. This leads to a highly responsive system to patient demands. Citizens of these countries have very high expectations of health services making it difficult to contain costs. However, there is a trade off to be made between the responsiveness of the system and the level of cost containment. We also note that it is hard to judge the direction of causality. It may be that social insurance schemes are highly responsive because of their structure. On the other hand they be more responsive simply because more money is spent in these systems, with higher amounts of capacity available to cope with peaks in demand and larger amounts of staff.

3.5.5 Private Health Insurance Models

Figure a

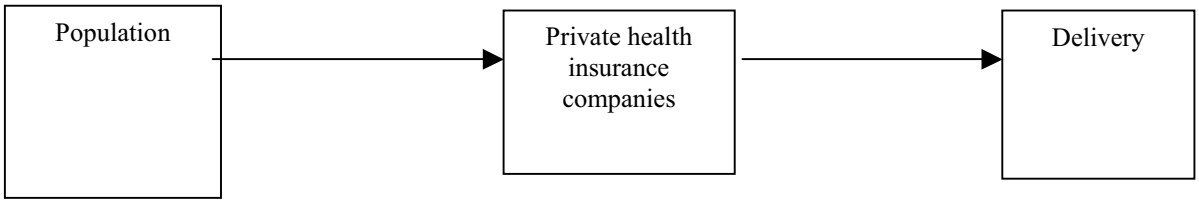


Figure b

Cost Containment

Traditionally private health insurance companies have simply reimbursed providers on a fee-for-service basis in a model like Figure a above. A private health insurer will be trying to match its price with the demands of the clients.

In a system where there is already public health insurance available, customers are generally attracted by a perception of a superior service which may lead to a higher cost per person overall compared to the public system.

In the United States, there has been a move towards the second model where healthy people pay to belong a health maintenance organisation and are provided with both primary and secondary care. There are incentives for an HMO to contain costs as they receive a fixed fee per annum for each customer. Having said this, only the United States uses Health Maintenance Organisations as the predominant method of funding Health Care and it is still spends the highest proportion of GDP on Health Care (13.6% of GDP in 1998 [OECD]).

Service Integration

A private health insurance company may choose to own services at the primary and secondary care level and employ vertical integration of services.

However, there are difficulties in integrating private and public services. For example, in Canada, services that are provided in the public sector are prohibited from being provided privately. In the UK again there is very little integration between the private and public sector. Other countries such as France and Australia have taken a different approach. In France, there is a policy of trying to merge private and public care and in Australia there is a greater degree integration between the public and private sector.

Service Planning

When there are many different private insurance companies in the market it is very difficult to plan services efficiently for the population at large. Measures such as community rating can be taken to ensure that insurance fees are not risk related. This prevents insurance companies from only insuring the very healthy and excluding those with a low health status.

A distinction should be made between countries such as Ireland where core services for everyone are provided by the state and private insurance provides supplementary services and countries like the United States where all services are provided through private health insurance. In the US the government has little control in the planning of services

Responsiveness

Private health insurance tends to be very responsive to the demands of customers as there is always the threat that they will move to another insurance firm. In the next section, the findings of the WHO report 2000 are shown where it was found that the US system is the most responsive in the world. However, the trade off is that it is also the most expensive system in the world. The responsiveness of private health insurance is only to those who are insured. This leads to the problem in America where 45 million people remain uninsured and there are large disparities in population health.

3.6 WORLD HEALTH ORGANISATION REPORT 2000 – A SUMMARY

This Section reviews the recent WHO report on health funding and delivery, from an Irish perspective.

Table 3.8: Summary of WHO Assessment

COUNTRY	ATTAINMENT OF GOALS					Health Expenditure Per Capita in International Dollars	PERFORMANCE	
	Health		Level of Responsiveness	Fairness in Financial Contribution	Overall Goal Attainment		On Level of Health	Overall Health System Performance
	Level	Distribution						
France	3	12	16-17	26-29	6	4	4	1
Netherlands	13	15	9	20-22	8	9	19	17
UK	14	2	26-27	8-11	9	26	24	18
Ireland	**27**	**13**	**25**	**6-7**	**25**	**25**	**32**	**19**
Belgium	16	26	16-17	3-5	13	15	28	21
Sweden	4	28	10	12-15	4	7	21	23
Switzerland	8	10	2	38-40	2	2	26	20
Germany	22	20	5	6-7	14	3	41	25
Canada	12	18	7-8	17-19	7	10	35	30
Australia	2	17	12-13	25-29	12	17	39	32
USA	24	32	1	54-55	15	1	72	37
New Zealand	31	16	22-23	23-25	26	20	80	41

The World Health Organisation (WHO) has tried to combine several different aspects of countries' Health Care systems to produce an overall assessment.

Health measures include the level of health and also its distribution. WHO rates countries with better health more highly, but reduces the rating where a country has greater variation in public health. Some countries with ethnic minorities with poor health were rated lower as a result.

Responsiveness refers to the extent to which the services available can be accessed rapidly and flexibly. Countries are rated lower where there are controls on access (for example the need to see a GP before a specialist) and waiting lists.

WHO is also interested in fairness of payment. Some health systems impose charges on the sick or reduce their insurance coverage. Others have similar costs for higher and lower income groups. These countries are rated lower by WHO.

The other measures of a health system combine the basic measures, predominantly to link health and spending. Per capita expenditure provides an indication of the relative level of health service resources. (Because of differences in prices in different countries, expenditure is typically adjusted to a common value in dollars that adjusts for the local price level.)

Health Level

At the current time, the level of health of people in Ireland is lower than the other countries with which it is being compared. The measure is based on the average health of the population, using Disability Adjusted Life Expectancy (DALE). The measure takes into account average life expectancy by age group. This is then weighted to take into account non-fatal health outcomes. The countries with the highest levels of health are France, Australia and Sweden.

Distribution of Health

However, Ireland scored highly on the distribution of health amongst different strata in society. Only the UK and France have a more equitable distribution. This reflects the large public sector element to Health Care provision in Ireland. The United States has the worse record for equity in health status amongst the population. The measure is based upon the WHO framework for measuring health inequality.

Responsiveness

The UK and Ireland both performed relatively poorly in responsiveness, whereas countries such as the United States and Germany were more responsive. There are two components to the responsiveness score:

- Respect of persons' 'dignity, autonomy and confidentiality';

- Client orientation, which takes into account:
  - Choice of providers;
  - Access to social support networks;
  - Quality of basic amenities;
  - Prompt attention.

The information was gathered through questionnaires to 2000 individuals in the population or, where unavailable, statistical modeling.

Fairness in Financial Contributions

Ireland ranks highly in the level of fairness with which people make contributions to Health Care finances, again due to its large public health sector. In the group of countries selected for comparison only Belgium ranks above. The worst performer from the selected group was the United States, which performed exceptionally badly on this measure, due to the substantial presence of risk-rated private insurance.

The measurement compares total household expenditure on health against income. The measure is designed to weight particularly heavily households that have spent a large share of their income on health.

Overall Goal Attainment

This is a composite measure taking into account the:

- Level of health;
- Distribution of health;

- Level of responsiveness;
- Distribution and fairness in financial contributions.

Against these criteria Ireland falls behind the other countries. Despite being an equitable system in health and financial contributions, the score was brought down by the lack of responsiveness in the Irish system and the lower health status overall.

Performance on Level of Health

This measure shows how efficiently health systems translate expenditure on health into health as measured by Disability Adjusted Life Years. The measure is a ratio between the level of health that is achieved and the level of health that could be achieved with the most efficient Health Care system. On this basis, the French system gives the best gain in levels of health for the money spent. Australia, which also has high levels of health overall, scores lower on this index as the gains in health are assessed as due to other determinants, outside the Health Care system.

Sweden, the Netherlands, the UK and Belgium all fare better than Ireland in translating money spent on health into gains in DALEs. Conversely, Canada, Australia and the US are further down the rankings than Ireland. This is one measure of how Ireland compares with its counterparts in value for money terms where the focus is on outcomes.

Overall Health Care System Performance

The overall performance uses a similar method. In this case it compared overall goal attainment to expenditure on health taking into account other determinants of health. The best performer according to the World Health Organisation was France, followed by the Netherlands, United Kingdom and Ireland. The next group included Belgium, Sweden and Germany. Australia, Canada and the United States were rated lowest under the World Health Organisation (WHO) criteria.

3.7 KEY ISSUES IN DIFFERENT FINANCING SYSTEMS

- **Control over Health Service Capacity**

Most health systems in developed countries (excluding the former Eastern Block) have not nationalised their Health Care providers. Most countries also do not operate any tight controls on the number of doctors trained or able to enter practice. (In Italy, for example, there have been legal challenges to such moves.)

The result of this relative independence of providers depends on the funding system. Where providers are funded by block grants from a collectively financed health agency (whether a large geographic sickness fund or a branch of government) there is considerable control over capacity. Once payment is made by multiple agencies or as a result of activities carried out for patients, reflecting separate clinical decisions, control over capacity is weak. Therefore, overall we conclude that the risk of excess capacity, which has to be funded through collective payments to insurers or the public sector, is greater where services are purchased through individual fees and by multiple insurers.

- **Control over Demand and Expenditure**

In its strongest form, for example in the UK or former Eastern Block countries, the government sets the level of expenditure for primary, secondary and community care. Control of expenditure is strong. Demand is not controlled, in the sense that there is no easy way of linking spending limits with demand decisions. For example, a GP deciding on referrals or a hospital consultant deciding on surgery for a patient cannot easily link the care of that patient to funding. They may know that demand in total is too high relative to budget but, other than arbitrarily rationing care, there is no basis for managing demand. That is, unless the cash limit has an orthopaedic budget, for example, which is calculated on good epidemiological data and clear thresholds for surgery, there is no easy way for a GP or surgeon to say that a patient does not qualify. If they do so, it is possible that other clinicians using different criteria are referring such patients so there are also equity problems. Overall, we conclude that demand management is not feasible or well conducted in centrally funded health systems and that rationing may be an inevitable result, in the absence of tightly defined care pathways.

In insurance-based systems of all kinds, where fees are paid, it is similarly difficult to contain demand growth as again tight clinical pathways may not be specified. Also, with the exception of the USA, Health Care information systems are still probably not sufficiently developed in most countries to allow rapid, regular and low cost monitoring of care pathways in detail. In consequence, we conclude that, due to incentives to intervene in systems where fees are paid, demand is not well managed and expenditure is not well contained in insurance-based Health Care systems.

- **Ability to Implement Coherent Planning and National Strategies**

Provider independence is historically strong and remains so in western developed countries. Primary care is particularly so, with little development of salaried GPs working for corporate bodies. An independent GP is almost bound to become less involved in integrated planning, because there are no corporate mechanisms to achieve this. It may happen but there are few sanctions where it does not happen.

In many fee-for-service countries, GPs also do not provide care for the whole population or provide it without registration of a population with a practice. This undermines coherent and integrated approaches to record keeping, registration for screening and immunisation programmes, for example. However, centralised payments systems by insurers can provide them with a comprehensive record of a patient's care (similar to GMS data held on prescribed medicines in Ireland), so fee-based systems may be able to introduce elements of integration or follow-up based on billing data from providers and clear identification of patients. However, our understanding is that such data is not widely used for these purposes, for example to call up those who have not visited their doctor for screening checks.

- **How far is the Government the effective guarantor of Health Care funding?**

In almost all developed countries, the government effectively stands as the final supporter of Health Care funding. This is because many of the sickest people will be elderly or unable to work. Their incomes and needs will typically place them outside any insurance scheme that relies on voluntary contributions or is linked to contributions by employers. Governments therefore have to provide some kind of safety net service for such groups, which effectively funds a proportion of Health Care in insurance-based countries. In some countries, governments may also have a major stake in emergency care, through the need to provide ambulance services and Accident & Emergency units. This potentially high cost element of Health Care may fall outside insurance payments and so leave the government guaranteeing Health Care for all in emergencies.

Insurance premiums are politically sensitive in countries where insurance is compulsory or where voluntary insurance covers a large part of the population. Governments may be reluctant to see premiums rise and so may feel that they have to provide financial support directly or through tax relief to maintain insurance funds.

Not every government has had to intervene to prop up insurers and some systems in Europe, with well-established insurance agencies, may not require such support currently. But unless governments are prepared to accept denial of services or medically induced bankruptcy, it is difficult to see how they cannot stand ready to support health insurance funds. This is particularly the case where insurance funds are mutuals or social institutions providing funding in an environment where there is a strong commitment to social solidarity. It may be that in the USA, the government can withstand pressure to help members of failing insurance schemes but this position is likely to be more difficult to sustain in other developed countries with a substantial insurance element in their Health Care funding.

- **What are the Merits of Fee-For-Service and Capitation?**

In essence, fee-for-service encourages providers of all kinds to intervene and provide services, even when these are of limited therapeutic value. Capitation provides no incentive to intervene and may encourage under-provision of care or monitoring. It may also lead to a culture where barriers are erected to consultations whereas in a fee-for-service system, consultations are likely to be encouraged.

Capitation systems, where they do not cover all types of care, may also encourage a shifting of activity to other services, which do offer a fee, for example out-of-hours or other services.

Overall, the introduction of fee for service within a capitation system is likely to increase costs.. In our view, the health benefits of higher rates of consultation or service utilisation are not clear-cut. Fee for service would increase the convenience of access to more responsive providers, but without evidence of improvement in health, we would not recommend a general move to fee-for-service from capitation.

- **Accountability to the Public**

Direct accountability to the public is limited in all developed countries' Health Care systems. This is because many decisions are taken around the technical and cost-effectiveness aspects of Health Care delivery that are likely to conflict with local public opinion.

At the lowest level, systems with fee for service are more responsive to patients and citizens because of the need to attract and retain custom. But where these systems operate more closely to a conventional market, decisions may be taken based on the financial position of providers rather than the will of the local community. Communities may be able to encourage public sector or other funding of threatened services but a more devolved approach does not of itself ensure accountability to the public.

Providers are typically independent professionals or non-nationalised institutions in social insurance countries. Individual clinicians are clearly not directly accountable to the public for decisions on their location or services, though the clinicians may respond to fee incentives. Institutions, which are not profit seeking, are likely to want to maintain their existence and offer continuity of services. They may have local community input to their decision-making. But again, if not publicly owned, institutions such as charitable or non-profit hospitals are not directly accountable to the public. Insofar as the public typically favours retention of local services, however, the interests of such providers and the public may be aligned.

Public sector providers and public funding bodies may have local participation in decision-making. The degree to which this operates and the extent to which it makes services locally accountable depends on how they are run. Where local government manages Health Care delivery, a Scandinavian model, there is clearly scope for the local population to use local elections to influence Health Care policy. Where small appointed panels are the mechanism for public involvement, there is less accountability, for example in the UK. But the key issue for public systems is the extent to which central governments wish to give local populations and their elected leaders control over funding and delivery issues. Where this occurs, the public may get services that accord more closely with local public opinion but there may still be little formal accountability for the quality and cost of such services.

- **Risks of Adverse Selection and Discrimination against the Sick**

Adverse selection and risk discrimination against poor risks are inevitable features of insurance. In most, if not all other applications, the clear focus of insurance is to discriminate against bad risks and to limit their ability to insure. By this means, those who have adopted a low risk strategy (for example careful driving, choice of a house outside a flood plain area, avoidance of smoking and risky pursuits) are protected from bearing the costs of those who have chosen to adopt more risky strategies. However, in Health Care (and to a degree in life insurance) there are widespread concerns that those facing high risks through no fault of their own, (which may include those whose life stress pushes them into high risk behaviour) should not be excluded from social protection. If insurance run by companies or sick funds is the basis for social protection, these agencies are likely to try to reduce the cost of high-risk cases to them, as this improves their financial position.

They may not do so overtly but may do so through selective marketing or other means. There are also likely to be disputes over the costs of high-risk groups and their distribution between funds, in any risk equalisation process. It is fair to say that disputes in Ireland, at an early stage in the social insurance market and with few insurers involved, demonstrate the difficulty of achieving a balanced approach to high risks when insurers are competing to any degree.

A solution, which is addressed to a degree by GMS and related schemes for prescribed medication, is to place all high risks that can be identified into a separate public Health Care scheme. This avoids discrimination but runs the risk that such groups receive a lower standard of care, for example for routine elective surgery, than healthier groups able to join less costly health insurance schemes with a predominance of healthy members. These issues are also likely to arise for the elderly in insurance-based schemes unless there are explicit provisions to fund elderly people in insurance schemes, particularly those linked to employment.

- **Universal Access**

The issue of access is frequently seen as differentiating factor between centrally funded and insurance systems. The issue is not a straightforward one.

Publicly funded Health Care (including universal social insurance) typically offers universal access as a principle, though it need not cover all aspects of the system (for example Irish primary care). This is the basis of most Health Care in Scandinavia, UK and Canada. But while everyone may have the same access to the same services, these services may in practice offer worse access to care than under an insurance model. That is, when tax funding is used, governments control expenditure and the level of service. Patients may be given equal access to a more limited range of services or only after a longer wait. For the middle income worker and above, access under public finance may be worse in that services are more limited than they could obtain under an insurance model of funding for themselves.

For the poorer, older, sicker citizen, however, access to services may be better than when they only receive a safety net service of the type typically present in insurance based systems.

In health systems in all developed countries, governments are not prepared, for good reasons, to see citizens denied access to Health Care, particularly in emergencies. This means that one way or another, governments must make some provision for the Health Care of poorer and older people with bad health. A safety net service of some kind is therefore generally provided by government even in an insurance based system (such as the USA) where there is a continuing reliance on private contributions to fund Health Care. For those close to poverty in the US, Health Care costs can be considerable and they may have to rely on charitable care in some cases.

Social insurance systems may also need a safety net, particularly where they are linked to employment. Older, sicker people are less likely to be at work and insured. But if all citizens are enrolled in an insurance system and funded in part by government, access to services is again likely to be driven in part by the total fiscal costs rather than solely by patient demand or doctor supply.

- **Funding and Delivery of Health Care**

Funding and delivery of Health Care can be separated by a variety of mechanisms, for example use of internal markets in public systems, or use of independent providers. But overall, healthy people in a society must pay the majority of the cost of Health Care for those who are relatively sick, including elderly people, if an acceptable level of equity is to be achieved.

Every developed country subscribes to this principle though some take it further and seek greater support for the old and sick. Whatever the funding mechanism, the cost of services for the sick and old are a cost to the younger and the healthier. They have to pay this through taxes or insurance premiums and the precise mechanisms used may not matter appreciably. However, where the old and sick are offered membership of systems which use fee-for-service to pay providers, there is clearly scope for the cost of care for these vulnerable groups to be higher. Where they are covered by universal or safety net public systems, the cost can be contained but this may limit the quality of care provided to these groups.

- **Use of Co-payments**

Co-payments are widely used in Health Care systems, even those with substantial public funding. However, there are often exemptions for those with serious health problems, because of concern that they may bear an unreasonable cost unfairly. Co-payments may generate a limited amount of revenue and are often not well collected by public Health Care agencies and philanthropic providers. However, they have a role, which is to discourage demand from those who are more healthy (and face a charge) but might make demands for minor illness. The key issue for co-payments is the extent to which patients with a major illness fail to consult because of the cost. The best quality research, the US Rand study, suggests that patients may be discouraged from seeking effective and less effective treatments so that the demand deflected is not merely a demand for minor treatment.

A potential solution is to classify all first assessments as free and then apply co-payments to subsequent treatments. Similarly, charges for medication can be tapered so that the highest charges are on medications which have a limited effect or few benefits over a cheaper alternative. (The latter model can be found in some European countries.)

Overall, if the relatively sick are not to face a burden from co-payments, their contribution to Health Care will be limited. They may discourage appropriate as well as inappropriate demand. Ideally, their impact will be carefully monitored to ensure that there are no adverse effects, which could include for example higher costs or worse outcomes due to late presentation. Modest charges may be unlikely to deter those who pay charges from seeking medical care when they are seriously ill. But as such the revenue generated may be small and must be balanced against any risk of late or non-presentation.

- **Overview**

Changing a nation's health financing system requires serious consideration, and is beyond the remit of this study. A new financing mechanism may address certain deficiencies, but create others. Changing the financing mechanism does not, in itself, necessarily improve health service delivery. Change should only be undertaken when the complex interrelationships between financing, cost access and delivery are assessed in detail.

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Glossary

Deductible: The out of pocket maximum amount that must be paid before benefits of the insurance programme become active (for example the patient pays the first $50 of the cost of hospital stay).

Co-payment: A flat rate amount that the beneficiary must pay for each service used (for example the patient pays $5 for each prescription).

Co-insurance: The percentage of the total charge that must be paid by the beneficiary. (for example the patient pays 20% of the total charge of inpatient care).

PART 3
POLICY AND DATA ANALYSIS AND REVIEW

SECTION 4: POLICY BACKGROUND

4.1 SECTION OVERVIEW

This Section provides an overview and assessment of policy development and implementation in the Irish Health Care sector during the 1990s. Appendix IV provides a more detailed description of the main features and recommendations of policy and strategy as applicable to the following areas:

- Cancer
- Cardiovascular Services
- Health Promotion
- Alcohol
- Women's' Health

We also review policy development across a sample of care groups including the Elderly, Psychiatric Services, Services for Persons with an Intellectual Disability and Childcare.

4.2 ASSESSMENT OF POLICY DEVELOPMENT AND IMPLEMENTATION

There was a significant amount of policy development in the Irish Health Care system during the 1990s. Considerable effort was made to address outstanding policy gaps and also to build on the work that was completed during the 1980s, which was by and large not implemented owing to the cutbacks and restraints on public expenditure at that time. While the information set out in Appendix IV is not intended to represent a complete overview of all policy, it does serve to highlight the fact that The Department of Health & Children has been proactive in the area of policy development. There are however still a number of noticeable policy gaps, for example in relation to acute hospital services, Accident & Emergency services, and in specific areas, for example ophthalmology. Such policy gaps will need to be filled to develop a complete policy framework for the Irish Health Care system.

Issues pertaining to the implementation of policy are discussed in Section 4.3 below.

4.2.1 Shaping a Healthier Future

Probably the most notable and fundamental development to shape Health Care in the 1990s was the publication of "Shaping a Healthier Future" in 1994. The document represented a key step forward in the strategic planning process not only in the health sector but also throughout the public system. This was achieved by integrating key policy objectives and principles (i.e. equity, quality and accountability) into a single framework that would serve to underpin the provision of all future health services and policies. In doing so, the strategy brought together earlier policies and reports and linked them to current provision and future requirements. These included "*Health – The Wider Dimension"* published in 1986 and the *"Report of the Commission on Health Funding"* published in 1989. The themes and targets of the World Health Organisation's *"Health for All Programme"* were also incorporated.

Fundamentally, Shaping A Healthier Future, also defined the strengths and weaknesses of the Irish Health Care system, a summary of which are set out below:

Strengths

- High quality services
- Well qualified staff trained to high standards
- A strong voluntary sector
- A mix of public and private services with a complementary rather than a conflicting role
- Political and social consensus on the importance of a well funded, high quality and equitable system
- A comprehensive planning framework already in place

Weaknesses

- The lack of goals and targets on which the services focus, such that the effectiveness cannot be measured
- Information to support measurement of performance is either unavailable or under utilised
- Insufficient attention has been paid to the causes of premature mortality
- Waiting times for many services are too long
- Inadequate links between sectors of the services, including hospitals, general practitioners and community services
- Under developed community services
- Organisational and management structures which require updating to provide improved decision-making and accountability

In recognition of the above, the core objective of the strategy is formulated as follows:

"The reorientation of the system towards improving effectiveness of health and personal social services by reshaping the way services are planned and delivered".

As part of the above, the strategy supported improvements along three broad areas:

- The services, which are to be more clearly focused on improvements in health status and quality through the provision of appropriate care.
- The framework, such that management and organisational structures will deliver and be more appropriate for improved decision-making and accountability at a regional level; this also requires better methods of performance management.
- The participants, such that services respond more closely to consumers' needs plus an increased recognition of the key role of staff.

As already highlighted, three principles underpinned the strategy:

1. Equity

The strategy recognised that there were a number of dimensions that would determine equitable access to the Health Care system:

- Access to Health Care should be determined by actual need for services rather than ability to pay or geographic location
- Those needing services should have them available in a reasonable time
- Equity should address variations in health status
- Equity is not just about ensuring fairness, but the system must be seen to be fair

In order to achieve the above, the following recommendations were made:

- Implementing uniform rules for eligibility and charges for services across the country
- Introducing measures to reduce waiting times for those using public services
- Paying special attention to certain disadvantaged groups

2. Quality of Service

Services must be of the highest possible quality within the availability of resources. This in turn required:

- A re-orientation towards a more critical evaluation of the outcome of services using techniques such as clinical audit
- Improved efficiency, courtesy and physical surroundings such that the consumer is more likely to be satisfied

3. Accountability

The key elements to underpin this were defined as:

- The development of the existing formal legal and financial accountability arrangements
- The requirement on those providing services to take explicit responsibility for the achievement of agreed objectives, the absence of which was acknowledged
- The implementation of mechanisms to ensure that those with decision-making powers are adequately accountable to the consumers

The output of the strategy was a four-year action plan, which covered the following services:

- Health promotion
- General practitioner services
- Dental services
- Women's' health
- Family planning
- Children's' health
- Child care and family support services
- Travellers health
- Addressing drug misuse
- Food and medicine control

- Acute hospital services
- HIV/AIDS
- Ill and dependent elderly
- Palliative care
- People with mental illness
- People with intellectual disabilities
- People with physical or sensory handicap

Other notable initiatives arising from the strategy included the development of specific strategies for Cancer and Cardiovascular Services in an effort to streamline and co-ordinate services in areas where significant health issues existed. In his annual report (1999) the Chief Medical Officer states that these strategies should serve as future benchmarks to achieve "improvements, particularly in respect of such areas as the standardisation and co-ordination of services, the development of national guidelines and protocols, and the introduction of systems for surveillance and performance of measurement".

What Has Actually Been Achieved?

A critique of "Shaping a Healthier Future" undertaken by the ESRI in 2001 drew the following conclusions, among others:

i) The most challenging issue that continues to face the Irish Health Care system is most probably equity in terms of access, experience and geography. However, the three principles outlined by the 1984 strategy should continue to form part of any future strategy.

ii) Little progress has been made in developing or implementing standardised measures or controls that provides for a comprehensive and integrated approach to quality assessment, monitoring and enforcement.

iii) Considerable progress has been made in financial accountability, while the implementation of clinical accountability has not been widespread.

iv) The gathering and analysis of information to track and measure health and social gain has largely been "philosophical rather than operational".

v) Service and business planning are valuable monitoring and evaluation tools. However, Health Boards have not developed detailed plans for implementation, monitoring or evaluation of the four-year action plan developed under the 1994 strategy. The lack of management information together with the deficiencies of management information systems were recognised as having a particular adverse impact in this regard.

The ESRI report also made a series of recommendations with regard to future strategy and policy development, a number of which are highlighted below:

- Strategy statements cannot feasibly cover all aspects of policy development and implementation. However, it is important that adequate attention is given to a number of key business processes, particularly;

  - Business planning
  - Performance management
  - Service delivery
  - Financial and human resource management and review
  - Evaluation

- Variations in mortality and morbidity have by and large been assumed to have been mainly influenced by health behaviours. This in turn has had a major influence on policy development. While behaviour is an important variable, socio-economic factors need to given greater attention and focus. Social and economic factors that influence peoples' health and general well-being are the most important measures of health inequality, not inequalities in access or in the utilisation of health services.
- Primary care services are under-developed and under-resourced and this is an area that needs to be addressed. Primary care has a potentially important role to play in promoting health and social gain. (This point has been consistently in evidence during this VFM study.)
- Policy should be based upon an extensive programme of research and discussion, not only as a means of informing policy but also as a means of assessing the extent by which policy objectives and targets are met. Although a significant amount of health-related data is collated to inform the aforementioned areas, this is of little benefit in the absence of socio-economic data.
- Strategy and policy objectives and targets should be specific, measurable, achievable, realistic and time-bound. The process of achieving targets needs to be supported by the preparation of detailed action and implementation plans, followed up by a process of monitoring and evaluation.

4.3 ISSUES IMPACTING ON POLICY DEVELOPMENT & IMPLEMENTATION

While The Department of Health & Children has been strong in the area of policy development, its track record in implementation is in comparison poor and quite often inconsistent. While this may in part be attributable to the lack of public funding that continued to impact on service delivery in the earlier part of the 1990s, the ESRI report highlights other issues that need to be considered. In the sections which follow, we take a closer look at these and we also assess the areas where progress has been made that should lead to improvements in policy development, implementation and evaluation in the future.

4.3.1 Funding

A lack of adequate public funding of the Health Care services during the first half of the 1990s militated against the implementation of policy objectives and targets. Furthermore, medium term policies are not supported by detailed implementation plans and multi-annual budgets, so that funding of policy is uncertain.

The review of policy set out in Appendix IV highlights that in many areas, the lack of investment had a significant impact on the development of the services and infrastructure which has resulted in a period of "catch-up" to try and achieve key targets and goals. However, this process has, and will, be facilitated by the significant increase in both capital and revenue expenditure that has been allocated to many services, particularly over the last two years.

This is evident from the data contained in Appendix IV, where, by way of example, we have tracked at a high level the funding allocations to the Elderly, Psychiatric Services and Persons with an Intellectual Disability. The trend in increased funding is expected to continue for at least the next two years, supported through the National Development Programme. While the increases are widely welcomed, there are also concerns relating to the uncertainty of funding in the medium to long term and the impact that this has on service planning and strategy development.

There are a number of issues in the area of financial processes and procedures that have had an adverse impact on policy implementation and long-term planning. These include;

- The lack of multi-annual budgeting, which has fostered a short-term approach to service planning.
- Historically the provision of funds to Health Boards and agencies has been on an ad hoc basis and not set within any medium term planning context, which gave rise to an impromptu approach to planning and development that did not always necessary coincide with policy objectives. The service planning process has considerably assisted in this area.
- The lack of an explicit resource allocation process to underpin the base budget for Health Boards.
- The lack of well developed costing systems at unit level throughout the health system to measure cost of services and activities.
- The focus of management reporting on statutory reporting and financial accounting requirements, with very little progress being made in financial performance by activity.
- Gaps in the availability of skills throughout the sector to plan and manage the significant increase in funding that has occurred. This in turn requires a change in culture to focus attention more on strategic development and value for money issues than has historically been the case.

4.3.2 Forward Planning

In Section 6 of the report, we review in greater detail the service planning process in terms of the role it plays and its current state of development. In summary, it is recognised as a valuable management tool that has facilitated improvements in the areas of policy planning and evaluation and control over expenditure. However, it is still regarded as being at an early stage of development with its full potential yet to be realised. Amongst other things, service-planning needs to be set in a multi-annual strategic planning context, with clinicians significantly more involved in the planning process.

A further issue identified relates to a lack of consistency in organisation processes and structures throughout the system, which impacts on the planning process. For example, with respect to the implementation of policy for the elderly, it appears that no two Health Boards have adopted the same approach to implementation, which makes the process of comparison and evaluation more difficult. As evidenced throughout this report, the general lack of a common approach to planning has resulted in inefficiencies at all levels in the system.

4.3.3 Service Integration

The ESRI report concluded that primary care services were by and large underdeveloped. We would agree with this, based on our review of policy and the output from this study. There is a general lack of integration between acute, primary and community services that hinders the effective implementation of policy. This is especially evident in the care of the elderly where hospital beds are being inappropriately occupied because of the lack of intermediate/sub-acute services and because of the general lack of communication between the acute and primary sectors. The proposed implementation of a Unique Patient Identifier is widely perceived as a potential solution to improved integration and while we concur with this, we also believe that changes in attitudes and working practices are required to achieve the desired impact.

Other issues that arise with regard to service integration include:

- The need to define and then develop regional self sufficiency in a wider range of services, to facilitate better planning and integration of local services, and to define the roles of hospitals and other agencies within a regional context.

- Co-ordination between The Department of Health & Children and other relevant Government Departments and Agencies. The role and functions of The Department of Health & Children are extremely broad ranging and go beyond pure health services. A consequence of this, is that the lines of demarcation and responsibilities with reference to the functions of other Government Departments and agencies is not always clear in relation to policy implementation. Examples include its role vis-à-vis:

  – The Department of Education and Science in the provision of educational services to persons with an Intellectual Disability and Autism.

  – The Department of Transport in the supply of local transport services to and from day centres.

  – The Department of the Environment and local authorities in the development and maintenance of housing.

  Over the last decade, this lack of clarity has impacted adversely on service implementation across a number of areas.

- Co-ordination between the health services and the voluntary sector. The voluntary sector plays a key role in the provision of services at a local level but in many instances the level of co-ordination and integration with regional health services is unstructured. It is fair to recognise that progress has been made to address this issue in the implementation of "Enhancing the Partnership" and "Widening the Partnership" for the delivery of services to persons with an Intellectual Disability (refer to Appendix IV for more detail on the key elements of these documents).

4.3.4 Accountability and Performance Management

A number of points warrant and attention under this area.

- Under current legislation, the ERHA is the only health agency that is required by law to monitor and evaluate performance. Across the remaining health Boards, the acceptance of ownership and accountability for service performance varies. While the service planning process and the development of a set of performance indicators will assist in addressing this issue, the deficiencies in management information systems and the availability of reliable and robust data has been a major impediment to realising significant improvements (also refer to Section 7). There is significant scope to improve monitoring at all levels of the health system.

Further clarification between the role of The Department of Health & Children and the Health Boards is required. As will be discussed in Section 6, it is our view that the Department is too involved in operational issues.

- Clinical audit and clinical governance is largely underdeveloped in the acute sector. (Refer to Section 6)
- It is widely perceived that accountability and performance management at GP level is lacking primarily due to the self-employment status of many GPs (Refer to Section 9).
- Attention to managerial capability and capacity to manage performance and value for money as part of the policy / strategy implementation process was not a priority issue during the 1990s. In turn, it also appears that the rewards and benefits of the process were not fully understood or appreciated.
- Performance measurement over the last decade has tended to focus on financial measures. There was a general lack of measurement of service outcomes and quality, personal outcomes and internal performance, for example. Many of the policy documents developed make reference to the requirement to evaluate service outcomes as part of the implementation process. This is happening to a limited extent only.

As we will discuss in Section 7, efforts are ongoing to address deficiencies. There is also a growing realisation and acceptance of the role and requirement of performance management and accountability in the Health Care system. However, currently there is no clear framework or vision in place to drive the process forward in a co-ordinated manner.

4.3.5 Management Information and Information Systems

The ESRI report identified that gaps exist with respect to the inclusion of socio-economic data to support the policy development and evaluation processes. It also recommended that policy should be developed in line with comprehensive research into needs assessment. Our review of policy would suggest that there are variations in the extent to which service needs and gaps in service provision, have been quantified for different care groups with much of the progress being made in the second half of the decade. In some areas, significant advances have been made with the establishment of databases that incorporate a comprehensive data set and which are updated on a regular basis. Examples include the National Cancer Register and the Intellectually Disability database. The application of these databases in tracking changing population demographics and social needs and in defining future service requirements is highly commendable but is a process that needs to be replicated across the system.

Overall, there is a need to gather performance measurement data as a basis for identifying issues and taking corrective action, and also as a means of assessing value for money in the system.

A further issue, discussed in Section 7, is the fragmented approach that has been widely adopted to system selection and implementation in the Health Care system against a background of low investment in IT. Too often, individual Boards have pursued their own systems selection agenda. A key priority for the future must be the assessment of existing system capabilities and future requirements to meet information needs and requirements on a conjoint basis.

4.3.6 Human Resources

For the greater part of the 1990s the availability of the appropriate number and level of skilled personnel was not a serious issue. However, this situation has changed in recent years and is likely to remain a serious threat to the successful implementation of policy for the foreseeable future.

Overseas recruitment initiatives have been implemented which have been largely perceived as being successful but significant skill shortages remain. These have been most prominent in the Dublin area, given the higher costs of living that exits there.

4.4 CONCLUSIONS

The key area to be addressed by The Department of Health & Children going forward relates to the implementation of strategy and policy. This will require that adequate attention is focused on resolving the issues outlined above that acted as a barrier to implementation during the 1990s. To be effective policy has to be monitored and evaluated on a regular basis in terms of efficiency, effectiveness and economy. This requires that the appropriate systems, structures and management processes and systems are in place.

There are a number of central themes which we would see as being central to future policy formulation:

- A focus on the regionalisation of services, reducing the historical dependency on the Eastern region, and providing greater local access to care. National strategies will still remain at the centre of any reorganisation strategy. The roles of hospitals and other service providers will in some cases need to be redefined within such a regional strategy. There needs to be an openness to this redefinition of roles among service providers in the context of improving patient care.
- The development of an acute sector policy.
- A high priority on health promotion in all aspects of society. As part of this, a strong effort should be made to have employers engage proactively in health promotion amongst their workforce.
- A strong emphasis on consistent protocols for treatment across the system.
- A focus on the integration of primary and community care into the treatment of patients. This will require significant improvements in integrating primary care providers into the secondary care system, requiring improved communication between GPs and practitioners in the acute system, and between Public Health Nurses and GPs at community level.
- Decision-making on an evidence basis- this will require a significant commitment to invest in information systems, and provide the necessary qualified resources to interpret and manage on the basis of the information provided.
- A multi-annual commitment to funding, to enable policy to be implemented and developed in a multi-annual planning framework.
- Clear performance indicators and targets developed for each policy.
- A continuous process of intensive audit of the effectiveness of policy. Regular reviews of Expenditure Programmes are an appropriate basis to effect such audit. To date, such reviews (e.g. Dental Services) have proven to be a useful mechanism to assess performance, but too few have been carried out.

SECTION 5: DATA ANALYSIS

5.1 INTRODUCTION

In this section of our report, we examine the trends in population, Health Care expenditure, manpower and activity over the period 1990 to 1999. Specifically we review:

- Population changes over the 1990s;
- Changes in health service expenditure;
- Changes in health service staffing;
- Changes in health service activity.

The analysis of health services covers each of the main areas of health and welfare services falling under the management of The Department of Health & Children and the Health Boards.

Throughout this section, but particularly in discussions around the acute hospital services, the relative complexity of health services should be borne in mind as a factor which makes comparative analysis more difficult. Changes in population are more easily measured or forecast than changes in population health that affect health service utilisation. While the different rates of use of services by different age groups are known and can be used to compare populations, the different health levels of different populations, by age or by area, are not directly measured. While mortality rates provide some indication of different rates of disease, at least for diseases which cause death, they do not necessarily provide an accurate basis for assessing the level of treatable illness or the need for hospital or other services. For diseases and social conditions that do not lead to death, there is little if any routine data available to assess the relative need, over time or between areas. The development of the National Health Information Strategy (NHIS), referred to in Section 7 of this report, provides a basis for improving the available information over time to enable improved measurement of these issues to take place.

For health and social services, in particular for acute hospital services, what is provided with resources available is likely to change over time. The changes in the complexity of service are not directly captured in the routine activity statistics such as the total number of cases treated. Nor is the direct resource intensity of different components of a service always available, though the development of the Casemix system for providing performance-related payments to acute hospitals does address some of these problems.

5.2 POPULATION CHANGES

Table 5.1 sets out a summary of the population and its demographic profile during the 1990s. Estimated growth in population for the period 1990 to 1999 was c.7% per cent.

This is clearly a relatively modest level of growth in population but is to be expected over a relatively short period of time. It is to a considerable degree the result of a falling number of births, with the population under 15 falling in total by about 10%. The elderly population rose, though the 65-74 age group marginally fell in number, reducing the likely impact of population ageing on the demand for services.

The highest rates of growth are in the middle-aged population group, where the demand for health and welfare services begins to rise, and in the over 85s, reflecting the effects of improved population health and survival in the period since 1950.

Table 5.1

Health Board Area	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Estimated Population by Board										
Eastern	1,234,015	1,245,225	1,258,534	1,268,444	1,275,579	1,283,991	1,295,939	1,309,122	1,326,201	1,341,813
Midland	202,719	202,984	203,990	204,474	204,522	204,770	205,542	207,320	209,603	211,623
Mid-Western	309,703	310,728	312,762	314,007	314,566	315,415	317,069	320,042	323,829	327,197
North-Western	207,854	208,174	209,202	209,726	209,785	210,079	210,872	212,757	216,168	217,284
South-Eastern	381,114	383,188	385,786	387,388	388,157	389,328	391,517	395,106	399,696	403,789
Southern	529,804	532,263	536,427	539,242	540,880	543,068	546,640	551,843	558,495	564,431
Western	341,985	342,974	345,672	347,529	348,618	350,064	352,353	355,558	359,608	363,177
North Eastern	298,705	300,183	302,128	303,290	303,792	304,585	306,155	308,852	312,313	315,386
TOTAL	3,505,899	3,525,719	3,554,500	3,574,100	3,585,899	3,601,300	3,626,087	3,660,600	3,704,903	3,744,700

Source: Department of Health & Children

In order to compare the level of resources provided to the health and welfare services over the 1990s, it would be useful to adjust the population for the level of demand in each age group. This is relatively difficult for many services, as the age-standardised rate of utilisation is not always measured, for example in a range of welfare services.

We have compared the crude population growth with a partial indicator of the potential demand for hospital and health services, the rate of use of hospital services at different ages. With the exception of services specifically for the elderly, this measure potentially gives greater weight to the old than any other measure of use of health and welfare services. It can be used in the analysis of individual services to assess the overall effect of population change, given the utilisation of health and social services by different age groups in the population.

Detailed population data to support this calculation are not available beyond 1996. For the period 1991 to 1996, even for services which are heavily used by the old and very old, (for example acute hospital services), the overall effect of adjusting for utilisation rates is to leave the adjusted change below 5%. Extrapolating this growth to 1999 suggests that growth in population, weighted by utilisation of hospital services, would be of the order of 7% for the period 1991-1999. In other words, the growth of the Irish population in the 1990s was not heavily concentrated in age groups likely to make the greatest use of health services and so growth in demand due to a change in age structure, as opposed to changing standards or population needs, was not of great significance. Again this partly reflects the short time period of ten years, over which population age structure is unlikely to change dramatically. There is an issue emerging, however, namely the increasing numbers of persons over 80 years of age.

It follows that, if Health Care needs remained constant for each age group over the 1990s and if medical technologies remained constant, a growth in resources of around 7.5% or less, in real terms, would probably have been sufficient to meet the demand of the slightly larger population by 1996***, to the extent that is was met in 1991***. That is, the utilisation of hospitals could have remained constant with a small real rate of growth of resources, though that rate may have been too low to meet all demands for treatment or provide all treatments to a standard that clinicians would seek to provide. This measure does have to be treated with caution because of the very low funding base in 1990, and concerns that demands for services were not being met at that date.

In practice, several changes have occurred during the period which have changed the demand for and provision of services. These have impacted most significantly on the acute hospital sector and change the level of resources needed to meet a given level of need for services:

- Medical technology has expanded the range of treatable conditions. It is difficult to generalise about the balance of technologies but overall we would expect that this change has led to increased costs and resource use rather than lower costs and resource use;
- Efficiency has changed as the length of stay in hospital has fallen (assuming no reduction in quality, which may not be the case) though for much of the 1990s, the fall in length of stay for most age groups except the elderly was relatively small;
- Resource costs may have changed. In particular, the rapid growth of the Irish economy in the late 1990s has caused labour shortages in a number of sectors. These are likely to be putting upward pressure on labour costs either through wage rates or other factors such as easier promotion or rising use of overtime. In these economic conditions, which particularly affect the late 1990s, the resource cost of providing a service is likely to rise.

In other service areas, other changes have occurred that will change the perceived level of demand for resources. This includes a change in the awareness and focus on child abuse and neglect, for example.

5.3 ESTIMATED OVERALL HEALTH EXPENDITURE

Table 5.2 sets out an analysis of Estimated Overall Health Expenditure in Ireland in the period 1990 to 1996 (the latest date for which complete data are available for all elements of the table). The table illustrates the significant increase in total health expenditure in the period, rising from £2bn in 1990 to £3.3bn. We estimate that by 1999 total health expenditure was £5bn. Approximately 75% of Estimated Total Health Expenditure is represented by Public Expenditure, which itself rose from £1.5bn in 1990 to £3.8bn in 1999, an increase of 153% in the period. By the time of the Estimate for 2001, public expenditure had risen to £5.4bn.

By far and away the greatest part of Public Expenditure arises from the Health Vote for Non-Capital Expenditure items. In 1990 Health Net Non-Capital Expenditure amounted to £1.46bn; by 1999, it had increased to £3.6bn, an increase of 147% over the ten year period. Over the same period, inflation in general was c.22%. Relative to overall inflation, this is equivalent to a growth in Health Care resources of about 125% in real terms. Note that this is the adjusted increase in expenditure when compared to the growth in consumer prices. It is possible, indeed likely, that some Health Care inputs changed in price by more than the retail price index, for example when new medicines replaced old ones. However, it is difficult to standardise precisely for all the different cost components in health and social care.

Overall, given population growth of the order of 7% and the likely use of different services, (if use had remained constant) this represents a very substantial increase in resources, over and above inflation. By 2001, the Health Vote for Non Capital Expenditure had increased to £5.1bn. In a period of predominantly low levels of general inflation, the increase over the 1990 to 2001 period represents significant incremental investment in the running of the Irish health system annually. The largest part of the increase arose between 1996 and 2001, when total Public Non-Capital Expenditure increased from a low base of £2.4bn to £5.1bn, a more than doubling in expenditure over the period.

Total Public Capital Expenditure represented between 2% and 3% of Total Public Expenditure in the period 1990 to 1994, increasing to between 4% and 5% in each of the years 1995 to 2001. In absolute monetary terms, capital expenditure remained relatively static for the first part of the decade; from 1996 onwards increased levels of capital expenditure have arisen annually. By 1999 capital expenditure of some £181m arose (including investment in information technology), a significant uplift on resources applied to capital in the early part of the decade, but nevertheless a relatively low level of capital investment in the context of maintaining the current capital infrastructure, and a tiny proportion of annual non capital expenditure levels. Some £270m has been provided in the 2001 Health Estimate for capital expenditure. By any standard, the levels of capital expenditure arising, whilst increasing, point to a significant lack of investment in the physical infrastructure of the system, including IT systems, a factor that is not sustainable over the medium term.

Private Health Expenditure is dominated by VHI expenditure and Household Expenditure. During the 1990s, VHI expenditure consistently represented between 11% and 12% of Public Net Non-Capital Expenditure, putting in perspective the dominant role of public health provision in the Irish health system. The statistic also places in context the relatively minor role private insurance has in the overall financing of the system, which is somewhat in contrast with the significant and often contentious profile private practice has in the public system.

Total Public Non-Capital Expenditure represented 6.4% of GNP in 1990, increasing to 7.3% of GNP in 1993, and falling back to 6.8% in 1999. Whilst the wealth of the nation has materially increased over the decade, it is of note that Public Non Capital Expenditure represents an almost identical proportion of GNP in 1999 as in 1990. When Total Private Expenditure is taken into account, Estimated Total Health Expenditure in Ireland represented 8.5% of GNP in 1990 and an estimated 8.8% in 1999.

Table 5.2

Estimated Overall Health Expenditure	**1990** (£m)	**1991** (£m)	**1992** (£m)	**1993** (£m)	**1994** (£m)	**1995** (£m)	**1996** (£m)
Public Health Expenditure							
Health Net Non-Capital Expenditure	1,455.3	1,609.5	1,799.4	1,998.2	2,126.9	2,280.8	2,336.1
European Social Fund	23.6	24.9	26.6	27.6	28.0	20.1	17.4
National Lottery Current Expenditure	8.6	21.5	30.3	18.4	18.9	18.2	18.1
Treatment Benefits	15.5	17.0	17.4	24.8	26.1	28.3	29.4
Total Public Non-Capital Expenditure	1,503.0	1,672.9	1,873.7	2,069.0	2,199.9	2,347.4	2,401.0
Health Capital Expenditure	44.2	35.9	33.0	33.0	54.4	92.0	115.8
National Lottery Capital Expenditure	2.0	6.6	11.0	11.0	11.1	4.0	4.0
Total Public Capital Expenditure	46.2	42.5	44.0	44.0	65.5	96.0	119.8
Total Public Expenditure	1,549.2	1,715.4	1,917.7	2,113.0	2,265.4	2,443.4	2,520.8
Estimated Private Health Expenditure							
VHI Expenditure	171.1	184.9	203.6	223.6	247.7	268.8	291.6
Other Non-Household Private Expenditure	6.0	6.7	7.4	8.3	8.8	9.4	9.7
Household Expenditure	288.9	321.6	350.6	350.8	361.5	382.4	398.9
Private Capital Expenditure	43.6	30.3	34.4	25.2	26.3	56.5	51.9
Total Private Expenditure	509.6	543.5	596.0	607.9	644.3	717.1	752.1
Estimated Total Health Expenditure							
Total Expenditure	2,058.8	2,258.9	2,513.7	2,720.9	2,909.7	3,160.5	3,272.9
As a % of GDP							
Total Public	5.7	6.1	6.4	6.5	6.4	6.2	5.9
Total Private	1.9	1.9	2.0	1.9	1.8	1.8	1.8
Total	7.6	8.0	8.3	8.4	8.3	8.0	7.6
As a % of GNP							
Total Public	6.4	6.7	7.1	7.3	7.2	7.0	6.7
Total Private	2.1	2.1	2.2	2.1	2.0	2.1	2.0
Total	8.5	8.9	9.3	9.4	9.2	9.1	8.7

Per capita spending is perhaps a better measure of health expenditure. Total non-capital Public Health Expenditure per capita increased from £442 in 1990 to c.£1,000 in 1999 and an estimated £1400 per capita in 2001. Whilst the structures of systems vary from country to country, this level is, although increasing, low by international standards.

5.4 PROVISIONAL OUTTURN 1986 TO 2000

Table 5.3 analyses the Provisional Outturns contained within the Revised Estimates for the Public Services for each of the years 1986 to 2000, together with the Estimate for 2001. The following points are of note:

1. The table confirms the relatively static nature of Total Public Health Expenditure in the period 1986 to 1989. During this period, total public health expenditure continued at c.£1.3bn in each year, before appropriations in aid.

2. From 1990 to 1995, total expenditure increased by 64% from c.£1.5bn to c.£2.5bn. From 1995 to 1999, the corresponding increase was 56%, bringing total expenditure to £3.8bn. In the two years since 1999, total expenditures increased to £4.5bn and £5.4bn respectively. The 2001 Estimate represents a 42% increase on the Outturn for 1999, just two years earlier. The comparative rate of increase at different points in time over the past twelve years emphasises the scale of the increase in public expenditure in recent years.

3. The table identifies a number of exceptional and non-recurring items of expenditure and shows the level of public health expenditure exclusive of these amounts. The items concerned relate to the cessation of the Disabled Persons' Maintenance Allowance (DPMA) in 1995 when it was transferred to the Department of Social Welfare, the re-financing of health agency debt in 1994 in the amount of £95m and various categories of payment relating to the Hepatitis C Compensation Tribunal arising in the period from 1995.

Table 5.4 analyses the Non-Capital Public Expenditure in each year by agency. Allocations to Health Boards represented between 59% and 63% of the total Non Capital Expenditure between 1990 and 1999. Voluntary hospitals, homes not run by Health Boards and voluntary mental handicapped homes between them accounted for between 23% and 28% of the Provisional Outturn over the same period. The expenses of operating the General Medical Services Scheme accounted for between 10% and 12% of annual expenditure in each of the ten years.

It is of note that the proportion of the total Non Capital Public Expenditure in 2000 represented by Health Boards/authorities increased to 67% in 2000 and to 86% in 2001, the latter a reflection of voluntary agencies being funded by Boards, principally in the ERHA region where the voluntary hospitals were funded directly by the ERHA for the first time.

Table 5.5 provides a Programme Analysis of the Provisional Outturn in the period 1986 to 2001. A detailed analysis is included in Appendix V**.**

The following points are relevant.

- **Community Protection Programme:**

Expenditure within the Community Protection Programme increased from £24m in 1990 to £107m in 1999, an increase of 346% over the period. The most significant increases have arisen in relation to food hygiene and standards, prevention of infectious diseases and other preventative services.

Table 5.3

PROVISIONAL OUTTURN OF HEALTH EXPENDITURE

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Administration																
Salaries, wages and allowances	5	5	5	5	6	6	7	9	9	9	10	11	11	12	13	16
Other	3	3	4	5	5	3	3	2	3	3	4	3	4	3	5	6
	9	9	9	10	11	9	10	10	11	12	14	14	15	15	19	22
Grants to Health Boards in respect of Net Expenditure																
Public Service Pay	443	449	452	475	524	568	646	721	784	804	850	1006	1146	1345	1682	2580
Social Welfare	17	18	18	18	22	24	27	30	32	34	38	43	51	66	81	166
Superannuation	20	20	22	23	24	26	29	32	34	36	37	44	55	73	89	146
Non Pay	176	176	173	180	168	175	184	216	229	248	268	308	331	454	682	662
	656	663	665	697	738	813	886	999	1080	1122	1181	1401	1582	1938	2433	3554
Grants to Health Boards in respect of Cash Allowances/Cash Grants																
DPMA	54	56	59	61	64	72	80	87	94	58						
Other	12	12	12	13	38	43	52	62	73	86	108	118	148	176	222	281
	66	68	71	74	103	115	132	149	167	144	108	118	149	176	222	281
Expenses of General Medical Services																
Public Service Pay/fees	46	48	49	65	75	84	97	100	106	109	113	119	139	180	169	180
Development of General Practice								9	14	18	16	17	17	17	19	19
Non Pay	60	63	78	88	83	93	111	118	126	131	138	148	159	230	246	300
	106	111	127	155	158	177	208	233	246	258	267	284	315	427	433	499
Grants to Certain Other Health Bodies	290	280	279	297	346	383	428	489	496	569	593	663	682	749	751	83
Grants relating to prior years																
Health Boards																
Public Service Pay	23	29	25	18	22	26	30	35	34	55	58	60	74	84	106	122
Non Pay	20	23	20	18	22	19	20	26	26	45	61	57	69	73	86	100
	43	52	45	36	44	45	50	61	60	100	119	117	143	157	192	222
Hospitals/ Homes not run by Health Boards	36	42	36	36	40	49	53	60	65	49	48	52	58	61	81	95
Voluntary Mental Handicapped Homes	4	4	4	4	4	4	4	5	5	7	8	7	8	9	9	
	83	98	85	78	88	98	107	126	130	156	165	176	209	227	281	317
Grants to Health Agencies- National Lottery funded					8	22	30	19	19	18	18	19	20	7	7	8
Refinancing of Health Agency Debt									95							
Scheme of Compensation Tribunal Account										60		42	111	63	51	41
Building, Equipping and Furnishing of Hospitals	59	50	41	42	31	29	30	37	59	90	112	123	132	161	217	260
Information Systems				3	4	4	5	6	6	6	6	8	14	20	14	28
Grants to Research Bodies	2	2	2	1	1	2	2	2	2	3	3	6	5	6	8	11
Other	3	1	3	4	8	4	3	7	8	7	11	12	14	16	19	40
Total	1282	1289	1282	1359	1490	1656	1861	2056	2298	2445	2470	2864	3248	3605	4454	5396
Appropriations in Aid	108	130	170	171	179	189	225	249	255	268	274	299	375	532	821	873
Total Expenditure	1174	1189	1112	1188	1311	1467	1636	1807	2043	2177	2196	2565	2873	3273	3633	4523

Table 5.4 Agency Analysis of Provisional Outturn of Health Expenditure

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Provisional Outturn by Category																
Allocations to Health Boards	766	770	781	807	886	973	1082	1209	1286	1366	1391	1634	1874	2271	2667	4327
Expenses of General Medical Services	106	111	127	155	160	177	208	233	246	258	267	284	315	427	433	499
Hospitals/ Homes not run by Health Boards	276	271	283	308	341	349	390	425	453	494	545	572	626	659	640	178
Voluntary Mental Handicapped Homes	61	65	68	69	79	87	96	109	116	131	135	140	123			0
Non Capital Expenditure	1210	1230	1227	1289	1434	1586	1773	1976	2098	2249	2306	2640	2937	3617	4120	5004
Building, Equipping and Furnishing of Hospitals	59	50	41	42	31	29	30	37	59	90	112	123	132	161	217	260
Information Systems	0	0	0	3	4	4	5	6	6	6	6	8	14	20	14	28
Grants to Health Agencies- National Lottery funded	0	0	0	0	9	22	30	19	19	18	18	19	20	7	7	8
Refinancing of Health Agency Debt	0	0	0	0	0	0	0	0	95	0	0	0	0	0	0	0
Scheme of Compensation Tribunal Account	0	0	0	0	0	0	0	0	0	60	0	42	111	63	51	41
Grants to Research Bodies	2	2	2	1	1	2	2	2	2	3	3	6	5	6	8	11
Other	3	1	3	4	0	4	3	7	8	7	11	12	14	16	19	40
Administration	9	9	9	10	11	9	10	10	11	12	14	14	15	15	19	22
	1282	1299	1282	1359	1490	1656	1861	2056	2298	2445	2470	2864	3248	3605	4454	5396

Table 5.5 Programme Analysis of Health Expenditure	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Programme Analysis																
Community Protection Programme	21	20	20	23	24	26	32	37	40	48	55	73	79	107	177	230
Community Health Services Programme	178	186	196	229	232	261	303	343	372	406	434	473	541	696	776	877
Community Welfare Programme	100	103	105	109	127	141	158	178	201	190	133	168	182	215	351	454
Psychiatric Programme	150	150	154	158	169	183	197	209	216	228	233	257	274	311	342	389
Programme for the Handicapped	128	133	135	141	152	166	182	202	223	258	287	309	344	410	513	631
General Hospital Programme	649	656	663	697	801	897	994	1097	1146	1227	1277	1486	1809	1875	2051	2554
General Support Programme	64	64	66	68	71	79	90	94	93	99	108	127	153	172	209	240
Gross Non Capital ExpenditureTotal	1289	1320	1338	1425	1576	1752	1956	2160	2291	2448	2507	2873	3182	3786	4419	5375
Income	80	98	107	107	112	121	127	144	145	147	153	161	174	184	186	213
Net Non Capital ExpenditureTotal	1219	1222	1231	1318	1464	1631	1829	2016	2146	2299	2354	2712	3008	3602	4221	5162
Capital	59	58	41	42	31	29	38	37	59	90	112	123	132	181	217	250
Total Expenditure	1278	1280	1272	1360	1495	1660	1867	2053	2205	2389	2466	2835	3140	3783	4438	5412

The Community Protection Programme accounted for between 2% and 3% of the total net Non-Capital Expenditure per annum during the 1990s. By 2001, funding of this programme had increased to £230m.

The services falling under the Community Protection element of the budget are all services whose impact will be difficult to monitor. The services are mainly preventive, and their impact may not be felt for some time. Equally, some of the consequences of failures to prevent certain problems occurring will be measurable relatively easily, for example outbreaks of preventable infections associated with food hygiene.

- **Community Health Services Programme:**

The Community Health Services Programme increased from £232m to £696m between 1990 and 1999. The most significant element of the programme concerns the General Practitioner (Choice of Doctor) Scheme, which accounted for £158m (68.1%) of total expenditure under this heading in 1990, increasing to £432m (62.1%) of total expenditure in 1999. Also of note is the significant increase in the subsidy for drugs purchased by persons ineligible under the GP service, which increased from £16.4m in 1990 to £123.7m by 1999. By 2001, expenditure in this programme had risen to £877m.

Although Health Boards are responsible for the local organisation of GP services, funding is provided for GP services through the GMS Payment Board. This body makes payments to GPs for patients covered by the Medical Card scheme, who are placed on a registered list with GPs.

GPs are paid a fee per person registered with them, though in the past they received fees for each item of service provided to patients. Although the capitation fee replaced the fees for basic consultations, a range of other fees continue, for example fees for out-of-hours consultations and emergency consultations with patients not on the GPs list. A small number of GPs are still paid on the fee per item basis.

In 1990, the Community Health Services Programme represented 15% of total Non-Capital Expenditure. By 1999 this programme had progressively increased to 18% of total net Non-Capital Expenditure.

- **Community Welfare Programme:**

The Community Welfare Programme increased from £127m in 1990 to £215m by 1999. Until 1995, this heading included Cash payments and Grants for Disabled Persons, which was transferred to the Department of Social Welfare at that stage. Excluding this from the base expenditure for 1990, the programme total increased from £60m to £215m in the period, or, from 4% of Total Non-Capital Expenditure in 1990 to 6% by 1999. The principal items of expenditure under this heading concern home health services, grants to voluntary welfare agencies, welfare homes for the aged and payments for children in residential homes, which increased from £7.2m in 1990 to £91m in 1999.

- **Psychiatric Programme:**

The Psychiatric Programme provides funding for the diagnosis, care and prevention of psychiatric ailments. In 1990, the Programme accounted for £168.6m or 10.7% of total Non Capital Expenditure. By 1999, the total expenditure on this programme had increased to £310.7m, or 8.6% of the total Non-Capital Expenditure.

- **Programme for the Handicapped:**

The Programme for the Handicapped provides for care of the handicapped in special homes, psychiatric hospital and in day centres. The Programme total increased from £151.9m in 1990 to £410.2m in 1999, which represented between 9% and 11% of total Non-Capital Expenditure throughout the period.

- **Hospital Programme:**

The Hospital Programme accounts for the largest element of the Total Public Non-Capital Expenditure. It accounted for £801.2m or 50.8% of total non-capital expenditure in 1990 increasing to £1.1bn, or 50% of non capital expenditure by 1994. Significant increases in the expenditure levels within this Programme occurred in the latter part of the decade and by 1999, the total expenditure within the Hospital Programme amounted to £1.87bn or 49% of Total Non-Capital Expenditure. The expenditure covers services in regional hospitals, public voluntary hospitals, health Board general hospitals and a range of district and long stay hospitals. It is of note that the percentage of expenditure on the Hospital Programme progressively reduced from 51% to 49% of the national Total Non-Capital Expenditure in the period 1990-1999. By 2001, the relevant percentage had dropped to 47.5%, a function mainly of increased expenditure in community care.

5.5 HEALTH SERVICE PERSONNEL AND PAY

Table 5.6 summarises the number of persons working within the Irish health system over the period 1990 to 1999. It is evident that in overall terms the number of people employed in the Irish health system has increased by some 13,000, or 22%, over the ten year period. This indicates the very significant commitment of additional resources to the public health system during the decade.

Within the categories of personnel, the following increases in staffing arose:

- There was an increase of 3,150 persons within the management and administration category, a rise of 43% over the 10 years. This category includes administrative staff who support clinicians in their work, for example personnel involved in out patients, admission offices, ward clerks, and in medical records.
- Medical and dental personnel increased by 1,350 over the period, a rise of 33% over the 10 years in this category. On a national basis, the numbers of medical/dental personnel rose from 1.1 to 1.4 per 1,000 of population over the 10-year period.

  The number of approved consultant posts increased from 1,122 in January 1990 to 1,440 in January 2000 and to 1,560 in December 2000, an increase of 39% in the number of Consultant posts in the public sector in the period. A significant part of the increased number of posts arose following the publication of the Tierney Report. There is now approximately one consultant per 2,400 population whereas at the start of the 1990s, it was closer to 1:3,000. This is still low relative to other developed countries such as Scotland.

  An analysis of the distribution of the consultant workforce and the distribution of the population show that in the ERHA region, each consultant represented at 1 January 2000 approximately 1,870 persons; in the North Western and Western Health Boards the numbers were 2,729 and 2,587 persons per consultant respectively.

Table 5.6

WHOLETIME EQUIVALENT NUMBERS EMPLOYED IN THE PUBLIC HEALTH SERVICE

HEALTH BOARD AREA	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
MANAGEMENT/ ADMIN										
Eastern	1,090	1,121	1,150	1,192	1,210	1,270	1,340	1,463	1,646	1,892
Midland	281	285	295	298	313	327	348	376	403	432
Mid-Western	464	474	492	510	480	470	504	567	639	691
North-Eastern	302	307	317	348	401	440	415	568	680	744
North-Western	511	515	521	526	528	563	585	622	650	710
South-Eastern	472	492	512	550	617	641	609	687	726	826
Southern	725	682	692	740	773	821	864	930	911	1,059
Western	573	596	617	647	697	730	759	781	829	918
HEALTH BOARDS TOTAL	4,418	4,472	4,596	4,811	5,019	5,262	5,424	5,994	6,484	7,272
Voluntary/Joint Board Hospitals	1,811	1,907	1,930	1,989	2,112	2,162	2,250	2,313	2,478	2,712
Mental handicap Homes	378	384	404	443	477	462	476	485	512	541
Commercial and Non-Commercial Semi-State Bodies	768									
GRAND TOTAL	**7,375**	**6,763**	**6,930**	**7,243**	**7,608**	**7,886**	**8,150**	**8,792**	**9,474**	**10,525**
MEDICAL/DENTAL										
Eastern	459	485	506	535	524	528	552	587	610	660
Midland	157	171	169	172	186	196	206	211	223	232
Mid-Western	238	259	258	253	242	280	281	318	333	341
North-Eastern	160	169	171	176	192	216	205	352	300	318
North-Western	190	226	219	223	227	233	246	253	260	262
South-Eastern	287	290	308	320	350	367	378	393	428	446
Southern	457	452	461	461	507	535	543	553	569	588
Western	380	392	375	400	410	415	423	433	457	431
HEALTH BOARDS TOTAL	2,328	2,444	2,467	2,540	2,638	2,770	2,834	3,100	3,180	3,278
Voluntary/Joint Board Hospitals	1,622	1,612	1,646	1,722	1,732	1,767	1,803	1,827	1,929	2,055
Mental handicap Homes	44	44	42	45	45	44	47	49	45	50
Commercial and Non-Commercial Semi-State Bodies	39									
GRAND TOTAL	**4,033**	**4,100**	**4,155**	**4,307**	**4,415**	**4,581**	**4,684**	**4,976**	**5,154**	**5,383**
NURSING										
Eastern	2,849	3,044	3,067	3,151	3,148	3,181	3,334	3,346	3,375	3,237
Midland	1,140	1,164	1,194	1,232	1,248	1,270	1,305	1,335	1,420	1,399
Mid-Western	1,670	1,735	1,780	1,729	1,763	1,748	1,660	1,689	1,769	1,748
North-Eastern	1,210	1,249	1,262	1,277	1,262	1,381	1,374	1,849	1,818	1,916
North-Western	1,492	1,536	1,559	1,570	1,552	1,580	1,545	1,541	1,539	1,667
South-Eastern	2,144	2,181	2,235	2,277	2,394	2,507	2,462	2,459	2,480	2,559
Southern	2,818	2,807	2,882	2,905	2,866	3,091	3,096	3,106	3,010	3,181
Western	2,513	2,498	2,555	2,544	2,552	2,481	2,458	2,493	2,580	2,572
HEALTH BOARDS TOTAL	15,836	16,214	16,534	16,685	16,785	17,239	17,234	17,818	17,991	18,279
Voluntary/Joint Board Hospitals	7,156	7,263	7,451	7,728	8,104	8,066	7,886	7,403	6,770	6,807
Mental handicap Homes	1,740	1,737	1,878	1,890	2,031	2,055	2,144	2,205	1,934	2,068
Commercial and Non-Commercial Semi-State Bodies	83									
GRAND TOTAL	**24,815**	**25,214**	**25,863**	**26,303**	**26,920**	**27,360**	**27,264**	**27,426**	**26,695**	**27,154**

PARAMEDICAL										
Eastern	564	592	595	681	754	827	936	1,034	1,145	1,196
Midland	177	180	181	191	216	239	254	267	289	304
Mid-Western	224	252	262	248	266	309	308	341	368	388
North-Eastern	142	137	143	153	178	222	225	309	330	374
North-Western	255	268	269	291	327	314	301	334	338	351
South-Eastern	211	221	244	272	318	355	352	402	427	465
Southern	377	384	392	407	454	484	497	532	579	628
Western	345	350	358	372	393	419	447	473	513	549
HEALTH BOARDS TOTAL	2,295	2,384	2,444	2,615	2,906	3,169	3,320	3,692	3,989	4,255
Voluntary/Joint Board Hospitals	1,511	1,541	1,590	1,641	1,741	1,779	1,883	1,914	2,029	2,189
Mental handicap Homes	375	373	361	371	378	397	373	364	404	387
Commercial and Non-Commercial Semi-State Bodies	108									
GRAND TOTAL	**4,289**	**4,298**	**4,395**	**4,627**	**5,025**	**5,345**	**5,576**	**5,970**	**6,422**	**6,831**
SUPPORT SERVICES										
Eastern	2,577	2,490	2,443	2,486	2,487	2,501	2,690	2,723	3,196	3,451
Midland	995	1,029	979	1,035	1,022	955	1,000	1,050	1,060	1,050
Mid-Western	907	912	915	934	961	1,002	1,011	1,067	1,057	1,075
North-Eastern	1,196	1,161	1,130	1,146	1,179	1,155	1,005	1,282	1,316	1,350
North-Western	1,289	1,300	1,341	1,307	1,386	1,249	1,294	1,360	1,404	1,484
South-Eastern	1,327	1,358	1,392	1,431	1,478	1,586	1,513	1,579	1,593	1,716
Southern	1,709	1,740	1,733	1,724	1,818	1,871	1,903	1,899	2,034	2,062
Western	1,917	1,847	1,819	1,794	1,865	1,860	1,618	1,617	1,672	1,726
HEALTH BOARDS TOTAL	11,917	11,837	11,752	11,857	12,196	12,179	12,034	12,577	13,332	13,914
Voluntary/Joint Board Hospitals	3,377	3,316	3,353	3,370	3,482	3,490	3,537	3,449	3,660	3,755
Mental handicap Homes	2,209	2,241	2,309	2,416	2,596	2,676	2,890	3,087	3,365	3,703
Commercial and Non-Commercial Semi-State Bodies	97									
GRAND TOTAL	**17,600**	**17,394**	**17,414**	**17,643**	**18,274**	**18,345**	**18,461**	**19,113**	**20,357**	**21,372**
MAINTENANCE/ TECHNICAL										
Eastern	272	267	259	257	248	252	246	245	238	214
Midland	80	88	81	83	86	85	86	86	91	90
Mid-Western	162	173	180	159	159	161	163	158	162	158
North-Eastern	65	63	64	61	63	61	58	80	72	62
North-Western	113	115	103	110	103	93	90	87	89	91
South-Eastern	112	122	125	127	132	127	117	125	121	125
Southern	229	227	221	219	230	221	220	207	199	202
Western	195	191	187	187	187	181	179	177	172	176
HEALTH BOARDS TOTAL	1,228	1,246	1,220	1,203	1,208	1,181	1,159	1,165	1,144	1,118
Voluntary/Joint Board Hospitals	380	372	382	384	390	383	366	357	389	387
Mental handicap Homes	114	109	100	100	100	92	94	96	92	87
Commercial and Non-Commercial Semi-State Bodies	18									
GRAND TOTAL	**1,740**	**1,727**	**1,702**	**1,687**	**1,698**	**1,656**	**1,619**	**1,618**	**1,625**	**1,592**
Totals										
Total Health Boards	**38,022**	**38,597**	**39,013**	**39,711**	**40,752**	**41,800**	**42,005**	**44,346**	**46,120**	**48,116**
Total Voluntaries	**15,857**	**16,011**	**16,352**	**16,834**	**17,561**	**17,647**	**17,725**	**17,263**	**17,255**	**17,905**
Total mental handicap homes	**4,860**	**4,888**	**5,094**	**5,265**	**5,627**	**5,726**	**6,024**	**6,286**	**6,352**	**6,836**
Other semi state	**1,113**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total Grand Totals	**59,852**	**59,496**	**60,459**	**61,810**	**63,940**	**65,173**	**65,754**	**67,895**	**69,727**	**72,857**

In the Southern Health Board the average number was 3,018 persons per consultant and in all other Boards the number was of the order of 3,400. The trend towards specialisation in the larger teaching hospitals, principally in Dublin, and the high level of cross boundary flows of patients into the region from other Boards, has historically tended to increase the numbers of consultants in the Eastern region relative to other Boards.

- Nursing staff numbers increased from 24,815 to 27,154, a rise of 9% over the period. In reality the increase was higher as the figures for 1990 include student nurses, who since 1998 participate in Nursing Registration/Diploma Programmes and are no longer accounted for as part of the rostered workforce. If student nurses are excluded from the 1990 base data for reasons of comparability, the increase in nursing personnel over the period 1990 to 1999 was nearer 27%. Nursing personnel (adjusted to exclude student nurses in 1990 for reasons of comparability) were 6.1 per 1,000 population in 1990 to an estimated 6.7 per 1,000 of population in 1999.
- The number of public health nurses increased from 1,358 in 1990 to 1,527 in 1999, an increase from 3.87 to 4.1 per 10,000 of population.
- Paramedical staff increased from 4,289 to 6,831 over the period, an increase of 59% in the period.

  Paramedical staff rose from 1.1 to an estimated 1.7 per 1000 of population over the 10 years.
- A 21% increase in staff numbers occurred in support services, representing an increase of 3,772 persons over the ten years.

In overall terms, the health service increased from 17 to 19 persons per 1,000 of population over the period 1990 to 1999.

An examination of the distribution of health service personnel in Health Boards and voluntary acute hospitals shows that approximately 40% are located in the Eastern region, which accounts for a 36% share of the population. The predominance of the Eastern region in the provision of care is also reflected in the proportions of doctors, nurses and paramedics working there in 1999; 45% of medical/dental personnel, 38% of nurses and 51% of paramedics were employed in the Eastern Health Board and voluntary hospitals in the region in that year.

These statistics reflect the dominant position of the Eastern region's major acute hospitals within the Irish hospital system. Both the Western and the North Western Health Board areas had a share of national health service personnel resources in excess of their proportionate share of the population. In the case of the North Western Health Board, it had 7.1% of total health service personnel in 1990, reducing to 6.9% by 1999. This compares with a share of the population in the period of c.6%. The Western Health Board area had 11.7% of health service personnel in 1990, reducing to 10.3% by 1999 compared with an approximate 9.7% share of the population throughout the period. A comparison with the Southern Health Board shows that its share of the population throughout the period was consistently 15.1% whereas its share of personnel resources was c.13.5% in the decade. The regional variations in personnel are for the most part not based on any strategic allocation of resources within the system, but rather reflect the incremental nature of how the Irish Health Care system has evolved and where capital investment has been made.

Table 5.7 provides a comparative analysis of pay and personnel numbers by category of staff for the Health Boards in Ireland during the 1990s. The Health Boards accounted for between 64% and 66% of all staff employed in the health service during the decade. The following points are of note:

(i) Average pay cost per person employed in the Health Boards rose from £15,700 in 1990 to £30,100 in 1999. Stated at 1990 base price, the average pay cost in 1999 is equivalent to £24,800, which represents a real increase in average pay per person employed in the Health Boards of 58% over the decade.

Table 5.7 **Health Board Average Pay**

Pay Costs (£m)	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Management / Admin	48.8	53.2	56.6	63.1	67.6	73.9	80.5	92.3	108.6	124.0
Medical / Dental	63.7	79.7	100.3	106.2	110.5	118.2	127.3	153.7	174.8	191.7
Nursing	249.0	278.0	306.7	339.4	352.9	369.3	382.1	456.3	481.2	585.2
Paramedical	33.3	35.9	45.2	55.2	62.4	71.9	80.1	92.0	111.1	122.3
Support Services	119.8	129.3	134.3	145.3	153.3	171.8	183.7	206.3	232.0	258.2
Maintenance / Technical	16.9	17.8	18.3	19.5	19.9	20.1	20.6	21.2	24.3	24.9
Superannuation	57.7	60.7	63.5	67.1	71.2	76.3	80.7	96.5	103.9	110.7
	589.3	654.5	724.8	795.8	837.7	901.5	954.9	1118.2	1235.8	1416.9
Numbers Of Staff										
Management / Admin	4,418	4,472	4,596	4,811	5,019	5,262	5,424	5,994	6,484	7,272
Medical / Dental	2,328	2,444	2,467	2,540	2,638	2,770	2,834	3,100	3,180	3,278
Nursing	15,836	16,214	16,534	16,685	16,785	17,239	17,234	17,818	17,991	18,279
Paramedical	2,295	2,384	2,444	2,615	2,906	3,169	3,320	3,692	3,989	4,255
Support Services	11,917	11,837	11,752	11,857	12,196	12,179	12,034	12,577	13,332	13,914
Maintenance / Technical	1,228	1,246	1,220	1,203	1,208	1,181	1,159	1,165	1,144	1,118
Superannuation										
	38,022	38,597	39,013	39,711	40,752	41,800	42,005	44,346	46,120	48,116
Average pay(£000's)										
Management / Admin	11.2	12.0	12.5	13.4	13.8	14.4	15.1	16.2	17.4	18.0
Medical / Dental	27.6	33.4	40.8	42.4	42.7	43.7	45.4	51.8	55.7	59.4
Nursing	16.0	17.3	18.7	20.4	21.1	21.7	22.2	26.0	26.9	32.3
Paramedical	14.7	15.3	18.7	21.8	22.6	23.7	24.7	26.2	28.9	29.7
Support Services	10.2	10.9	11.4	12.3	12.7	14.1	15.2	16.8	17.9	19.0
Maintenance / Technical	13.5	14.4	14.8	16.1	16.5	16.8	17.6	18.2	21.0	22.0
	15.7	17.1	18.7	20.2	20.8	21.8	22.8	25.9	27.3	30.1
Inflation adjusted (£ 000's)										
Management / Admin	11.2	11.6	11.7	12.4	12.5	12.7	13.1	13.8	14.5	14.8
Medical / Dental	27.6	32.4	38.4	39.3	38.7	38.6	39.5	44.3	46.5	48.9
Nursing	16.0	16.8	17.6	18.9	19.1	19.2	19.3	22.3	22.5	26.6
Paramedical	14.7	14.9	17.6	20.2	20.5	20.9	21.4	22.5	24.2	24.4
Support Services	10.2	10.5	10.7	11.4	11.5	12.5	13.2	14.4	15.0	15.6
Maintenance / Technical	13.5	13.9	13.9	14.9	14.9	14.9	15.3	15.6	17.6	18.1
	15.7	16.6	17.6	18.7	18.9	19.3	19.8	22.2	22.8	24.8

(ii) The most significant increases occurred in the average pay of health professionals; average pay cost for medical and dental personnel increased by 115% over the 10 years, a real increase of 77%. Average pay cost for nursing personnel increased by 102% in the period, a real increase of some 66%. Paramedical staff enjoyed an increase of 102% in average pay cost over the period. Average pay cost for management/administrative staff increased by 61% in the period, support services by 86% and maintenance and technical staff by 63% (equivalent to 32%, 53% and 34% in real terms).

Table 5.8 provides an analysis of pay costs by programme and by category of staff throughout the 1990s. It can be seen that total pay costs in the health sector rose from just under £600 million in 1990 to £1.4 billion in 1999, an increase of 140%. Of particular note is the increase in the level of pay costs in the Community Care Programme, which rose almost fourfold in the period, an indication of the increased numbers of personnel (social workers, childcare workers, public health nurses) devoted to this area over the decade.

5.6 NON-PAY EXPENDITURE IN HEALTH BOARDS

Table 5.9 aggregates non pay expenditure within the Health Boards during the 1990s by category of expenditure and by programme. It can be seen that non pay expenditure increased from £400m to £1.1bn over the period. The general hospital programme accounted for 29% of non pay in 1990 and 27% in 1999. The majority of non pay expenditure arises within the Community Care Programme, which accounted for £197m of total expenditure in 1990 (49%) and £590m in 1999 (54%).

The principal items of note are as follows:

(i) The cost of drugs and medicines in the General Hospital Programme increased from £11.8m to £32.3m over the ten years. During the same period, the cost of drugs in voluntary acute hospitals rose from £19m to £46m. Across the acute sector, drug costs increased by c.150% in the ten years. The more than doubling of drugs cost in this period is in line with international experience.

(ii) The cost of medical and surgical supplies in the General Hospital Programme increased from £10.8m to £41m over the decade. A significant increase from £5.2m to £21m also arose under this heading within the Community Care Programme over the period.

(iii) Maintenance costs (excluding minor capital items) increased from £8.1m in 1990 to £27.1m in 1999. Given the capital investment in the health system historically, this level of maintenance expenditure is extremely low and in all probability inadequate to maintain the capital base of the system. While £90m was provided in the capital programme in 2000 on a once-off basis for re-equipping of hospitals, this is still significantly short of the investment required, particularly as increasingly specialised medical equipment has shorter useful life. Such equipment is commonly accepted to have a seven year useful life on average, whereas previously ten years was more common. The health system has lacked a significant equipment replacement and refurbishment programme until the funding of £90m was provided for the first time in 2000.

The lack of investment in re-equipping the system adversely affects value for money in terms of efficiency where existing equipment is not fully functional.

(iv) Grants to agencies increased from £32.8m to £249.4m over the ten years. In the latter part of the decade, Health Boards took on the direct funding of certain voluntary agencies, which accounts for a significant part of the increase.

Table 5.8

Analysis of Health Board Payroll Costs

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Management / Admin										
General Hospital Programme	15.6	17.5	18.5	20.1	22.6	24.7	26.9	31.6	37.1	41.6
Special Hospital Programme	5.6	6.1	6.5	7.1	7.6	8.3	8.7	9.4	11.1	12.6
Community Care Programme	16.4	17.1	18.1	21.1	22.4	24.4	27.2	31.9	36.0	42.2
Central Services	11.2	12.5	13.5	14.8	15.1	16.5	17.7	19.4	24.3	27.6
Total	48.8	53.2	56.6	63.1	67.6	73.9	80.5	92.3	108.6	124.0
Medical / Dental										
General Hospital Programme	40.1	49.4	64.1	67.1	68.9	73.3	78.3	97.4	114.9	127.6
Special Hospital Programme	10.3	12.5	17.3	16.5	16.7	17.3	18.6	21.3	25.3	27.0
Community Care Programme	13.2	17.8	18.8	22.5	24.9	27.4	28.9	33.2	32.3	34.5
Central Services	0.1	0.1	0.1	0.1	0.1	0.3	1.4	1.8	2.3	2.6
Total	63.7	79.7	100.3	106.2	110.5	118.2	127.3	153.7	174.8	191.7
Nursing										
General Hospital Programme	122.3	136.3	148.3	155.2	155.9	169.0	173.5	209.4	224.5	273.0
Special Hospital Programme	97.8	109.4	122.1	131.1	134.4	135.3	139.9	159.9	164.0	196.5
Community Care Programme	28.9	32.3	36.2	53.0	62.4	64.7	67.4	86.5	91.5	114.1
Central Services	0.0	0.1	0.1	0.1	0.2	0.3	1.2	0.5	1.2	1.6
Total	249.0	278.0	306.7	339.4	352.9	369.3	382.1	456.3	481.2	585.2
Paramedical										
General Hospital Programme	20.2	20.1	24.7	27.7	28.7	30.9	34.4	39.9	47.2	52.2
Special Hospital Programme	3.0	3.4	3.8	4.4	5.3	5.4	5.8	6.3	8.5	9.9
Community Care Programme	9.9	12.2	16.4	22.9	28.1	35.3	39.5	45.4	54.8	59.8
Central Services	0.2	0.2	0.2	0.2	0.2	0.3	0.4	0.4	0.6	0.4
Total	33.3	35.9	45.2	55.2	62.4	71.9	80.1	92.0	111.1	122.3
Support Services										
General Hospital Programme	63.9	68.6	71.5	69.8	75.0	82.2	86.0	98.7	109.3	121.4
Special Hospital Programme	39.3	41.5	40.8	40.2	43.6	50.7	52.3	49.3	55.9	57.7
Community Care Programme	13.6	14.8	17.2	32.5	33.1	37.6	44.0	56.7	64.5	75.2
Central Services	2.9	4.4	4.7	2.9	1.6	1.4	1.5	1.5	2.3	3.9
Total	119.8	129.3	134.3	145.3	153.3	171.8	183.7	206.3	232.0	258.2
Maintenance / Technical										
General Hospital Programme	7.7	8.1	8.2	8.6	8.9	8.9	9.1	9.8	11.0	11.3
Special Hospital Programme	7.1	7.5	7.6	7.9	7.9	7.9	8.1	7.7	8.8	9.0
Community Care Programme	1.5	1.5	1.7	2.2	2.5	2.5	2.7	2.8	3.5	3.3
Central Services	0.6	0.7	0.7	0.7	0.6	0.7	0.7	0.9	0.9	1.3
Total	16.9	17.8	18.3	19.5	19.9	20.1	20.6	21.2	24.3	24.9
Superannuation										
General Hospital Programme	13.4	14.5	15.2	13.4	25.2	27.0	31.2	37.4	47.9	51.0
Special Hospital Programme	15.5	15.6	15.8	13.6	17.2	18.7	19.9	22.4	27.6	29.1
Community Care Programme	7.6	7.7	7.5	8.2	12.5	13.8	17.1	21.8	25.5	26.6
Central Services	21.3	22.9	25.0	31.9	16.3	16.8	12.5	14.9	2.8	4.0
Total	57.7	60.7	63.5	67.1	71.2	76.3	80.7	96.5	103.9	110.7
Total										
General Hospital Programme	283.3	314.5	350.6	361.9	385.2	416.0	439.3	524.3	591.8	678.1
Special Hospital Programme	178.6	195.9	213.9	220.8	232.6	243.6	253.4	276.3	301.3	341.8
Community Care Programme	91.1	103.3	115.9	162.4	185.9	205.7	226.8	278.3	308.3	355.7
Central Services	36.2	40.8	44.4	50.7	34.1	36.2	35.4	39.4	34.4	41.3
Grand Total	589.3	654.5	724.8	795.8	837.7	901.5	954.9	1118.2	1235.8	1416.9

Table 5.9

Aggregate Non Pay Expenditure in Health Boards

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Drugs & Medicines										
General Hospital Programme	11.8	15.9	16.3	16.8	17.4	20.4	21.8	26.0	28.9	32.3
Special Hospital Programme	4.2	4.8	5.1	5.2	4.9	5.7	5.6	5.9	6.7	7.0
Community Care Programme	26.0	33.9	38.3	43.8	7.2	7.8	8.2	10.1	8.2	9.4
Central Services	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1
Total	41.9	54.6	59.7	65.7	29.5	33.8	35.6	42.1	44.0	48.8
Medical / Surgical Supplies										
General Hospital Programme	10.8	15.8	17.7	20.2	21.8	25.9	28.9	26.0	37.3	41.0
Special Hospital Programme	1.3	1.3	1.3	1.5	1.3	1.5	1.6	1.1	1.9	1.9
Community Care Programme	5.2	8.2	9.5	10.7	10.7	11.6	13.7	10.7	17.7	21.0
Central Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Total	17.3	25.3	28.5	32.4	33.8	39.0	44.3	37.8	56.9	64.0
Laboratory										
General Hospital Programme	5.8	7.2	7.6	6.9	10.6	11.1	12.9	14.6	17.5	20.1
Special Hospital Programme	0.1	0.0	0.0	0.0	0.2	0.1	0.3	0.3	0.2	0.8
Community Care Programme	1.2	0.9	1.5	1.2	2.3	2.5	1.5	2.0	2.2	2.7
Central Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0
Total	7.1	8.1	9.1	8.1	13.1	13.7	14.7	16.9	20.1	23.6
Catering										
General Hospital Programme	0.0	3.5	5.4	5.9	10.5	11.2	12.3	12.8	13.9	14.6
Special Hospital Programme	0.0	1.8	3.2	3.4	8.9	9.2	9.1	8.5	8.7	9.2
Community Care Programme	0.0	0.0	0.3	2.1	3.7	3.8	4.4	5.2	5.7	6.3
Central Services	0.0	0.0	0.0	0.0	0.1	0.3	0.1	0.1	0.2	0.7
Total	0.0	5.4	8.9	11.4	23.2	24.5	25.9	26.6	28.5	30.8
Maintenance										
General Hospital Programme	3.6	3.9	6.1	6.9	7.5	7.4	6.7	8.1	9.6	11.4
Special Hospital Programme	3.3	3.6	3.9	4.3	5.1	4.5	4.4	4.8	7.4	7.8
Community Care Programme	1.0	1.1	1.2	3.1	4.0	4.3	3.3	7.0	4.0	7.0
Central Services	0.2	0.2	0.2	0.6	1.5	0.9	0.9	0.4	1.0	0.9
Total	8.1	8.8	11.4	14.8	18.1	17.2	15.3	20.3	21.9	27.1
Computer										
General Hospital Programme	0.2	0.5	0.4	1.3	1.1	1.2	1.2	1.8	2.3	3.4
Special Hospital Programme	0.0	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.5	1.0
Community Care Programme	0.1	0.2	0.2	0.5	0.7	1.0	1.1	1.6	2.9	3.8
Central Services	1.3	2.2	2.9	2.5	3.8	4.1	3.9	5.8	7.0	7.1
Total	1.6	3.0	3.6	4.4	5.8	6.5	6.4	9.5	12.6	15.3
Dental Services Treatment Scheme										
General Hospital Programme	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Special Hospital Programme	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Community Care Programme	0.0	0.0	0.0	0.0	0.0	0.5	0.6	1.1	12.6	16.1
Central Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.0	0.0	0.0	0.0	0.0	0.5	0.6	1.1	12.6	16.1
All Grants to Agencies										
General Hospital Programme	3.5	3.6	6.6	8.0	11.2	12.2	14.5	16.1	17.1	22.2
Special Hospital Programme	7.7	8.5	11.0	13.6	21.8	27.2	27.9	31.3	39.1	48.3
Community Care Programme	21.5	23.1	31.8	36.1	40.3	51.6	59.3	71.9	99.5	175.3
Central Services	0.1	0.1	0.1	0.1	0.1	0.1	0.1	7.7	6.6	3.5
Total	32.8	35.3	49.4	57.8	73.3	91.0	101.9	129.0	162.3	249.4
Cash Allowances										
General Hospital Programme	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Special Hospital Programme	0.4	0.5	0.5	0.6	1.4	1.3	1.6	1.7	1.7	1.9
Community Care Programme	71.6	97.6	108.1	115.3	125.5	88.3	25.8	28.8	31.6	36.4
Central Services	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	72.1	98.1	108.6	115.9	127.0	89.6	27.4	30.5	33.3	38.3
Capitation Payments										
General Hospital Programme	8.3	13.6	12.3	12.2	13.8	16.5	17.3	23.6	25.4	19.2
Special Hospital Programme	4.8	4.8	5.0	4.3	5.4	9.1	9.7	11.3	37.7	41.9
Community Care Programme	9.4	12.7	14.4	19.3	25.0	28.0	30.5	33.5	41.8	59.5
Central Services	1.3	1.3	1.3	1.5	1.7	0.4	1.0	0.8	1.0	0.9
Total	23.8	32.4	33.0	37.3	45.8	54.0	58.5	69.2	105.9	121.5
Community Drug Schemes										
General Hospital Programme	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0
Special Hospital Programme	0.9	1.0	1.1	1.1	0.0	0.0	0.0	0.0	0.0	0.0
Community Care Programme	0.0	0.0	0.0	0.0	59.2	71.5	85.8	104.0	131.5	163.0
Central Services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	0.9	1.0	1.1	1.1	59.2	71.5	85.8	104.0	131.5	163.0
Other										
General Hospital Programme	73.3	65.4	68.1	75.5	68.6	76.6	78.1	95.1	100.0	131.3
Special Hospital Programme	37.5	39.5	39.2	39.9	29.4	30.4	30.8	31.0	34.5	42.5
Community Care Programme	60.9	45.1	46.6	55.2	53.9	61.1	62.8	80.2	70.6	89.6
Central Services	23.1	28.1	31.3	29.3	24.8	27.6	24.3	27.7	29.2	37.1
Total	194.8	178.1	185.2	200.0	176.8	195.8	195.9	234.1	234.3	300.4
Grand Total										
General Hospital Programme	117.3	129.4	140.5	153.6	162.5	182.5	193.6	226.0	252.0	295.5
Special Hospital Programme	60.3	66.0	70.4	74.1	78.5	89.2	91.3	96.3	138.4	162.2
Community Care Programme	196.8	222.7	251.9	287.2	332.3	331.9	297.1	355.9	428.3	590.0
Central Services	26.0	29.9	35.8	34.0	32.1	33.4	30.4	42.7	45.2	50.4
Total	400.4	448.0	498.6	548.9	605.3	637.0	612.3	721.0	863.9	1098.1

(v) Capitation payments arose from £23.8m to £121.5m over the period. This includes the change in funding of mental handicap agencies, who became directly funded by Boards at the end of the decade.

(vi) Expenditure on the Community Drugs Scheme (separately identified from 1995 onwards) has risen significantly, particularly towards the end of the decade and accounted for £163m of total non pay expenditure in 1999, or 15% of total non pay expenditure nationally.

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5.7 ACUTE HOSPITAL PROGRAMME:

Table 5.10 sets out relevant data for the acute hospital programme for the 10 years 1990 to 1999. The expenditure data shows that the Hospital Programme increased from £621m to £1.5bn over the period. Voluntary acute hospitals accounted for 43% of total expenditure in 1990 and 42% of the Programme in 1999, principally a reflection of the fact that a number of the large acute hospitals in Dublin are voluntary in nature.

During the period, a marginal reduction in the total number of acute beds available in the Irish hospital system occurred from 11,868 in 1990 to 11,783 in 1999, a reduction from 3.4 to 3.1 in-patient beds per thousand of population (these figures exclude beds in District hospitals). By way of comparison, these bed numbers compare with c 15,000 in 1983, prior to the significant cutbacks of the late 1980s.

In-patient admissions rose from 514,932 in 1990 to a peak of 537,785 in 1996, reducing to 531,456 in 1999 (the latter figure was influenced by the nurses' strike in that year). In essence, in patient admissions remained relatively static throughout the period, not unsurprising given the relatively stable in-patient stock available in the period. It is of note that the rate of inpatient admission per 1,000 of population has remained virtually unchanged throughout the decade ranging from a minimum 142 to a maximum of 148 in the period. In 2000, inpatient admissions increased to 548,000 cases, an increase of 3.3% on the previous year.

Throughout the period, the average occupancy rate in the acute hospital sector remained extremely high ranging from 85.3% in 1990, the highest over the decade, to 82.2% in 1996. This level of occupancy is high by international standards, and reflects high utilisation of available capacity in the Irish acute hospital system. It also masks the fact that some hospitals operate at much higher occupancy rates. The persistency of the occupancy rate at 82/85% throughout the period points to an efficient hospital system in terms of the utilisation of existing capacity; it also raises the question of the adequacy of the inpatient bed capacity particularly when considered in conjunction with the continuing presence of waiting lists for inpatients throughout the period, a matter to which we return in Section 8 of this report. It is also of note that average length of stay has marginally decreased over the 10-year period from 6.9 days for inpatient stay in 1990 to 6.7 in 1999.

One of the most significant advances in acute hospital performance in the decade concerns the significant increase in the number of day beds available, rising from 284 in 1990 to 704 in 1999. During the same period, there was an increase in day cases from 124,769 to 299,631, a 140% increase in the period. Day cases represented 20% of total admissions in 1990; by 1999 this had increased to 36% nationally. In 2000, day cases increased to 320,000 cases, up 7% on the previous year.
When combined, the total number of admissions to hospital (in patient and day cases) in 1990 rose from 639,701 to 831,087 in 1999, with each year showing an increase on the prior. In 2000, total admissions rose significantly to 868,000 cases, an increase of 4% on the previous year. The number of admissions in 1999 represented a 30% increase in the number of patients treated in 1990. The increase in activity took place against a background of a static number of in patient beds, but with increases in both day facilities and in medical manpower to treat the increased number of patients. In every year during the decade a progressive increase in day cases occurred within the acute hospital system. This is a significant measure of increased efficiency in the Irish acute hospital system during the decade.

Table 5.10										
Key Statistics	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Total Allocations to Health Boards										
General Hospital Programme	352	393	435	455	471	528	569	666	744	867
Special Hospital Programme	212	232	252	262	269	296	315	339	403	470
Community Care Programme	278	315	358	431	492	511	498	599	697	900
Central Services	63	71	84	86	59	61	56	72	69	79
Total Net Current Expenditure	894	1004	1115	1223	1307	1394	1415	1676	1912	2316
Acute Hospital Programme										
	£m	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Expenditure Data										
Pay	283	315	352	362	385	416	439	524	592	678
Non Pay	117	129	141	154	163	183	194	226	252	296
Gross Expenditure	400	445	493	516	548	598	633	750	844	973
Income	47	52	58	61	76	70	64	84	99	107
Net Expenditure	352	393	435	455	471	528	569	666	744	867
Voluntary Acute Hospitals	269	311	346	387	428	451	495	520	574	635
	621	**704**	**781**	**841**	**900**	**979**	**1064**	**1186**	**1319**	**1502**
Acute Hospital Data										
Total Beds Available	11868	11979	12136	11809	11853	11953	11937	11861	11788	11783
In-Patient Admissions	514932	511626	511586	522662	522803	529393	537785	536817	538390	531456
% Occupancy	85.3%	83.8%	83.4%	83.6%	82.9%	82.4%	82.2%	83.3%	84.2%	82.8%
Average Length of Stay	6.9	6.9	6.7	6.7	6.6	6.6	6.5	6.5	6.7	6.7
Day Beds Available	284	368	462	516	521	543	583	612	646	704
Day Cases	124769	142374	155326	186842	193018	207308	233908	249472	270240	299631
Total Cases	639701	654000	666912	709504	715821	736701	771693	786289	808630	831087
Casualty Attendences	1119767	1120146	1131805	1124572	1137683	1199452	1193677	1213321	1242243	1225109
Dialysis Treatments	31657	27720	40094	42082	48582	52474	55846	60759	66883	72110
Day cases as a % of total cases	20%	22%	23%	26%	27%	28%	30%	32%	33%	36%
per 1000 of population										
Number of inpatient beds	3.4	3.4	3.4	3.3	3.3	3.3	3.3	3.2	3.2	3.1
Rate of inpatient admission	147	145	144	146	146	147	148	147	145	142
Number of day beds	0.08	0.10	0.13	0.14	0.15	0.15	0.16	0.17	0.17	0.19
Casualty attendances	319	318	318	315	317	333	329	331	335	327
Personnel data	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Medical/Dental personnel	3950	4058	4113	4265	4370	4537	4638	4999	5108	5333
Nursing	22987	23472	23983	24408	24883	25302	25123	25653	24762	25086
Paramedics	3806	3925	4024	4260	4648	4948	5207	5671	6019	6444
Healthcare professionals	**30,743**	**31,455**	**32,120**	**32,933**	**33,901**	**34,787**	**34,968**	**36,323**	**35,889**	**36,863**
Management/admin	6232	6379	6725	6799	7127	7417	7676	8416	8962	9984
Other	16904	16774	16520	16813	17285	17243	17086	16870	18524	19174
Total Health Board and Voluntary Hospitals	**53879**	**54608**	**55365**	**56545**	**58313**	**59447**	**59730**	**61609**	**63375**	**66021**
Intellectually Disabled	**4860**	**4888**	**5094**	**5265**	**5627**	**5726**	**6024**	**6286**	**6352**	**6836**
Total	**58739**	**59496**	**60459**	**61810**	**63940**	**65173**	**65754**	**67895**	**69727**	**72857**
per 1000 of population										
Medical/Dental personnel	**1.1**	**1.2**	**1.2**	**1.2**	**1.2**	**1.3**	**1.3**	**1.4**	**1.4**	**1.4**
Nursing	**6.6**	**6.7**	**6.7**	**6.8**	**6.9**	**7.0**	**6.9**	**7.0**	**6.7**	**6.7**
Paramedics	**1.1**	**1.1**	**1.1**	**1.2**	**1.3**	**1.4**	**1.4**	**1.5**	**1.6**	**1.7**
Healthcare professionals	**8.8**	**8.9**	**9.0**	**9.2**	**9.5**	**9.7**	**9.6**	**9.9**	**9.7**	**9.8**
Management/admin	**1.8**	**1.8**	**1.9**	**1.9**	**2.0**	**2.1**	**2.1**	**2.3**	**2.4**	**2.7**
Other	**4.8**	**4.8**	**4.6**	**4.7**	**4.8**	**4.8**	**4.7**	**4.6**	**5.0**	**5.1**
	15.4	**15.5**	**15.6**	**15.8**	**16.3**	**16.5**	**16.5**	**16.8**	**17.1**	**17.6**
Intellectually Disabled	**1.4**	**1.4**	**1.4**	**1.5**	**1.6**	**1.6**	**1.7**	**1.7**	**1.7**	**1.8**
Number of public health nurses	**1,358**	**1,367**	**1,363**	**1,383**	**1,389**	**1,409**	**1,417**	**1,449**	**1,475**	**1,527**
Per 10000 of population	**3.9**	**3.9**	**3.8**	**3.9**	**3.9**	**3.9**	**3.9**	**4.0**	**4.0**	**4.1**
Number of consultants	**1,077**	**1,090**	**1,107**	**1,128**	**1,154**	**1,191**	**1,210**	**1,308**	**1,319**	**1,373**
Per 10000 of population	**3.1**	**3.1**	**3.1**	**3.2**	**3.2**	**3.3**	**3.3**	**3.6**	**3.6**	**3.7**
Expenditure per 10,000 of population	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
General Hospitals	1772	1996	2198	2354	2509	2719	2933	3241	3560	4011
Special Hospitals	583	646	699	731	767	821	849	928	1088	1252
Community Care	778	883	982	1178	1376	1421	1361	1633	1882	2407

Casualty attendances were consistently around 1.2m per annum throughout the period, a rate of between 319 and 327 per 1,000 population. It is of note that casualty attendances have been falling since 1998 from 1.24m to 1.2m in 2000; this is due primarily to reduced casualty attendances in the Eastern region. There is no definitive explanation for this- it could well be that waiting times in Dublin Accident & Emergency Departments now act as a deterrent to patients presenting there.

5.8 SPECIAL HOSPITAL PROGRAMME

Table 5.11 analyses the total net expenditure in the Special Hospital Programme nationally during the decade. It can be seen that the net expenditure increased from £212m in 1990 to some £470m in 1999. The most significant part of this increase concerned pay costs which increased from £179m to £342m or 91% in the period.

The number of inpatients in psychiatric hospitals reduced from 7,807 to 4,374 over the decade, a reduction of some 44%. This reflects an increase in the treatment of psychiatric patients in community units and in designated psychiatric wards of acute hospitals. As a consequence, the rate of admission per one thousand of population to psychiatric hospitals has reduced from 6.6 to 5.6 over the decade. This can reasonably be used to point to more effective care in the community for psychiatric patients, and a measure of increased value for money.

Progress has been made in developing community services. New mental health centres, day hospitals and other day facilities have been set up and at the same time additional community-based residential accommodation has also been made available. The number of community residences established in 1990 stood at 306 providing 2,233 places, increasing to 398 in 1999 and providing 2,923 places. In the same period the number of day hospitals and day centres increased from 98 to 176 in 1999.

5.9 INCOME

Table 5.12 provides an analysis of aggregate income for the Health Boards over the decade. Of note is the increase in patient income from £51m to £102m in the period. In overall terms, income generated by Boards from payroll deductions, patients, grants and other sources, increased from £100m to £200m over the 10 years.

5.10 REGIONAL ANALYSIS

Appendix VI provides selected regional information for each of the Health Boards over the 10 year period.

In Ireland there is no explicit formula for allocating resources to Health Boards, based on, for example population, morbidity and service utilisation, as used in the NHS in the UK.

As a result, it is difficult to assess whether, for specific services, the allocation to each Board is proportional to its needs-weighted populations or not. Since the breadth of the services provided by Boards is also greater than the comparable health authorities in the NHS, it is also more complex to derive such a formula for all services. Nevertheless, the introduction of the Public Health Information System and other databases will facilitate needs based allocations in the future.

Board populations differ to some degree in their age structure. For example, 14% of the population of the Western and North Western Boards were over 65 in the 1996 census, compared to 12.1 per cent in Midland and Southern and less than 10% in the Eastern Board. Given the higher utilisation of these age groups for many services, their weighted population would be higher than other Boards and so we would expect to find them receiving a higher share of resources per head.

There are also appreciable flows of patients from some Boards into Eastern Board services. To meet the cost of these services, the Eastern Board could legitimately receive a higher level of expenditure per head than other Boards.

Table 5.11

Aggregate Expenditure on Special Hospital Programme by Health Boards

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Grand total										
Pay	178.6	195.9	213.9	220.8	232.6	243.6	253.4	276.3	301.3	341.8
Non-Pay	60.3	66.0	70.4	74.1	78.5	89.2	91.3	96.3	138.4	162.2
Gross Expenditure	238.9	261.9	284.3	294.9	311.1	332.8	344.6	372.6	439.7	504.0
Income	27.4	30.3	32.6	33.0	41.9	37.2	30.0	33.2	36.5	33.9
Net Expenditure	211.5	231.7	251.7	261.8	269.1	295.6	314.6	339.4	403.2	470.1

Table 5.12 Income Generated by Boards

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Payroll Deductions										
General Hospital Programme	7.9	9.4	10.5	10.6	14.8	16.2	13.8	20.3	22.0	28.4
Special Hospital Programme	4.5	5.1	5.7	5.9	9.7	9.0	7.9	10.1	12.8	11.4
Community Care Programme	2.1	2.4	2.5	4.1	6.9	7.4	6.5	9.4	11.3	10.3
Central Services	5.3	6.4	6.9	6.9	1.7	2.4	1.4	3.0	3.1	2.3
Total	19.7	23.2	25.6	27.5	33.0	35.0	29.5	42.8	49.3	52.4
Patient Income										
General Hospital Programme	33.0	34.7	39.1	42.0	43.7	43.8	40.0	52.2	63.3	63.3
Special Hospital Programme	15.5	17.9	17.1	17.4	16.9	16.8	14.5	13.7	13.6	15.0
Community Care Programme	1.3	1.8	1.5	7.2	8.7	8.9	8.5	12.3	13.5	19.9
Central Services	0.8	0.7	0.3	0.3	0.0	0.0	0.0	0.0	0.0	3.3
Total	50.6	55.0	58.0	66.9	69.3	69.5	63.0	78.1	90.5	101.5
Other Income										
General Hospital Programme	6.5	7.3	7.9	8.0	9.6	10.3	10.1	11.8	13.9	14.9
Special Hospital Programme	6.4	6.4	7.8	7.6	6.3	7.6	5.6	6.9	7.4	6.9
Community Care Programme	6.2	6.6	5.7	6.8	9.7	9.7	9.5	13.0	13.3	13.7
Central Services	7.8	7.3	6.9	7.2	6.1	5.5	4.4	6.7	7.1	8.3
Total	26.9	27.6	28.4	29.6	31.7	33.0	29.7	38.4	41.6	43.9
Other Grants										
General Hospital Programme	0.0	0.0	0.0	0.0	8.1	0.0	0.0	0.0	0.0	0.0
Special Hospital Programme	1.0	0.9	1.9	2.2	9.0	3.9	2.0	2.5	2.7	2.7
Community Care Programme	0.4	0.4	0.2	0.4	1.0	0.4	0.9	0.9	1.2	2.8
Central Services	1.4	2.0	0.0	0.0	0.8	0.5	0.2	0.1	0.2	0.3
Total	2.8	3.3	2.2	2.6	18.9	4.8	3.1	3.6	4.1	5.8
Total										
General Hospital Programme	47.4	51.7	57.8	60.7	76.2	70.3	63.9	84.2	99.2	106.6
Special Hospital Programme	27.4	30.3	32.6	33.0	41.9	37.2	30.0	33.2	36.5	33.9
Community Care Programme	9.9	11.1	10.0	18.4	26.4	26.4	25.4	35.6	39.3	45.8
Central Services	15.3	16.4	14.1	14.4	8.5	8.4	5.9	9.9	10.5	14.2
Total	100.0	109.5	114.6	126.5	153.0	142.3	125.3	162.9	185.5	200.5

5.11 ACUTE HOSPITAL AND SPECIALTY COSTS

Data from the Casemix Programme enables an assessment to be made of the costs of various specialties within the Acute Hospital sector. Data for the 1999 Casemix Programme, the latest available at the time of this study, has been examined for this purpose.

Table 5.13 sets out a summary of the trends in Casemix data for the period 1996 to 1999. It is of note that the overall Casemix Adjusted Base Prices for the Group 1 hospitals has increased significantly over the period, by 10% in 1997, 7% in 1998 and 18% in 1999.

The Group 2 hospitals show an increase in average adjusted costs per case of 10% in 1997, and 15% in 1999 (the figures for 1998 show a reduction in the average cost due to inclusion of three hospitals in the scheme for the first time).

It is of note that the average costs in the Group 2 hospitals were 77% of those in the Group 1 category in 1999, illustrating the higher costs per case associated with larger acute units.

The table also demonstrates the increase in day cases in the Group 1 category in the period.

Table 5.14 shows the composition of total hospital costs and related activity for both the Group 1 and Group 2 hospitals based on casemix returns for 1999. Inpatient costs account for 59% of total costs in the Group 1 hospitals in aggregate, and 62% in Group 2. This emphasises the need for a robust Casemix system to ensure efficiency in these costs. Of particular note is the difference in day case surgery relative to inpatient costs. In the Group 1 hospitals, day cases within the Casemix scheme cost 17% of the average inpatient cost; within the Group 2 hospitals, day cases cost some 22% of inpatient care. Again this emphasises the benefits in cost terms of optimising the level of day case treatment through the Irish hospital system.

Each outpatient attendance cost £82 on average in 1999, which emphasises the need to manage attendances effectively, and particularly the benefit of integration with primary care providers where the provision of equivalent care would be cheaper.

Similarly, a reduction in Accident & Emergency attendances through the development of a more effective gatekeeper role for GPs has potential to impact on not only the effectiveness of Accident & Emergency, but potentially reduce costs - Accident & Emergency patients had an average cost of £88 in 1999.

Table 5.15 presents an analysis of the cost per case per specialty in the Group 1 hospitals in 1999. The table demonstrates the high costs per case in dermatology, geriatric assessment, cardio-thoracic surgery, haematology, oncology, neurosurgery, nephrology and vascular surgery. The national strategies in cardiology and cancer will increasingly impact on the treatments for these illness categories in acute hospitals, and it is evident that these are among the higher cost specialties. What is of note is the degree of variation between average costs per case across different hospitals; even when adjusted for Casemix intensity, the average costs per case vary from hospital quite considerably as shown in Table 5.16. This points to a need to have more robust costing systems in place at hospital level, and an evaluation on an ongoing basis of reasons for variations in cost, particularly to establish the costs of variations in medical practice to treat patients suffering from the same ailments. Cost variations identified should be assessed against patient outcome data to establish if increased costs of treatment are justified. There is currently no routine audit of these matters, so it is not possible to assess the impact on cost or effectiveness of variations in clinical practice. We recognise that significant enhancements in information systems are required to get to the stage where such an evaluation is possible, but this should be the objective. The development of costing systems at hospital level will provide an opportunity to perform more timely and robust comparison of costs across the acute sector.

Table 5.13 Summary of Hospital Casemix Data 1996-1999

GROUP 1	**1996**	**1997**	**1998**	**1999**
Number of Hospitals	9	7	7	8
HIPE Discharges	141,671	123,705	121,730	141,695
In-Patient costs [£m]	235	258	275	372
In-Patient costs CMI	1.24	1.25	1.25	1.24
Casemix Adj Hosp Base Price	1,491	1,637	1759	2,074
HIPE day cases	67,298	74,419	82,484	98,904

GROUP 2	**1996**	**1997**	**1998**	**1999**
Number of Hospitals	21	21	24	24
HIPE Discharges	201,490	198,287	222,549	249,366
In-Patient costs [£m]	198	226	262	337
In-Patient costs CMI	0.847	0.854	0.85	0.86
Casemix Adj Hosp Base Price	1,318	1,447	1,383	1,587
HIPE day cases	56,408	61,276	72,216	78,673

Table 5.14 Costs of Acute Hospitals in Casemix Scheme-1999

Costs	**Group 1**	**Group 2**	**Total**
	£m	**£m**	**£m**
Inpatient Costs	325	280	605
Day cases			
Casemix Scheme	36	19	55
Non Casemix Scheme	6	2	8
Psychiatry	10	9	19
Dialysis	6	8	14
Geriatric care	9	6	15
OPD	55	44	99
A&E	34	32	66
Specialties total	481	400	881
Externs	74	50	124
Total Hospital Costs	555	450	1005
Number of Cases	**000's**	**000's**	**000's**
Inpatient	135	212	347
Day cases			
Casemix Scheme	88	66	154
Non Casemix Scheme	18	12	30
	241	290	531
OPD	603	604	1207
A&E	328	418	746
Average Cost per Case	**£**	**£**	**£**
Inpatient	2407	1321	1744
Day cases			
Casemix Scheme	409	288	357
Non Casemix Scheme	333	167	267
OPD	91	73	82
A&E	104	77	88

Table 5.15

Actual Cost per Case	JCMH	Beaumont	St James	Mater	St Vincents	Cork	UCHG	Weighted Average
GENERAL MEDICINE + Paediatrics		1863	2399	1460		3857		2554
GENERAL SURGERY	2052	3395	2985	2512	2737	2445	2295	2623
DERMATOLOGY		5784	4549	3103	3036		5454	3966
E.N.T.		1462	1900	2304	1133		1178	1547
ENDOCRINOLOGY	2597	1649	2375	3223	3717		2383	2562
GERIATRIC ASSESSMENT	4137	4371	4185	4372	6857	2143	2473	3559
GASTRO-ENTEROLOGY	1812	1723	3160	2424	3466	1726	2776	2441
CARDIO THORACIC			5391	12080	9728	8270	2601	7199
CARDIOLOGY	2710	3493	2027	3085	2255	2221	1934	2214
GENITO-URINARY (UROLOGY)	2057	3180	2025	0	1515	1935	2333	2097
GYNAECOLOGY	6582	2188	2581	2276	2042	4174		2729
HAEMATOLOGY		6667	10358	6194	4715	3095	3065	5333
INFECTIOUS DISEASES		2707	4625	3721		2171		3215
NEPHROLOGY		4317	4944	4671	2946	1551		3541
NEURO SURGERY		5172				4164		4869
NEUROLOGY		3522	3279	5668	4778	1914	3894	3047
ONCOLOGY		2122	3342	2494	2835		1755	2767
OPHTHALMOLOGY		3327	0	1571	1192	1971	1561	1646
ORTHOPAEDIC	2157	2801	3055	3301	2631	2002		2611
PAEDIATRIC						825	1147	958
PLASTIC SURGERY	3172	3833	2238	1397	2260	1795	2313	2112
RHEUMATOLOGY	1975	2296	2438	3370	3127	1175		2215
RESPIRATORY MEDICINE	1767	2184	2445	2799	2242	2329		2275
VASCULAR SURGERY		3482	4880		5481		2831	3637

Table 5.16 ADJUSTED COST PER CASE

SPECIALTY	Jcmh	Beaumont	St James	Mater	St Vincents	Cork	UCHG	Weighted Average
GENERAL MEDICINE + Paediatrics		1,680	2,114	1,695		3,841		2,476
GENERAL SURGERY	2,252	2,305	2,287	1,590	2,232	1,913	2,133	2,067
DERMATOLOGY		6,342	5,589	2,786	2,982		6,108	4,202
E.N.T.		1,490	1,971	1,884	1,638		1,603	1,672
ENDOCRINOLOGY	2,589	1,472	2,096	2,622	3,131		2,366	2,276
GERIATRIC ASSESSMENT	3,391	3,021	3,158	2,712	4,658	1,793	2,301	2,725
GASTRO-ENTEROLOGY	1,949	1,526	2,876	2,097	2,155	1,880	2,703	2,218
CARDIO THORACIC			2,034	2,855	3,366	2,273	1,981	2,358
CARDIOLOGY	2,820	2,381	1,438	1,811	1,586	1,641	1,553	1,793
GENITO-URINARY (UROLOGY)	2,460	2,143	2,098		1,484	1,651	2,187	1,906
GYNAECOLOGY	5,199	1,712	2,047	1,594	1,722	3,652		2,242
HAEMATOLOGY		2,999	2,702	2,205	1,968	1,382	2,063	2,099
INFECTIOUS DISEASES		2,231	2,720	2,720		2,220		2,459
NEPHROLOGY		2,127	2,470	2,439	2,321	1,272		2,035
NEURO SURGERY		1,993				2,197		2,055
NEUROLOGY		2,950	3,250	3,804	3,211	1,891	3,428	2,606
ONCOLOGY		1,507	2,324	1,523	1,806		1,469	1,854
OPHTHALMOLOGY		1,524		1,657	1,477	2,122	1,682	1,784
ORTHOPAEDIC	1,775	2,047	2,318	2,218	2,012	1,873		2,039
PAEDIATRIC						1,598	1,771	1,669
PLASTIC SURGERY	2,635	2,738	1,865	885	1,608	1,404	1,663	1,641
RHEUMATOLOGY	2,090	2,005	2,228	2,785	2,486	1,164		1,999
RESPIRATORY MEDICINE	1,729	1,840	1,911	2,239	1,818	2,355		1,923
VASCULAR SURGERY		2,009	2,683		2,698		2,274	2,287

Source:1999 Casemix Data

5.12 PRIMARY CARE

In this Section, we examine expenditure and value for money issues under the GMS scheme and related schemes covering primary care and medication.

The main source of data is the routine analysis and reports produced by the GMS Payments Board for the years 1991 to 1999. These provide a wide range of data on payments to GPs and pharmacies, for primary care and for medication, as well as payments to other suppliers for primary care, notably for optical and dental services.

The need to collect data on every single prescription, in order to pay the dispensing pharmacy, means that the GMS Payments Board has a very large data set on the medication of individuals. This data set has not been used for further analysis here and its use for such purposes raises some questions of data protection. However, the data set potentially offers scope for a wide range of reviews of the medication of GMS patients and its cost-effectiveness and wider studies of the use of one drug following use of another, for example where potentially more effective drugs are introduced and savings in other medication are anticipated.

The GMS Payments Board pays for:

- GP services for GMS cardholders;
- Prescriptions for GMS cardholders;
- Payments for other prescriptions under the Long Term Illness scheme and Drug Cost Subsidisation Scheme;
- Payments for Dental Care;
- Payments for Optical Services.

5.12.1 Expenditure on GP Services

Table 5.17 shows expenditure in money terms over the 1990s on medical services. It also shows the reported expenditure per head (which differs slightly from the exact division of expenditure reported by eligible population reported). Detailed components of expenditure are examined in the discussion that follows.

Over the 1990s expenditure per eligible person, in money terms, grew by 124%, more than doubling. After adjustment for inflation, this growth falls to 87%, a substantial real increase in expenditure per head.

The demand for primary care of all kinds has probably been rising steadily throughout the last twenty years due to increased patient expectations and improved access to private transport. The GMS scheme historically paid for each consultation by an eligible person and so data was available on the number of consultations made. However, partly because this gives an open-ended commitment, which could encourage GPs to see repeat patients frequently for little clinical benefit, the payment system was changed to a capitation system, in which GPs are paid for each patient on their registered list. This takes away the incentive to see patients more frequently though payments for out-of-hours services and for certain procedures are added to the capitation payment for each GP.

Throughout the 1990s, the capitation system was a key component of funding for GP services. Capitation payments made up 77% of payments to doctors in 1999 and are the main component of funding of medical services under GMS.

Table 5.18 shows the growth in the payment per eligible person in money terms and real terms over the period 1990 to 1999.

Table 5.17: GMS Expenditure on Medical Services 1990-99

	1990	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Eligible Persons	1,221,284	1,237,772	1,263,001	1,274,621	1,286,632	1,277,055	1,252,385	1,219,852	1,183,554	1,164,187
Doctor Contracts	1,578	1,586	1,636	1,645	1,666	1,652	1,647	1,641	1,629	1,679
Total Doctor Payments	£53,565,000	£56,058,000	£70,589,000	£83,390,000	£89,446,000	£91,903,000	£95,169,000	£100,769,000	£122,945,000	£119,152,000
Doctor Payment/Person	£43.39	£45.55	£56.20	£65.99	£67.48	£69.24	£72.91	£81.07	£97.80	£97.01

Table 5.18: Expenditure per Head on GMS Capitation

	1990	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Eligible Population Spend per Head	1,221,284	1,237,772	1,263,001	1,274,621	1,286,632	1,277,055	1,252,385	1,219,852	1,183,554	1,164,187
Capitation	£30.83	£31.56	£39.11	£40.35	£40.79	£41.59	£43.90	£45.56	£52.31	£51.09
Adj. Spend per Head										
Capitation	£30.83	£30.64	£37.41	£37.69	£37.17	£37.30	£38.80	£39.32	£44.43	£42.67

In money terms, the payment per head of eligible population has grown from £30.83 to £51.09 over the period 1990 to 1999. In real terms, this reduces to growth from £30.83 to £42.67. This is an increase of about 40% during the 1990s.

Clearly, to provide primary medical care for an individual for a cost of £51 per year represents real value for money. If this is seen as a premium paid to GPs to cover their registered population, the cost per person per year is relatively low. It should be noted that a proportion of patients will make no major demands on their GP for consultations. Others may make very frequent demands, though the GP can exercise some influence on the frequency with which patients return for treatment.

The lack of detailed data on consultations means that it is difficult to identify what additional services have been provided for this capitation expenditure over the period, in their normal working hours. This is a difficulty of most health systems with free provision of care since, in the absence of payment, there is no direct incentive for data collection on consultations.

We would expect that the demand for GP consultations from card holders is growing. Growth may occur due to changes in expectations, illness and in the age of the eligible population. Elderly people and women of child-bearing age tend to have higher consultation rates than males of working age and children also have higher rates of consultation.

During the 1990s, the population covered by the GMS scheme did not change markedly in its age structure. The over 65 population, for example, increased by only 1.3% of the total and children under five fell as a proportion by 0.6%.

These changes would not alone generate a large change in the demand for GP services. However, the growth in the over 65 population, while modest, may mask more rapid growth in very elderly people or those with chronic diseases but maintained outside hospital. These would contribute to an increased demand for GP services. (This will clearly be an issue to be addressed in the forthcoming review of Primary Care.)

The next largest component of expenditure on GMS medical services is the payment for out-of-hours services. These are consultations with patients that take place outside the normal consulting hours and may occur in the practice premises or in the patient's home.

Table 5.19 shows the growth in expenditure on out-of-hours services, again in money terms and real terms, per head of eligible GMS membership.

Over the 1990s, expenditure per head on out-of-hours services has grown from £1.07 to £9.68. In real terms, it has grown from £1.07 to £8.08, growth of over six times. Expenditure in total out-of-hours services grew from £1.3m to £11.3m at a time when the eligible population was not growing rapidly. In both 1997 and 1998, the cost of out-of-hours rose by more than one hundred percent in a single year. That is, it doubled in 1997 and doubled again in 1998. This partly reflects changes in the payments for out-of-hours but the average payment per claim did not rise appreciably. The number of out-of hours claims rose substantially, principally because of changes in the criteria for out-of-hour claims (GPs can now claim after 5pm, previously this was 10pm) and partly because of the predominance of both parents working, thus placing additional demands on the out-of-hours service.

More generally, over the 1990s as a whole, the number of out-of-hours claims rose from 76,857 to 448,297, that is, by almost six times, while the eligible population fell slightly over the same period.

The current rate of out-of-hours claims is about 0.38 per eligible person per year. That is, the current GMS eligible population is generating out-of-hours claims at a rate of about 1 in 3 persons covered, compared to about 1 in 16 in 1990. We have not identified any detailed analysis of this growth in out-of-hours claims but it represents a large item of expenditure and its value for money potentially requires further examination in the proposed review of primary care.

Recent UK research (Salisbury, C, Trivella, M, Bruster, B, Demand for and supply of out-of-hours care from general practitioners in England and Scotland: observational study based on routinely collected data, BMJ 2000; 320: 618-21) suggests that the comparable rate of out-of-hours contact in the NHS is around 159 calls per 1,000 patients, or just over one in six of the population covered. This population is potentially comparable to the GMS population in that it has access to free Health Care but since it includes all income and social groups, it may be that the average health state of all NHS patients is better than for GMS patients.

Of those consulting in the NHS, almost a quarter were seen at home and 30 per cent at an out-of-hours primary care centre. 45% of contacts were handled by telephone only. Related material in the BMJ indicates that in parts of Wales, a rate of one out-of-hours call per three registered patients has been found in an urban area, suggesting that at least some parts of the NHS have similar rates to Ireland. Again this may reflect social conditions.

It is also noteworthy that while out-of-hours claims in the 1990s grew across all Health Boards, in two areas they grew particularly rapidly during the years of overall rapid growth, 1997 and 1998. In the Mid West growth of close to 500% occurred and in the North-East the growth was closer to 800%. (That is, the number of out-of-hours claims was 5 times greater in the Mid West after two years and 8 times greater in the North East.)

While we have not seen reports or inquiries which demonstrate that out-of-hours consultations are inappropriate, it remains the case that since they generate a specific fee, the incentive to undertake them is greater than for a normal surgery consultation. At the same time, they necessarily impose a burden on GPs in time and travel and this is likely to provide some disincentive to undertake out-of-hours consultations for minor illness. The incentives also differ for an individual GP and for a Co-op, which shares the out-of-hours work. Potentially the distribution of out-of-hours claims between GPs should be examined in more detail to test how far the growth rate is consistent across different areas and individual practices. It may be that the development of other services such as telephone consultations may offer a cost-effective alternative to out-of-hours visits for some patients.

A number of other special payments make up the remaining expenditure on doctors' services under the GMS. These made up 9% of expenditure in 1999. These include payments for a range of minor surgical procedures (for example removal of warts, suturing of cuts, treatment of acute asthma with a nebuliser and taking and interpretation of an ECG).

Overall, these procedures have grown steadily over the 1990s, by about 40% in total. Use of nebulisers has grown less than this and removal of warts, suturing and ECGs by more. The rates of growth for these interventions are low per year and do not immediately raise issues of value for money. However, as with many other areas of primary care, it will be important in the future to ensure that where GPs are carrying out diagnostic tests such as ECGs, there are appropriate protocols in place to ensure accurate diagnosis and appropriate and consistent referral of patients to cardiologists.

5.12.2 Expenditure on Pharmaceuticals

The GMS Board makes payments for prescriptions provided at GP consultations with card holders and also for those needing expensive and long-term therapy. We focus here initially on the items prescribed under the main GMS scheme.

Table 5.20 shows the main elements of expenditure under GMS prescribing.

Over the 1990s, the number of pharmacies with GMS contracts rose gradually, from 1,079 to 1,174. The total costs of prescriptions rose from £107m to £222m, more than double in money terms. However, after adjustment for general inflation, the rate of increase in costs of prescribed drugs is smaller than might have been anticipated.

Table 5.19: Expenditure per Head on Out-of-Hours GP Services

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Eligible Population Spend per Head	1,221,284	1,237,772	1,263,001	1,274,621	1,286,632	1,277,055	1,252,385	1,219,852	1,183,554	1,164,187
Out of Hours	£1.07	£1.06	£1.22	£1.35	£1.34	£1.61	£1.68	£3.80	£8.18	£9.68
Adj. Spend per Head										
Out of Hours	£1.07	£1.03	£1.17	£1.26	£1.22	£1.44	£1.49	£3.28	£6.94	£8.08

Table 5.20: GMS Expenditure on Prescription

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Pharmacy Contracts	1,079	1,084	1,099	1,107	1,135	1,151	1,153	1,186	1,168	1,174
Total Cost of Scripts	£107,208,000	£113,260,000	£127,662,000	£133,274,000	£141,012,000	£153,239,000	£162,471,000	£176,005,000	£196,094,000	£221,856,000
Ingredients	£83,765,000	£87,930,000	£100,078,000	£102,038,000	£108,072,000	£117,623,000	£125,337,000	£135,972,000	£153,301,000	£175,791,000
Dispensing	£20,719,000	£22,634,000	£24,494,000	£28,119,000	£29,494,000	£31,926,000	£33,268,000	£36,364,000	£38,751,000	£41,617,000
VAT	£2,724,000	£2,696,000	£3,090,000	£3,117,000	£3,446,000	£3,690,000	£3,866,000	£3,669,000	£4,042,000	£4,448,000
No. of Forms	7,136,000	7,546,000	8,016,000	8,465,000	8,740,000	9,191,000	9,160,000	9,356,000	9,475,000	9,631,000
No. of Items	14,636,000	15,478,000	16,534,000	17,252,000	17,906,000	18,879,000	19,131,000	19,944,000	20,696,000	21,679,000
Cost per Form	£15.02	£15.01	£15.93	£15.74	£16.13	£16.67	£17.74	£18.81	£20.70	£23.03
Ingredient Cost per Item	£5.72	£5.68	£6.05	£5.91	£6.04	£6.23	£6.55	£6.82	£7.41	£8.11
Items per Form	2.05	2.05	2.06	2.04	2.05	2.05	2.09	2.13	2.18	2.25

Pharmaceutical costs tend to rise because new and more effective drugs are introduced to Health Care markets in developed countries at typically higher prices. The companies argue that such prices are appropriate, given the costs of their research and the added value of the new products. However, where new medicines have a rapid uptake, they can increase costs rapidly.

Ireland has addressed this issue in several ways. Firstly, there are price agreements with manufacturers that to a degree allow Ireland to exploit its relatively small size as a pharmaceutical market. That is, because the market is relatively small, the cost to the manufacturers of supplying at a controlled price is relatively low and so there is potentially less resistance than there would be in a large country. Ireland has an agreement that allows it to buy pharmaceuticals for its health services at a price that reflects the prices in Europe and the UK NHS.

The four-year agreement on drug prices in 1993 included provision for:

- A 3% price cut;
- A 5% rebate on all drugs supplied under the GMS;
- A four-year price freeze;
- A currency adjustment payment of £2m from the industry to GMS;
- The price agreement, giving prices based on the UK and on the average in a group of European countries;
- A safety net to renegotiate prices if they changed in a group of European countries by more than 10%, up or down;
- Freedom for hospitals and Health Boards to negotiate lower prices with individual suppliers.

There was a further agreement on prices in 1997.

These price agreements potentially offer considerable value for money.

As a result of this restraint on prices, the cost per item prescribed in Ireland under GMS has grown relatively slowly. For example, the average ingredient cost per item fell in real terms after 1993 and did not return to its 1993 level until 1997.

Nonetheless, new medicines represent a major component of the overall cost of prescribing. For example, in 1990, two treatments for dyspepsia, ulcers and related problems, Cimetidine and Ranitidine, made up 9% of the cost of the GMS prescribing scheme, with an ingredient cost of almost £8m for 370,000 prescriptions. By 1995, the prescriptions for these drugs had fallen slightly to 362,000 at a cost of £5.7m, reflecting the fall in the price of drugs as they approach and pass their patent lifetime and move to lower cost generic production or face competition from new products. But by 1995, a new drug, Omeprazole, (a proton pump inhibitor that is more effective for some gastric problems than Cimetidine and Ranitidine) was being prescribed 138,000 times at a cost of £5.2m, in addition to the earlier two drugs. By 1999, Omeprazole had grown to 266,000 prescriptions per year at a cost of almost £10m with the other two therapies falling to 279,000 prescriptions at a cost of £4m. Taking all these drugs together, the cost of these therapies had risen from £8 million in 1990 to £14m in 1999, an illustration of the effects of new therapies on costs. We return to the use of Omeprazole in later discussion of the cost effectiveness and value for money of prescribing under GMS and related schemes.

The ingredient cost per item supplied, adjusted for general price inflation, has risen by only 18.4% over the ten years 1990 to 1999. This represents a relatively limited rate of growth given the high price of some new products on world markets.

Over the same period, the number of items per form (that is, the number of different drugs prescribed on one prescription) rose from 2.05 to 2.25, a growth of just under ten per cent. This gives growth in the cost per form, after adjusting for general inflation, of 28 per cent over the period 1990 to 1999.

(It should be noted that "the item", though widely used as a basis for the analysis of pharmaceutical costs, is not a reliable measure. GPs may prescribe different size "items", for example a week or a month's supply, different strengths of similar medications or a high cost item in place of a low cost item. While we would not expect the variation in items to change rapidly in a single year, over a period of ten years the mix of drugs prescribed and the quantities provided may change appreciably. As a result, the number of items gives only a limited guide to prescribing.)

However, overall, pharmaceutical spending rose by 68% (after adjustment for the general level of inflation) between 1990 and 1999. This is because of the increase in the number of prescriptions per eligible person, which rose from 5.8 per year to 8.3, an increase of 42%. This could reflect an increase in actual prescribing and/or a change in dosing strategies, such as greater use of prescriptions giving medicines for a shorter period, so that patients who recover or whose symptoms are relieved early on would not have unused medicines. However, given the costs of each prescription form and the rising cost per form, this does not appear to have occurred to any great extent.

We have not identified any systematic attempts to manage prescribing by GPs directly under GMS. In 1997, the Comptroller and Auditor General (C&AG) produced a report on Prescribing Patterns and the Development of General Practice Services, 1997. This report looked at Omeprazole among other medicines. Omeprazole is therefore an interesting case study of the extent to which the current GMS system is able to achieve improved value for money. Essentially, Omeprazole is very effective but much more expensive than the alternative therapies. It is recommended for short-term use but long term maintenance is likely to be cost-effective using the older, lower cost medicines, which may be available from generic manufacturers. The C&AG report notes that a minor shift in prescribing of Omeprazole could result in significant savings. Yet in the period before and after this report, prescriptions for Omeprazole grew as follows:

1996	169,000 scripts	£6.2m
1997	194,000 scripts	£7.0m
1998	230,000 scripts	£8.5m
1999	266,000 scripts	£10m

(Note: costs rounded to nearest £0.1m up or down.)

The steady growth of Omeprazole over this period does not indicate any significant response to the issues addressed in the C&AG report.

We are not qualified to judge in any detail the appropriateness of this growth in the use of Omeprazole. But we believe that the lack of investigation or follow-up of this issue (so far as we are aware) is an indication of the lack of resources devoted to achieving value for money in prescribing under the GMS. This in turn probably reflects the resourcing of the GMS Payments Board, which does not have the specialist skills and staff to examine such issues but is essentially limited to data collection and payment roles.

To reinforce this point, it should be noted that the C&AG report also commented on the extent of prescribing of mucolytics, medicines which provide relatively little relief from respiratory problems and which have been excluded from the reimbursement list in the UK NHS. There is no evidence in the available GMS data of any significant reduction in prescribing for example coughs and colds. A fall of 6,000 scripts in 1998 was offset by a rise of almost 12,000 scripts in 1999 to a total of over 220,000 (potentially reflecting variation in the incidence of colds and influenza) at a cost of £812,000, compared to £730,000 in 1996.

In its 1997 report, the C&AG projected potential savings of £700,000 from reduced use of mucolytics but the expenditure figures suggest this did not occur. If the wider cost of respiratory medicines is considered, at £21.2m in 1999, compared to £16.4m in 1996, there is again no obvious evidence in the trend in expenditure of the achievement of the level of savings from reduced use of mucolytics, as projected by the C&AG.

The trend in expenditure on both these areas of medication and the absence of any direct management of the level of prescribing suggests that the current GMS system lacks the tools and processes to shift prescribing towards improved value for money.

The value for money of prescribing is not readily assessed without detailed data on the variance in prescribing between clinicians and protocols specifying appropriate therapies. For example, it is possible to develop broad indicators of potential prescribing across an area and compare GPs against the average pattern. It is similarly possible to analyse the use made of specific combinations of medication that should be routinely used together. The prescribing data held by the GMS scheme, with patient identifiers, offers an enormously valuable resource for the analysis of prescribing, its effectiveness and value for money. At present that resource is not being exploited, so far as we are aware.

5.12.3 Indicative Drug Targets

Aside from the price controls noted earlier, a further restraint on the growth of prescribing costs in Ireland is the Indicative Drug Target scheme.

The Indicative Drug Target scheme specifies a level of expenditure on medicines for each GMS GP. Where savings are made, these can be used to fund improvements in practice premises and related service developments. The Target scheme is seen as a highly effective means of controlling the growth of expenditure on prescription medicines under GMS. As noted in the review by the C&AG, expenditure on medicines in GMS rose by only five per cent per year in the period after indicative targets were introduced compared to 10% in the four years before its introduction. However, the rate of growth of expenditure was much higher in 1998 and 1999, at 10% above the general level of inflation, indicating that the gains from the scheme may be being exhausted.

This result is consistent with the likely effects of targets on GP behaviour. GPs may be able to bring expenditure closer to target by:

- Increasing their use of generics;
- Reducing their use of specific high cost medicines.

However, once they have done this in the first year, their scope for further savings depends on what happens to their targets. A grant system has been introduced which recognises that after a time, further savings may be difficult to achieve. GPs also operate within a given percentage of target set quality for grant. It is possible that many of the easy savings are readily achieved but that further savings are then not easy to achieve because prescribing is now closer to the cost-minimising level. The C&AG study found, for example, that while 73% of GPs had spending below target at some time in the period 1993 to 1996, only 5% achieved savings against target in all four years. 27% of GPs did not achieve savings against target in any of the four years up to the C&AG report.

To continue to provide incentives to GPs, targets are revised under the current target-setting methodology for GPs, other than those with expenditure significantly above target in the previous years. This can be seen as providing some planned growth as an alternative to unplanned and more costly growth in prescribing expenditure.

This rolling target-setting therefore continues to offer some incentives each year to contain prescribing and could be contributing to value for money.

Ideally, a study should be conducted to compare in more detail the prescribing of GPs achieving savings and not achieving savings. This would identify whether in practice savings are being achieved on medicines where reduced use is compatible with value for money, rather than savings being achieved by arbitrary reductions in the prescribing of some medicines which do offer value for money.

This might be a costly piece of research, though the GMS data would provide relatively good information for such a study, potentially at a low cost.

Such research and its costs should also be seen within the context of expenditure on prescriptions growing at over £20m per year in money terms over the two years 1998 to 1999. That is, spending of 1-2% to analyse growth alone would give a research budget of £200,000. Research might also be linked to the C&AG reports, which have suggested changes in some types of prescribing. It is not obvious from the available data that the indicative Drug Target scheme has led to savings in the areas identified by the C&AG, for example.

It should also be noted that the Indicative scheme and the savings generated from it are the predominant method of funding improvements in GP practices. It is not obvious that the practices most in need of improvement will be those with the greatest scope for achieving savings on prescribing. Potentially other methods of funding practice improvements may be required. However, the issue of practice premises also raises the issue of the ownership of premises in an environment where GPs are contractors to the GMS and not publicly employed providers of Health Care.

In this model of primary care, it is not clear how readily public investment in privately owned practices can be recouped in the future or what balance is most appropriate, in investing in facilities, between GPs and the public purse. To a considerable degree, these issues have always dogged negotiations between GPs and the public sector in Ireland and the UK, because of the unusual contractual status of GPs, who cannot be seen as simply small businessmen and women competing in a market place where patients have a choice of provider (for registered patients). The greater number of privately paying patients in Ireland potentially complicates the relationship more than in the UK. For example, practice premises improvements funded from the public purse may increase the number of private patients who choose to attend a general practice. The distribution of the gains from any such increased market share, between the GP and the public sector, is bound to be contentious.

The National Pharmo Economic Centre in Trinity College has been funded by the Department to conduct pharmo-economic studies, to support negotiations on drugs prices, and on prescription patterns.

5.12.4 Other Drug Subsidisation Schemes

In addition to payments for the prescriptions of GMS card holders, the GMS system makes payments under two other schemes for prescribed drugs:

- The Drug Cost Subsidisation Scheme (DCS) (superseded by the Drug Payment Scheme);
- The Long Term Illness Scheme (LTI).

The DCS was introduced as a new scheme in September 1990. It is for those receiving regular medication but who are not in GMS. The initial cut-off for benefits was a regular and ongoing medical requirement for prescriptions costing £32 per month or more and not covered by the LTI. Those eligible and claiming pay only the specified limit to their pharmacists per month. Eligibility is determined by the local health Board and payments made by the GMS Board on their account.

The LTI is an older scheme. It was taken over by GMS for payment on behalf of Health Boards in May 1991. This scheme allows those who suffer from one of a schedule of illnesses to obtain without charge the drugs, medicines and appliances necessary for the patient to be treated.

Tables 5.21 and 5.22 show the growth in expenditure on these two schemes during the 1990s. Both schemes experienced very rapid growth in the 1990s. By 1998, its last full year, the cost of the DCS had grown by over 500% (that is, to a value over six times higher) than its level in the first full year, 1991.

The number of applicants or claimants grew much more slowly, by about 300% for applicants and somewhat less for claimants, so more of the growth in real spending is due to the cost per person of medication provided. This reflects the rising costs of some new medicines.

Over the same period, the cost of the LTI scheme in real terms increased by 239%, to a level close to three and a half times its 1990 level. Applicants and claimants again increased much more slowly so the growth in real expenditure is again a reflection of the higher prices of new medicines.

The two schemes appear in practice to be providing different types of medication to different patient populations.

The most frequently used and most costly drugs and materials supplied under each scheme are reported each year by the GMS Board. The data show that by 1999 expenditure under the LTI was dominated by diagnostic products and a range of materials and medicines, including Insulin, used by diabetics. The diagnostic materials are likely to include a range of blood testing equipment introduced in recent years for diabetics.

The DCS has a wider range of medicines in its high cost list, including Omeprazole for digestive problems, several Asthma treatments and some heart disease treatments.

The existence of two schemes, LTI and DCS (and its successor) raises questions about the benefits and costs of having two such schemes rather than one. Both schemes are likely to face difficulties in controlling total spending: Under LTI, if the range of diseases is fixed, the total cost will depend on the incidence and prevalence of the diseases covered. This means that expenditure will grow or fall depending on the pattern of disease, which is appropriate from a Health Care perspective but may mean that from time to time costs rise rapidly, for example if the particular therapies provided or the incidence and prevalence change significantly in a short time. Under DPS, it is likely to prove difficult, for political reasons, to keep the financial cut-off for eligibility under review as medicines' prices change. That is, the rate of medical price inflation may be too high for the DCS payment level to be raised to meet it without considerable political resistance. In consequence, as new and more expensive therapies are provided, a growing number of people are likely to fall into the eligibility criteria and the value of their payments will be less and less important.

More generally, it is not obvious what policy objective is being served by operating two similar schemes. If some patients with specific diseases merit free medication, why should others facing similar long-term medication have to pay up to the DCS or DP threshold? £42 is either an affordable cost or not. If it is affordable, why should LTI members not pay it? If it is too high a price for those with a long-term medical problem to pay, why should such a payment be required under the DP scheme? That is, what particular values underpin these two schemes and why is the link between those values and the cost to patients different? The cost per claimant under DCS also typically exceeds the cost per claimant under LTI so overall DCS patients are being prescribed more expensive medication, again potentially reinforcing the case for greater subsidy to this group.

In practice, it would appear that the development of DCS and DP was an attempt to provide a further safety net for non-GMS members and avoid the higher costs if this was extended on the same terms as LTI.

Table 5.21: DCS Expenditure

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
DCS	£1,044,644	£6,355,344	£10,171,244	£13,063,577	£17,082,440	£22,527,189	£28,688,578	£35,859,106	£47,253,487	£27,813,175
Applicants/Persons Covered	12,688	20,178	28,379	39,023	46,926	60,111	71,660	57,221	80,293	87,158
Claimants			13,621	17,039	21,056	26,287	31,843	38,816	48,588	54,586

Notes: 1990 DCS for quarter year only
1992 DCS and LTI reports persons covered and number of claimants instead of number of applicants
1997 DCS excluded ineligible persons on eligible DCS cards
1999 DCS replaced by DP scheme, so expenditure on DCS for half year only

Table 5.22: LTI Expenditure

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
LTI		£6,899,252	£11,788,328	£13,106,154	£14,648,675	£16,273,391	£17,632,789	£19,721,634	£23,239,067	£27,209,488
Applicants/Persons Covered		47,223	50,808	53,728	57,137	60,754	64,205	66,696	71,440	76,848
Claimants			17,968	19,454	20,693	21,741	32,815	24,124	25,710	26,885

5.12.5 Dental Treatment Services Scheme

The Dental Treatment Service under GMS began in June 1995. This scheme, in common with others, has grown rapidly, as shown in Table 5.23.

However, some aspects of this scheme have remained relatively stable. For example, payment per item of service has changed relatively little and has fallen for some elements, for example below the line treatments. (These are treatments for which approval is required.) In comparison, some components of the scheme have grown substantially in volume over a relatively short period.

Relative to the first full year of operation, 1996, the volume of emergency treatments grew by only 7.4% to 1999. In contrast, above the line treatments grew by 341% and below the line treatments by 220.5%. This growth was particularly marked for above the line treatments in the second full year and for below the line treatments in the third full year. This may suggest that it took several years for dentists and patients to become familiar with the scheme and to make appropriate demands upon it.

In 1999, volume growth was relatively low, suggesting that either demand has begun to plateau or that there are other constraints in the system that are limiting the growth in demand. One element here is the fee payment to dentists. Dental fees were higher in 1999 than in 1995 and have grown more than the rate of general price inflation:

Most routine treatment fees increased in real terms by just under 8% from 1995 to 1999;

- The fee for restoration of amalgam increased by almost two thirds or 65% and emergency restoration by almost 40%;
- The fee for provision of dentures for patients with no teeth also increased markedly, by 115% over the same period.

(Note that these real increases do not take account of any increased costs faced by dentists, only the background rate of price inflation.)

Of greater potential concern than the growth in expenditure on GMS dental services is the wider issue examined by the Comptroller and Auditor General (C&AG) in DATE. This concerns the fact that Ireland currently operates two different systems for providing dental treatment to its citizens, one under the social security provision and one under GMS to card holders. It is not obvious that there are benefits from providing two such schemes with their own administration and data collection. It is also possible that some double claims are made, for patients who are covered by both schemes.

The Dental Services were the subject of a Programme Expenditure review. This service evaluation clarified needs, and helped focus the future direction of Dental services. Expenditure reviews of this nature are a useful mechanism for improving value for money, and should be conducted more widely across the health sector.

5.12.6 Ophthalmic Services

These have only recently been introduced under GMS from July 1999. No time trend comparisons are therefore possible.

Table 5.23: Dental Treatment Services

No. of Treatments	**1995**	**1996**	**1997**	**1998**	**1999**
Emergency	143,647	171,424	148,638	171,561	184,118
Above the Line	30,310	58,054	198,156	266,691	256,077
Below the Line	4,036	6,782	12,629	19,601	21,738
Dentures	9,286	14,284	18,992	20,494	19,359
Payment					
Emergency	£3,750,378	£5,006,517	£4,287,026	£4,923,259	£5,277,175
Above the Line	£530,743	£1,080,471	£3,631,697	£4,897,263	£4,674,541
Below the Line	£556,220	£842,113	£1,360,943	£1,925,713	£2,113,823
Dentures	£793,673	£1,683,989	£2,476,198	£2,457,419	£2,318,103
Cost per Item					
Emergency	£26.11	£29.21	£28.84	£28.70	£28.66
Above the Line	£17.51	£18.61	£18.33	£18.36	£18.25
Below the Line	£137.81	£124.17	£107.76	£98.25	£97.24
Dentures	£85.47	£117.89	£130.38	£119.91	£119.74

Note: Above the Line treatments can be provided routinely but Below the Line treatments need prior approval.

PART 4
ORGANISATION, STRUCTURES AND SYSTEMS

SECTION 6:IRISH HEALTH SYSTEM ORGANISATION AND MANAGEMENT STRUCTURES

This section of the report provides an overview of the management structure for the current health system at a national and regional level. It reflects on the changes that have occurred since the Commission on Health Funding Report of 1989. It will conclude by focusing on the barriers that exist, and the issues and opportunities that the current structure provides in terms of delivering an effective, value for money, and quality health service

6.1 OVERVIEW OF CURRENT HEALTH SYSTEM MANAGEMENT STRUCTURE

6.1.1 Background

There has been little change to the overall management structure of the Health system in the last 30 years. The current structure dates back to the Health Act of 1970, which established the Health Boards and defined their role in terms of service provision. The report of the Commission on Health Funding 1989 set out the structure and identified a number of weaknesses which created barriers to the delivery of an efficient and effective system. That report also proposed structural improvements to rectify these problems. As we will see later many of the conclusions in terms of improving the efficiency and effectiveness of the Irish health system, both fundamental elements of VFM, remain valid today.

Figure 6.1: The General Structure of Ireland's Health Care System

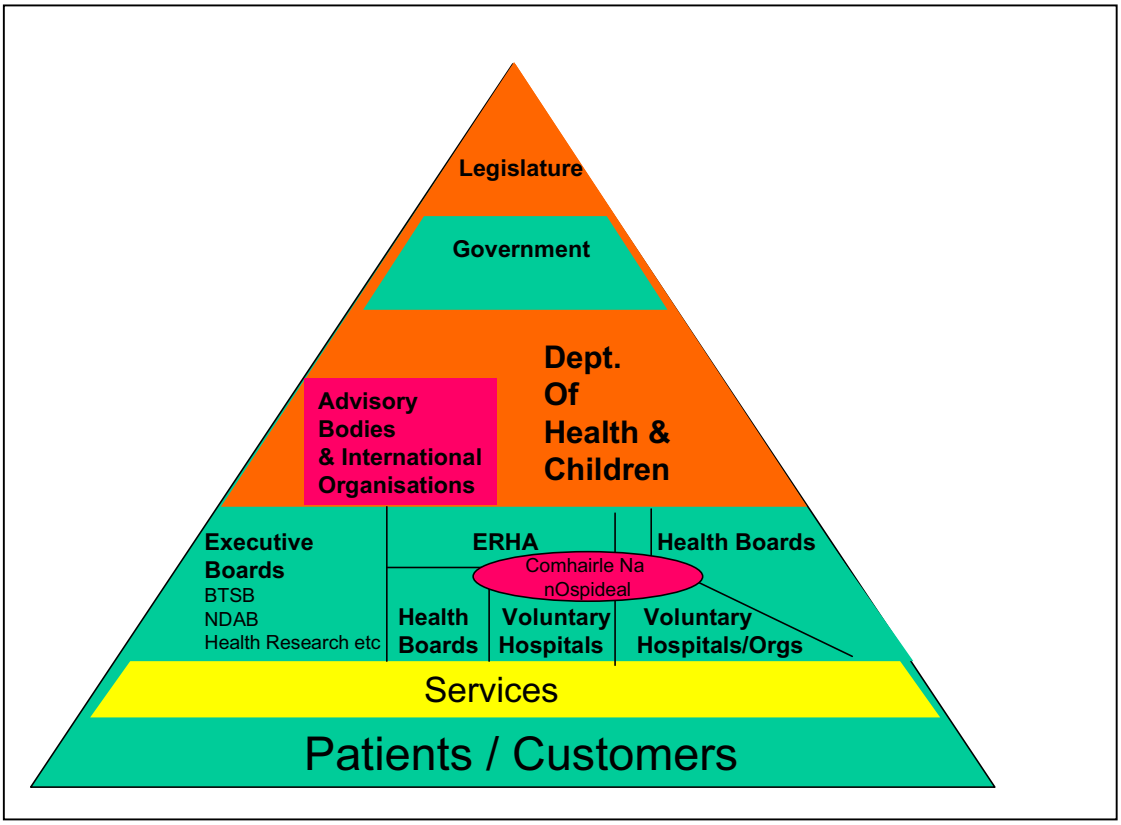


Figure 6.1 sets out the general structure of Ireland's Health Care system. Executive powers of the state are exercised by or on the authority of the Government, in accordance with laws enacted by the Oireachtas. The responsibility for The Department of Health & Children is assigned to a Minister, who is responsible with the support of The Department of Health & Children for its execution.

In summary the role of the Department is to develop policy and manage overall control of expenditure. Its role is not in the detailed operational management of health services.

Functions outside the normal health service delivery remit of the Health Boards are carried out by a number of executive and advisory Boards such as the Blood Transfusion Service Board (BTSB), The Health Research Board, the National Drugs Advisory Board, etc.

The statutory responsibility for administering the services is provided for in health legislation and by ministerial initiative, and is vested in seven Regional Health Boards and the Eastern Region Health Authority (comprising three area Health Boards). Their specific role is discussed in the sections below.

The approval of Comhairle na nOspidéal is needed for the replacement or creation of any medical consultant post.

In the following sections we will see the changes to the system since the Commission's report, and we will look at how structures have, or are changing at Department and Health Board level.

6.1.2 Key Changes since Commission on Health Funding Report 1989

A conclusion of the Report of the Commission on Health Funding September 1989 was that the *"solution to the problem facing the Irish Health Services does not lie primarily in the system of funding but rather in the way that services are planned, organised and delivered"*. It is our view that nothing has fundamentally changed since the publication of that report i.e. the issues and challenges facing the health service are fundamentally the same, except that they are compounded by much higher expectations / demands by the consumer.

The major changes to the structure of the system that have been introduced, namely the Health Amendment (No 3) Act 1996, and the Eastern Regional Health Authority Act of 1999, have focused on looking at ways to improve accountability, service planning and delivery.

The Health Amendment (No.3) Act 1996 requires Health Boards to adopt annual service plans and to operate within these plans throughout the year. This is a binding legislative requirement, which sets out to ensure that service planning and the associated funding once the plan is agreed are managed appropriately. In this context any over spending in one year is carried forward as a charge on the subsequent years funding.

The Health (Eastern Regional Health Authority) Act of 1999 established the Eastern Regional Health Authority as a mechanism to ensure that the optimum structure and systems are in place to facilitate and co-ordinate best practice service planning and to provide a mechanism for the appropriate evaluation of service provision. This is discussed in more detail below in the section on the Eastern Regional Health Authority.

6.1.3 Department of Health

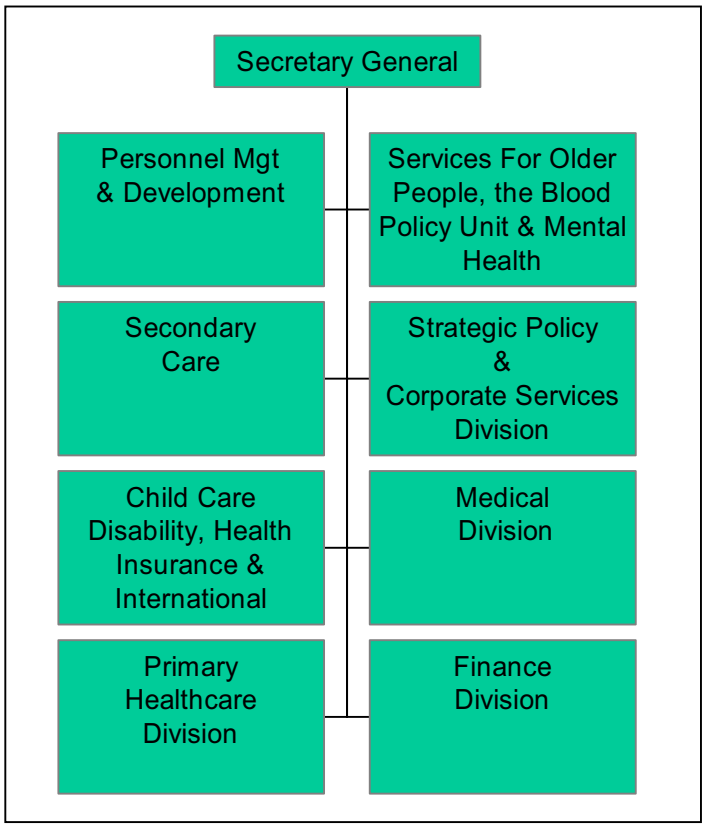
The Department of Health & Children is broadly structured as indicated in the organisation chart in Figure 6.2 below (March 2000).

The Department of Health & Children is responsible for:

- The formation of policy for consideration by the Minister and the Government.
- The development of programmes for implementation of policy.
- Strategic planning and management at a National level.
- Advising the Minister and the Government in its determination of the annual health estimate.

- Determining the allocation of available funding between the various health agencies.
- Determining the overall personnel policies within which Health Boards/Authorities function.
- Monitoring and evaluating the service and financial performance of Boards and authorities against National objectives and standards.
- Identifying and supporting the introduction of more effective management practices.
- Co-ordination of the international activities of the health services.
- Provision of support to the Minister in his ministerial and parliamentary functions.

Figure 6.2 Organisation Structure for Department of Health and Children



This structure is not replicated in any of the Health Boards. Whilst one may consider that it reflects the broad programme structure of the Boards, this is only true to a certain extent. The current structure is not aligned to the Health Board's programme management structure. Furthermore, given the current changes in organisation structure at Health Board level, namely the move from a programme management structure to a care group management structure, the Department's structure and modus operandi presents some difficulties in terms of easy facilitation of service integration. For example, issues relating to one care group may now require dealing with numerous different units and divisions within the Department.

Whilst we are not suggesting replicating the Health Board structures, we consider it important for the Department to look at the way it does its business such that it can handle better cross programme or care group issues. Planning and Evaluation should be a separate function . In addition the structure needs to be looked at to ensure that there are adequate resources, skills

and processes in place in the Department to effect its core policy formulation, planning and evaluation roles. The current resourcing of the Department does not enable it to effectively meet these responsibilities to the required extent.

Reporting to the eight main divisions indicated above are a significant number of units excluding the various ministers' offices. Whilst the purpose of this report was not to carry out a review of the organisation structure of The Department of Health & Children, there is sufficient evidence from the structure alone to suggest that the Department is still involved in much more than policy formulation. The intention with service planning and the accountability legislation was to free up the Department to focus more on policy and strategy – the view from the Health Boards and indeed within the Department itself, is that this is not happening; if anything there continues to be a significant level of operational involvement. One of the recommendations of this study is to establish a Health Information and Evaluation Agency, which would help emphasise the strategic role of the Department.

There are a number of reasons for the continuing operational involvement of the Department in the system; perhaps an unwillingness on the part of the Department to let go, and, across the Health Boards, a varied response to taking real ownership and accountability. There is also now a gap within the current legislative framework; the Health (Eastern Regional Health Authority) Act of 1999 made provision for the Authority to be accountable for the evaluation of service provision for the first time. This is not currently part of the remit of the remaining Health Boards. The lack of an explicit evaluation responsibility for Boards may perversely emphasise the need for continuing operational involvement of the Department in accounting for the expenditure on voted funds, and in a range of micro aspects of the system. This needs to change.

The remit of the Department is too broad, spanning a range of health and social service issues. The fact that the Department's focus is not purely on health matters impacts on its ability to plan effectively and fund the health service. The Department has been continually asked to do more; this arises is in an environment where 20% of the positions within the Department are vacant (some may be temporarily filled by contract staff). Furthermore there are a whole range of skill sets where the Department is either under-resourced for example strategic planning, financial, quantity surveying, or has no resource at all, for example health economics and policy analysts.

One area of major concern is that the values inherent in the Irish Health Care system are not explicit i.e. what are we trying to achieve through our particular system is not clear. The principles of equity and access as set out in the Health Strategy 'Shaping a Healthier Future' are not sufficient in themselves. At one level the value system sets the framework or boundaries within which needs assessment should be carried out. It also sets out what, based on needs assessment, can be achieved and what should be prioritised within the health system. The value system must be practical, results oriented, based on needs. Access, equity, and quality are important but the value system must set out what is or is not acceptable in terms of Health Care service provision. Clearly the criteria for what is acceptable should be based on evidence based medicine/protocols. Other criteria should relate to VFM measures. Such a value system is required to provide the basic building blocks for needs assessment and service planning. It should also provide the basis for determining how investment in Health Care should be prioritised.

It is evident that the Department has over the years been very strong in the areas of policy development (this is discussed further in Section 4). On the other hand implementation of policy throughout the system has been poor and inconsistent. One of the main considerations here has been the absence of performance measurement and policy evaluation frameworks and their associated systems and people resources.

Whilst this on the one hand may appear to contradict the statement above that the Department is still too operationally focused, it is our view that there has been an overall inconsistent and irregular (in terms of frequency) approach to monitoring and evaluation. There are resourcing

issues within the Department, which affects its ability to monitor and evaluate the services provided on an ongoing basis. A further issue relates to the incompatibility of its Regulatory versus Funder roles.

Throughout this report, increasing regionalisation of services is advocated. Any such process must be led by the Department, providing leadership to the Boards. An appropriate regional structure will need to be agreed. Leadership is required to set national strategies and priorities, and to enable decisions on engineering the system to implement this national agenda, to be effected at Health Board level. Boards cannot be expected to effect this change without direction; in its absence, there is a serious risk that regionalisation plans will be adversely impacted by local political imperatives.

There are very few people within the Department who have actually worked in the Health Service. This creates lack of understanding between key stakeholders and further emphasises conflicting priorities between service providers, service managers/administrators, and Department staff.

There are a number of issues relating to the way the system is funded, which also limits the development of an effective service:

- The lack of Multi-annual Budgets, has led to a very short-term view being taken by all the service providers. This has created a stop – start incremental approach to investment in the system. Some of the issues in terms of the current state of the health system relate to this incrementalism.
- Longer term planning requires certainty, albeit within parameters, on funding
- The assessment of funding of developments is quite often not fully costed, and subsequently the funding of developments is often inadequate, and even if fully costed, often restricted. This can have a significant impact on the core budget of the Health Boards.
- It is unclear whether the core funding provided is adequate to support the core services. In our view resource allocation to regions needs to be fundamentally assessed going forward, and mechanisms need to be in place to effectively deal with cross boundary flows

The health system receives a significant level of comment in the press, most of which is negative. The Department is currently under the spotlight from the media on a number of fronts namely the BTSB, various tribunals, waiting lists, etc. This in itself is not surprising; health is a sector which lends itself to a high level of media focus on a small number of politically sensitive issues. While the issues are not unimportant, in our view the focus needs to widen to whether appropriate actions are planned and being taken to deal with these and other issues in the sector, to develop a more informed debate on a much broader agenda of health issues in terms of all the dimensions of value for money of the system.

Issues such as waiting lists, shortages of beds, discharge planning and the condition of the infrastructure are being addressed, but there is no instantaneous panacea. It takes time to introduce new capacity, it takes time to fill the positions related to service developments. The pace with which change occurs is also dependent on the level of funding, and given the recent commitments in terms of revenue and NDP funding, some improvements should be anticipated. It is our view that the Department needs to take a much more proactive approach to ensuring media representation of the health system is much more balanced. We would suggest that how the Department interacts with the media needs to be reconsidered, and that there is a clear case for the Department to market itself better.

6.1.4 Health Boards (Board composition, management structures)

The Health Act, 1970 provided the basis for the establishment of the Health Boards. The role of the Health Boards is to provide or make arrangements with other bodies to provide public health, childcare, and other social services.

In the past many of the agencies providing services had little or no funding relationship with the Health Boards, for example, all voluntary hospitals were funded directly by the Department and were not accountable to any Health Board.

This is fundamentally changing; the introduction of the ERHA has created funding and accountability relationships between the voluntary hospitals in the Eastern region and the ERHA, and removed the relationship that existed with the Department. In addition the funding of the majority of voluntary service providers in the areas of physical and intellectual disabilities is now carried out through the auspices of the various Health Boards.

Each Health Board is required under law to have a Chief Executive Officer. The management of health services delivered within the functional area of the Board is delegated to the CEO. The role of the Board should relate primarily to policy approval and approval of service plans and the associated financial implications thereof.

The devolution of the management of service delivery from the Health Board management to the various service units within the Health Boards, for example public hospitals, varies considerably across the Health Boards. Some manage these units from afar, others have devolved responsibility for general management, financial management and personnel management to the hospitals and in doing so started a process of establishing these resources within these organisations. There is a requirement for the larger units (for example, large acute hospitals) to have properly resourced management structures autonomous of the Health Boards, but accountable to them. This is beginning to develop, for example Cork University Hospital, the Dublin Academic Teaching Hospitals, but there is considerable scope to expand this across the whole system.

Despite this structure, the Minister and the Department had until the accountability legislation was established (some would say continues to have), a significant involvement in the determination of priorities, and an inescapable involvement in management and financial control within the system.

As such the requirement remains to clearly define the roles of both the Health Boards, the Department and to operate the systems as defined. Clearly if the role of the Department is one of policy, then the interactions between the Department and the Health Boards should reflect this. Boards will require the necessary skills and resources to provide the appropriate level of management, accountability and governance.

The issue that the role of the Department is not concerned purely with health matters impacts greatly on the complexity involved in service delivery at Health Board level. This requires the Health Boards to interact on ongoing basis with the Department of Justice Equality & Law Reform in dealing with asylum seekers and childcare service provision, the Department of the Environment and Local Authorities in terms of quality of Water/ sewerage, the Department of Education in terms of Child care, Psychiatric and Psychological assessments, etc. The area of adult homelessness could also be considered as a non-core service area for the Health Boards.

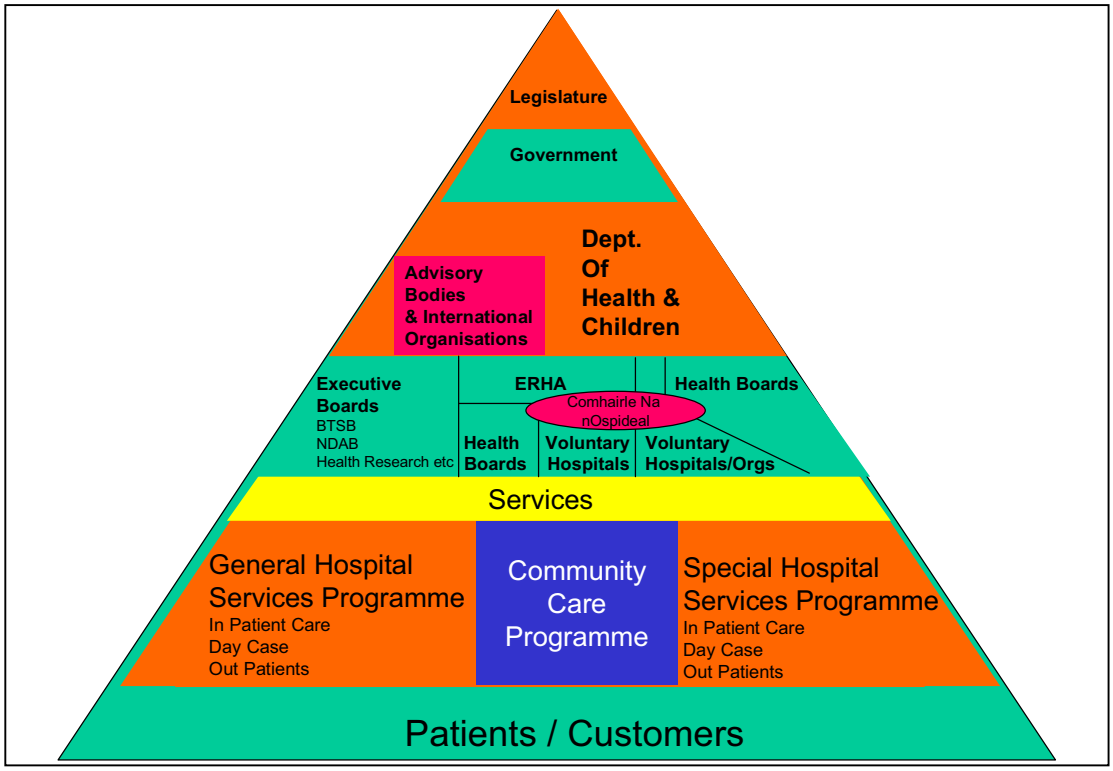
The prevalent emphasis in terms of the role of Health Boards has been curative i.e. one of providing services to the sick, with inadequate attention to promoting health and social gain, primary care and preventative measures. This is starting to be addressed through the new policies in the areas of Health Promotion and Cardiovascular and Cancer strategies.

Figure 6.3 below shows the traditional model for service delivery from the Health Boards. This was known as the programme management structure, focusing on three major programme areas; general hospital services; community care; and special hospital services.

Fundamentally the management of service delivery is different across the Health Boards, and in the absence of care/clinical protocols and best practice management concepts, this results in variations relating to access and equity and potentially the quality of care across the Health Boards. Again until an agreed value system underpinned by needs assessment is in place it is impossible to ascertain the scale of problems associated with access and equity.

The differences in the management of service delivery are also reflected in inconsistent structures across the Health Boards. This in itself is not necessarily a bad thing if it involves the delivery of a more customer-focussed service, however there is evidence to suggest that many of the differences cannot be so explained. One difficulty this presents is that there is a degree of fragmentation of roles within some Boards, which not only makes comparisons across the Health Boards difficult, it can also result in a lack of focus in terms of service delivery.

Fig 6.3 Traditional organisation model for Health Service Delivery



These inconsistencies are further compounded by the increasing introduction of a care group management structure by Health Boards, as indicated in Figure 6.4 below.

The care group concept is a move to a patient focused system, which recognises that the needs of particular care groups are not delivered from within one programme. As such developing care group structures provides, from the patient's or client's perspective, a much more seamless delivery of service. This type of structure also provides a framework for much better service integration.

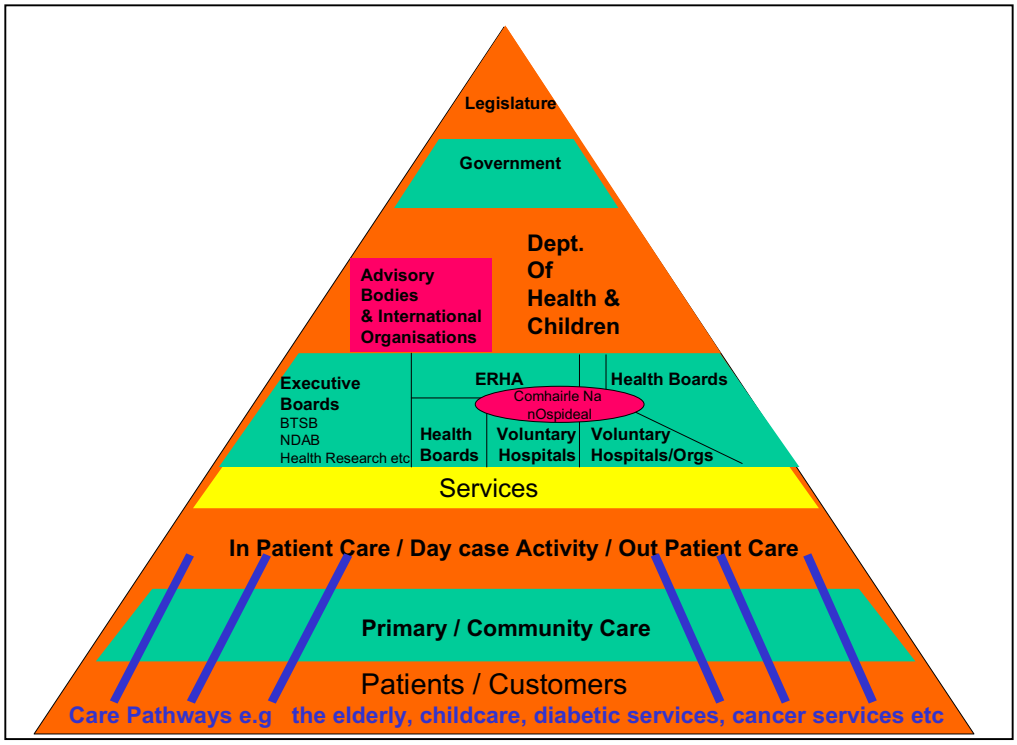
The move from programme management to care group management is in its infancy within the Health Boards. How this is planned presents its own set of difficulties, as there are inconsistent definitions as to what the different care groups comprise. The movement from the Programme Structure to 'care group' management is not moving at the same pace within all the Boards and

certain views suggest that this concept has not been fully accepted on the ground in all the Health Boards.

In some Boards the care group concept is based purely at a policy level. Directors of care groups are established whose role is primarily a planning role, with all operational aspects being carried out by separate divisions. Some Boards have all operational activities reporting to one overall operations manager, who discharges his responsibilities through district/area managers i.e. line managers administer services across all the care group disciplines.

Below the programme manager/ care group manager level within the Health Boards there are further variations in terms of how services are managed.

Fig 6.4 Emerging Model for Health Service Delivery



The introduction to the Medical Manpower report refers to a number of problems with the current medical manpower system relating to; the distribution of hospital staff; the unfavourable mix between untrained and trained staff; the limited availability of senior clinical decision-making; shortages in particular specialties; difficulties with career structure; and difficulties in terms of cover arrangements. These are all structural and management organisation issues, some of which are related to funding and the lack of a values system or context around which hospital services could be best managed.

The lack of a career structure and the poor availability of higher level training for NCHDs in specialist areas within this country is reflected in the numbers who go overseas for training and for the better career prospects.

The report of the Commission on Health Funding identified that there is an absence of clearly specified roles for many hospitals within the public sector. This remains valid; there is still a requirement to define explicitly the catchment area of each hospital and its role at local regional and national level. As additional resources are put into the system, there is a need for regional strategies and structures compatible with national strategies. A major focus should be on the development of regional centres of excellence, within which the roles of hospitals or groups of hospitals are defined in complementary terms. This will require an acceptance by hospitals of potentially changing roles.

The other roles of the senior management team within each Board namely Finance, HR/Personnel, Technical Services, Management Service Officer and Public Health etc, are commonly defined across Boards. However, the responsibilities of these roles, or the particular focus of the individual roles varies across the Boards. Whilst the Boards were established at the same time they have not developed at the same pace, and there is some variations in terms of capabilities across the various Boards. This can be attributed to a number of factors;

- The particular focus of the CEO
- The needs of particular Boards
- Investment decisions by the Boards
- The skill sets of the respective managers
- The individual preferences of the respective managers
- The state of development of management processes
- The level of ISIT
- Policies with respect to devolution

Few of the Health Boards have people within their organisation structure whose sole responsibility is dedicated to delivering VFM in terms of efficiency and effectiveness. The roles do not specifically exist, and in addition there are no formal frameworks, management processes, or information systems in place to allow ongoing monitoring or assessment of efficiency and effectiveness of how services are provided. This is not to suggest that managers within the system do not care about VFM. By in large managers in the system, are under resourced, provide a 'fire-fighting' service and have little if any time to engage in VFM assessments.

The recent establishment of the function of the Directors of Public Health is a positive step in terms of providing a clinical platform for needs assessment for the population within a Health Board area. It also provides for the establishment of outcome measurement in terms of health gain. This is an area which needs significant support in terms of measurement processes, information systems and resources.

The health system by its nature is complex and needs a balance between management and administration. Most of the current managers have grown up within the system, where the focus was much more on administration than the management of service delivery. Whilst their dedication to the service is unquestioned, this environment creates difficulties in terms of skill sets and also limits new thinking within these organisations. This is fundamentally a cultural issue; a culture change will be required to move mindsets away from a traditional administration focus to one of modern Health Care management. The Health cuts of the late 1980s have impacted on the culture. This has influenced the mindset of managers.

The culture has, until recently, been one of cost containment in particular a focus on economy rather than efficiency and effectiveness. A focus on economy does not necessarily deliver VFM as cheapest does not always equate to the best from an efficiency and effectiveness perspective.

One aspect of the current system and culture of the health service is a basic lack of management accountability within the system. In today's environment where significant additional capital funding is available, the emphasis is now on spending the funds, which has significant potential to compromise VFM. There is an unaccustomed pressure on people within the system to spend funds. The skills required to contain cost are different to those required to manage investment

in an effective manner. Some of these difficulties stem from the inadequate level of capital investment planning at Health Board level and the ability to gear up to spend against these commitments, particularly outside the acute hospital programme. The obvious risk is that investment will be not be made against agreed and acceptable criteria, will be wrongly directed and potentially wasted.

The use of Public Private Partnerships PPP is an emerging mechanism for funding the development of major public sector capital programmes. Such an approach allows for private funding to supplement public funding for capital projects. This could be of major value in financing service delivery infrastructure.

Given the scale of some projects in community care, psychiatric units, care of the elderly, administration blocks etc, it may be necessary to bundle groups of these projects together in order to attract private interest in such developments. More significantly, however, PPP provides a platform to introduce skill sets such as design, quantity surveying, planning, project management, operations, project finance etc, that are not readily available in sufficient numbers in the health service for capital projects.

It is our view that the appropriate skills and resourcing to manage the delivery of an evidence based health service are currently not sufficient within the Health Boards. When we talk about evidence based we are not only referring to evidence based medicine and the related protocols which would support this, we also mean that there are no evidence based management processes in place. It is our view that there are skills and/or resource deficits in areas such as service planning, strategy development, financial planning and management, costing, human resources, IT and change management across all Boards.

The skill sets required are in today's environment extremely difficult to attract into the health service. If the system is to develop and be managed effectively then an appropriate level of reward and remuneration will be required to attract the necessary resources.

In the past, organisational development within the system and at Board level was limited, in part a function of the lack of available resources for this purpose, given the significant cutbacks in health spending and the requirement to ensure that all monies were seen to be spent on patient care. However, in our view, investment in management capability is now necessary within the health service. Such investment is essential to provide a basis for cost effective, value for money, efficient and effective health services.

In today's environment where there is significant additional investment in the health service it is incumbent on the Health Boards to ensure they are properly resourced to ensure delivery of a quality patient focused health service. If Boards are to take on devolved responsibilities for regional health services, they require leadership supported by multi-annual funding arrangements to reengineer their organisations to provide effective evidence based Health Care, facilitated by best practice management processes.

There has been a lack of real debate around allocation processes both to the Boards and within the Boards. A radical re-engineering is required to ensure that the current core service, which has been developed on an incremental basis and is now institutionalised, is reassessed in the light of a current assessment of needs. The current focus of Boards on maximising funding through service developments (now part of the ingrained psyche of the system, and a product of times when it was extremely difficult to attract additional funding other than through a service development justification) has taken focus off any serious questioning and reappraisal of existing core services, which account for the vast bulk of expenditure. Development funding is typically of the order of 5% of the annual health spend, therefore focusing on the 95% of spend should provide greater opportunities for identifying VFM initiatives.

No one is promoting the debate as to what is the appropriate level of Accident & Emergency or other specialty service for a region? The Fitzgerald report suggested the closure of a number of hospitals as far back as 1968. This report recommended the concentration of resources on a limited number of hospitals, each with the resources and technology to provide the highest calibre service to people in its catchment area. Those hospitals not selected for development were recommended to be downgraded or closed. Public and political opposition has restricted the level and pace of rationalisation. This issue remains, and irrespective of the potential impact in terms of VFM, or quality of care, there is no political will to engage in such a debate or to make such hard political decisions.

Whilst in our view there is no real cultural context for VFM within Health Boards, some VFM initiatives are evident across the Health service. In the overall context we consider them to be small in scale. These initiatives which tend to be focused on economy aspects, are relatively straightforward, but not unimportant targets in the non-health service delivery areas. Example include:

- Regional materials management
- Centralisation and or outsourcing of catering, laundry or other 'hotel' services
- Energy management initiatives
- Other initiatives focusing on efficiency and effectiveness, which have arisen out of operational necessity rather than an explicit VFM, focus, for example:
  - Appointment of bed managers and development of protocols for admissions and discharge in the hospitals
  - Appointment of nurse specialists to validate waiting lists

From an economy perspective the Estimates process, and in turn the Department, in more recent years, set VFM targets. The Dublin voluntary hospitals have worked well together in achieving these targets. A Health Materials Management Board (HMMB) was also established, whose focus was on setting standards, developing protocols and establishing best practice in terms of materials management. Drugs spend does not come under the remit of the HMMB. The HMMB includes representatives of the Health Boards and the Dublin Academic Teaching Hospitals (DATHs), however it does not have a statutory role. It has not been seen as at the core of the Health Board system. This needs to change; fundamentally the service provided is necessary for the Health Boards to manage their material spend effectively.

Within Health Boards the role of regional materials managers was established. These have had mixed success. They have worked together on some aspects of spend, however we would suggest a need to work much more closely together, and with the HMMB.

The CEOs of the Boards should take a greater interest in the function and challenging cost reduction targets should be issued on annual basis. Challenging targets should be set not just for savings in terms of material purchases but also for savings in terms of how services are delivered. Savings generated should be shared with Boards for service provision and enhancement.

E-Procurement if implemented on the basis of having best practice value for money purchasing processes can assist on the material procurement side, though we recognise that the availability of structures and systems to support operational performance improvement may in the short term limit progress in achieving operational savings.

Fundamentally there is no focus on the biggest cost area namely people costs, where there are fundamental issues in terms of skills mix, etc. Pay costs represent the single biggest area of spend in the health service. Given the incremental way the health system has grown in this

country, the absence of fundamental reviews of service provision and their associated resourcing and organisation structures, it is our view that a review of pay costs from a VFM perspective is overdue.

Industrial Relation issues of demarcation, on call costs, absenteeism, working practices, skilled professions doing inappropriate levels of unskilled work, absences of certain skills provide further opportunities in terms of assessing value for money in pay costs. Such an assessment whilst recognising the IR environment and the strength of the trade unions, should not be constrained in terms of developing innovative and pragmatic solutions.

If we try to assess the outcomes associated with the current level of spend, then there are even more serious issues. There are no real measures of outcomes from the system. It must be stressed that this is not unique to Ireland, few countries have robust processes to measure clinical outcomes. In our system, clinical information systems are poor and there is no tradition of publishing or accounting for clinical outcomes. This presents a major issue in terms of the lack of clinical audit, clinical governance and the lack of processes and resources to ensure that this happens.

A further cultural issue pertaining to the Health Boards relates to the nature of their interactions. The culture between Health Boards has been one of competition rather than co-operation, sharing and learning. This competition goes beyond competing for the limited funding in the system, there is ongoing competition for human resources and perhaps most significant, an un-preparedness to share knowledge and experiences. The new health strategy must emphasise and reinforce the need for conjoint working between Boards, which in fairness has seen improvement in recent years.

A number of steps are being taken to address the above including the establishment of the Health Boards Executive (HeBE), which should provide a mechanism to support increased cooperation. The Health Boards Executive will carry out certain executive functions, as may be specified, on behalf of the Chief Executive Officers of the Health Boards and such other executive functions relating to the efficiency and effectiveness of the services as the Minister may direct. It may be appropriate to place the function of the HMMB within the role of the HeBE.

We would suggest, given the current deficits in IT in the Irish health system (refer to Section 7 of this report) that this body could deliver significant VFM savings if it were tasked with providing a range of shared services for all the Health Boards in areas such as financial management, materials management, purchasing, personnel management, and IT. Even if this is not the appropriate body for delivering such shared services, the opportunity remains for some organisation to provide these services.

Despite the strong competition between Boards there are serious issues for many of the Boards in relation to inflows/outflows of patients from/to other Boards. The ERHA reports that inflows from other Boards to its functional area represent up to 40% of its acute hospital activity. This cannot be accounted for by the presence of the national centres for some specialties in Dublin. No explicit examination or evaluation of this phenomenon has ever taken place. In the context of the development of regional centres of excellence for acute hospital services, explicit protocols should be put in place, which would determine how and whether activity arising from one Board area should be handled in a different Board area. Until such time as regional strategies and protocols are in place, there is limited value in determining what, if any, the requirements are for mechanisms to allow cross charging the Boards for activities carried out outside their functional area, that are contrary to the developed protocols. If cross charging mechanisms are put in place, it will be imperative that they do not form the basis for perverse incentives to exist within the health system.

The current structure has provided a strong element of local democracy in the health service. The 1970 Act stipulates that a majority of the members of each Board must be appointed by the county councils and corporations in the Board's functional area. The balance comprises elected representatives of certain health professions and a number of ministerial nominees. The current membership of Boards excludes other potentially relevant business experience.

There is, however, a counter argument to this level of local democracy, namely that the political nature of Health Boards constrains the delivery of VFM health services and can make a nonsense of some elements of decision-making within the regions. There are a number of examples of units which, not only for financial but also for quality of care issues, should be closed and/or services integrated in other facilities. But the political will demands that they remain open. This clearly is contrary to the delivery of a quality patient focused VFM service. There needs to be a greater acceptance that a small, local hospital may not provide the best care to a local population, who may be better served by a larger, but more distant hospital in the region, with a range of specialists and better facilities.

We would suggest that at Board level, there is a requirement for smaller tighter Boards. In addition, there is a need to change the political process such that the focus of local political input is on a representation basis i.e. representing the local population, and not on a decision-making basis. There are two issues to be considered here; the first relates to ensuring that national strategies and their associated resource allocations determined by the Department are implemented in an effective manner as planned; the second relates to ensuring that the needs of a region are optimised as opposed to optimising the needs of local areas within a region. The intention here is not to remove the value pertaining to local democracy; rather it is to provide different formats and mechanisms for achieving this.

Governance in a health context has received increasing attention in recent years. Whilst structures for governance may vary we would suggest the following as key principles in any good governance structure:

- The Board, be it the Health Board or the Board of a service provider unit, should establish a mission for service provision in line with the interests of all stakeholders, and in line with legal and ethical considerations.
- The Board should focus on policies, strategies and plans, rather than operational matters.
- The Board should oversee financial policies, funding policy, approve budgets/service plans and monitor financial performance, including ensuring appropriate internal audit/audit committees exist.
- There should be a process for Board evaluation and performance review.
- The Board should ensure appropriate systems (both corporate and clinical) are in place to meet its obligations and comply with law and regulation. In the context of Health Care, good governance clearly implies taking responsibility for systems to provide quality of care and the monitoring of the same.

  This includes implementing methods to ensure the perspective of patients are taken into account, participating with other service providers in developing Health Care strategies, and developing methods to measure performance on a regular basis.

Good governance requires Boards to focus its involvement at policy level and not to interfere in operational matters, and to implement structures to clearly delegate responsibility to executives to manage the activities at unit level.

At a unit level, for example an acute hospital, it is the duty of management to provide a reasonable regime of care for patients, which in turn implies a duty to provide efficient and competent staff, proper facilities, safe systems etc. This emphasises the need for Boards to have an appropriate level of freedom of action to govern the affairs of such units. Against this background, Boards have responsibility for the establishment of organisational structures and systems to ensure proper clinical practice is in place. Hence the reality is that Boards are now faced with the increasing burdens of applying best practice both in terms of corporate and clinical governance. The requirement for clinical governance creates the need to ensure systems of clinical audit are in place.

It is in our view important to codify and clarify precisely what is meant by governance in a Health Care environment and thus ensure that there are no misunderstandings by Boards of their responsibilities in this regard. (It is fair to acknowledge the advances made by Boards of some of the larger voluntary hospitals in Dublin in addressing governance issues.) This in turn should encourage Boards to provide appropriate training to its members. It should be clear from the above that there are skill mix implications in terms of Board membership. It should also encourage Boards to implement appropriate systems and structures in their organisations to meet the standards of good governance. It is important to understand the distinctions between corporate and clinical governance and to emphasise that the responsibilities of the Boards and management extends to clinical governance i.e. clinical governance is not the total responsibility of clinicians.

A number of the concerns raised above are not new; the Commission on Health Funding in 1989 summarised the main structural issues as follows:

- the current structure confuses political and executive functions, and therefore undermines both;
- it fails to achieve an appropriate balance between national and local decision-making;
- the decision-making process is not underpinned by management information or process/system evaluation;
- inadequate accountability within the system;
- insufficient integration of related services;
- inadequate effective representation of the interests of individual patients and clients within the structure.

Whilst changes to the structure and the accountability legislation address some of the above, they are still in the early stages of implementation. Issues remain in relation to:

- The confusion of political and executive functions, which reflect weaknesses in terms of accountability and governance at Board level in the Health Boards.
- The lack of information to support decision-making – there is a major deficit across all the Health Boards, which if rectified individually by each Health Board will necessitate on a conservative estimate an investment corresponding to several multiples of the current planned spend of £143m over 7 years.

  It is important that this type of spend is not replicated across all the Health Boards as the required spend could be significantly reduced if a single shared services centre was established. Focusing the spend in a shared service environment will still require multiples of what is currently planned to be spent on IT throughout the system.

On a positive note there is evidence across a number of the Boards of a significantly increased emphasis being placed on becoming patient focused. However, this in itself does not prohibit a

more determined effort to create a more effective representation of the interests of patients/clients within the structure.

Given the issues presented above, we have to question whether the current structure in terms of having the ten Health Boards is in itself contrary to VFM concepts. The Health Boards have been in place for some 30 years, in which time the scope and level of activity for which Health Boards are now responsible has increased. We believe that the time is right for a detailed review of the composition of, and role of Health Boards such that an assessment can be made as to whether the Health Board model is still the most appropriate means of delivering service at a local level. Such a review needs to consider the requirements for regionalisation and how these can best be met.

6.1.5 Eastern Regional Health Authority

The objective of the Health (Eastern Regional Health Authority) Act, 1999, was to reform organisational structures in the health services in the Eastern Region so as to improve co-ordination and integration in the planning and delivery of services. The Act established the Eastern Regional Health Authority (ERHA) as the responsible body for planning, commissioning and overseeing all health and personal social services in Dublin, Kildare, and Wicklow.

A key aspect of the Act was to give the Authority responsibility for those services, which until its establishment had been directly funded by The Department of Health & Children, namely the greater part of general hospital services in the region, and the mental handicap service provision. Three Area Health Boards were established with delegated responsibility from the Authority for the management and delivery of the statutory services formerly provided by the Eastern Health Board.

Key features of the ERHA are set out below:

- Voluntary service providers (including the major voluntary hospitals) are now funded by the ERHA;
- Funding of voluntary service providers is by means of a service agreement between the providers and the Authority. Similar arrangements exist between the area Boards and the Authority;
- The functions of the ERHA consist of the existing functions of a Health Board and new functions of:
  - planning, arranging for and overseeing the provision of health services in the region
  - putting in place systems to monitor and evaluate service provision
- The Department of Public Health that existed within the Eastern Health Board has been transferred to the Authority, and retitled as the Department of Health and Social Improvement. This differentiates the three Area Boards from the other Health Boards in not having dedicated Departments of Public Health, with the function being provided centrally by the Authority.
- Whilst the Area Boards operate as Health Boards, they must do so under the direction of the Authority i.e. they must co-operate with each other and work with the other service providers in the region to provide seamless planning and service delivery.

The ERHA has described its rationale in terms of addressing a range of key issues, i.e. fragmentation of service provision; integration of services around patients and institutions; and the better co-ordination of Accident & Emergency services, waiting lists, etc. Fundamentally its role is to:

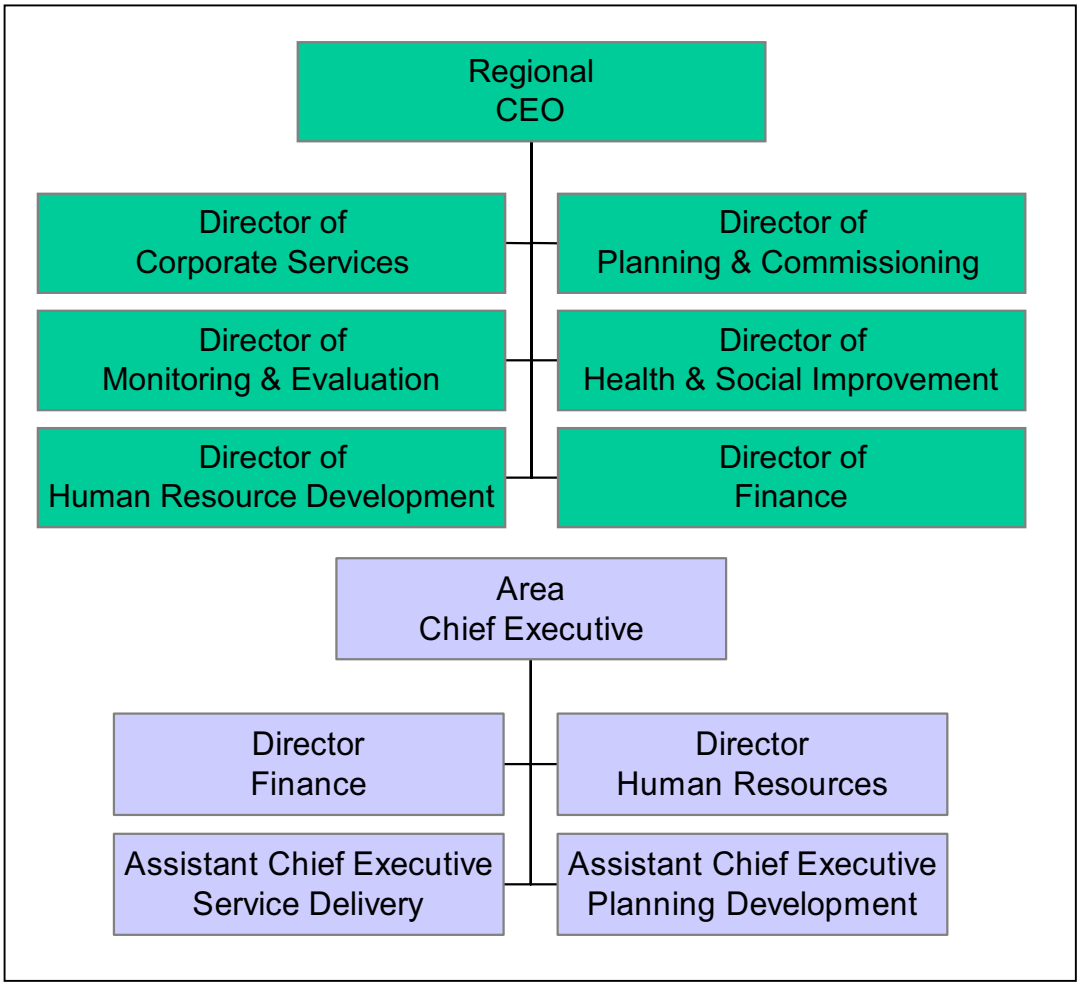
- Assess the underlying need within the region for health and social services by care group;
- Plan the delivery of services by care group;
- Agree funding with the Department to secure the resources required to deliver planned services;
- Commission these services with the various providing agencies; and
- Monitor service provision and evaluate results.

The organisation structure (as shown in Fig 6.5) of the ERHA reflects its role as described above.

The ERHA structure operates in a matrix management style, as each of the Directors has different levels of involvement in the different key roles of the organisation.

At Area Board level, there are some variations in organisation structure. The core structures tend to be as above, with an Assistant Chief Executive charged with responsibility for all of service delivery be it at district level, or at sector level. District General Managers, Acute Services General Managers, Primary Care Unit Managers etc. report in to the Assistant Chief Executive. The General/Unit Managers have responsibility for the overall management and co-ordination of services. Five Care Group Directors report to the Assistant Chief Executive and have responsibility for Planning Development of child & family care; services for older persons, services for person with a disability; mental health and; episodic illness.

Figure 6.5: ERHA & Area Board top Level Management Structures



The ERHA has also established a shared services centre managed by a director. The objective of this centre is to support the administrative needs of the ERHA and its three Area Boards, by providing management, financial and information systems support. This is a positive initiative that avoids significant cost duplication and as such does indicate a focus on VFM. This could provide the platform for service delivery to a broader range of stakeholders both inside and outside the functional area of the Authority.

The establishment of this shared services centre does reduce some of the concerns expressed on whether the establishment of three additional Area Health Boards represents VFM or whether there are more appropriate organisation structures to deliver Health Care.

At Authority level, there are 55 members, thirty of which are public representatives appointed by the six local authorities in the functional area of the Authority.

The remaining members consist of members of registered health service professions, representatives of the voluntary service providers and Ministerial nominees. The members of the three Area Health Boards are appointed from the membership of the Authority. Public representatives hold a majority on the Area Health Boards.

6.1.6 Other Executive and Advisory Bodies

This report has not focused on whether the other executive or advisory bodies (GMS, Health Research Board, Blood Transfusion Services Board, National Drugs Advisory Board, Comhairle na nOispidéal, The Medical Council, etc.) deliver VFM through their respective organisations.

We have reviewed the funding associated with the GMS, and further issues in relation to GMS are addressed in Section 9, on Primary care services. VFM issues arise in relation to the potential to make greater use of GMS data, and to more proactively monitor trends. Other issues in relation to these bodies are considered in the appropriate sections.

6.1.7 Integration with Northern Ireland Health System

It is evident that opportunities exist for delivering VFM through increased cross border co-operation and utilisation of resources available within Northern Ireland. From a patient's perspective, particularly in the border areas, the locations of such facilities frequently provide easier access than those available within the Republic of Ireland. Our system is accustomed to cross boundary flows between Health Boards, though no specific recognition of such flows is made in the present funding. A certain element of the service in the border areas is provided through the infrastructure in Northern Ireland.

It is clear from recent initiatives such as the establishment of an all Island National Cancer Institute arrangement and Institute of Public Health, that there is a much greater focus on how the health services of both the North and South can work better together. Whilst these initiatives are in their early stages, this can only be seen as a positive move in the context of VFM.

6.1.8 Organisation structure for implementation of national strategies

The national health strategies (for example: cancer and cardiovascular disease strategies) are discussed separately in this report. The general consensus is that the strategies are excellent but that issues exist around planning for implementation, implementation itself, and evaluation of implementation. The organisation structures at national level are not in place to ensure that implementation, which is carried out under the auspices of the Health Board, is effective. As a result, the activities funded, while invariably focused in the area of care relevant to the strategy, may not be fully aligned with the overall strategy. The structures to monitor and evaluate the benefits arising from investment in these particular strategies need to be developed. Another issue here is the degree to which Health Boards are competing with each other, which must have an adverse impact on the effective delivery of an equitable and efficient system to all.

In the sections that follow we take a more micro look at two of the key stakeholders in the health system, namely the GPs and the consultants, both of which operate in an independent fashion, the GPs as independent contractors and the consultants within the independence assured to them by the nature of their contract with the Health Boards.

6.1.9 GPs and other primary care service providers

Primary Health Care is provided by many practitioners including General Practitioners (GPs), Practice Nurses, Public Health Nurses (PHNs), Community Psychiatric Nurses (CPNs) General Dental Practitioners (GDPs), Opticians and Community Pharmacists. These people are supported by a range of other professionals working in community settings, such as physiotherapists, occupational therapists (OTs) and home helps, for example.

In "Shaping a Healthier Future", GPs were identified as the usual first point of contact within the Health Care system, and should be the common thread running through a programme of care. The health strategy identified that general practice suffers from a degree of isolation from the rest of the system and therefore its full potential is not realised. GPs, as independent contractors, have traditionally operated separately from other community-based services and have inadequate links with the acute hospitals. A blue print for developing general practice was agreed in 1992, which emphasised need for integration.

Key issues relating to this aspect of the health system are:

- Need to develop the GP model – move away from single practitioners to Co-op model. The current proportion of single practitioners is c.50%.
- The role of GPs needs to be clearly defined; at present it is inadequately framed, disaggregated, and patchy. The GP should have a better developed, more integrated role in the Irish Health system.
- Delivery of primary care needs to be on a team basis.
- One option is to align primary care providers on a geographical basis. There is an indisputable need for a team based approach to chronic diseases; for example diabetes needs the input of a GP, PHN, Chiropodist and Ophthalmologist.
- Inadequate use of IT at GP level, despite significant grant aid from the Department for training, software and hardware.
- Training in medical school needs to emphasise a team based approach.

Section 9 of this report provides a more detailed assessment of primary care issues.

6.1.10 Role of Consultant

The role of the consultant as defined by the Consultant Contract is;
"A consultant is a registered medical practitioner in a hospital practice who, by reason of his training, skill and experience in a designated specialty, is consulted by other registered medical practitioners and undertakes full clinical responsibility for patients in his care, or that aspect of care on which he has been consulted, without supervision in professional matters by any other person. He will be a person of considerable professional capacity and personal integrity."

Consultants may have their own private patients, or their patients are referred to them by general practitioners, other consultants or through Accident & Emergency departments. Consultants also may have responsibilities for teaching, research, or the running of a department.

While consultants have ultimate responsibility for each patient assigned to him, the investigation and treatment of patients on an outpatient or in-patient basis may be carried out by junior medical staff under their general supervision, with referral to the consultant of more difficult or complex cases.

The majority of consultants have a scheduled commitment of 33 hours per week comprising a mixture of fixed and flexible sessions. Each session is of duration of three hours. A fixed session is a time commitment, which typically must be fulfilled because of the impact that consultant activities have on the utilisation of other resources and the deployment of other staff. This type of session predominantly covers outpatient clinics, ward rounds, theatre sessions' etc. Flexible sessions are for other regular and predictable time commitments, which may be discharged in a more flexible manner within a specific time frame. Such sessions cover activities such as teaching, research, hospital management, and clinical audit.

A consultant's commitment will comprise a mix of fixed and flexible sessions, the ratio of which can vary depending on specialty. There is no restriction on the level of private practice which a consultant may take in addition to the public commitment.

There are issues in terms of the interactions between GPs and consultants, which can prohibit VFM;

- Limited co-ordination and integration of services between primary care and acute hospital based services
- The need for mutual recognition of the respective roles that GPs and consultants play in the system
- Inappropriate referrals by GPs – the referral interface with GPs needs to be addressed
- Relationships between GPs and consultants outside the functional area of their Health Boards, which can lead to significant cross boundary flows

Some of these can impact on waiting lists. It is interesting that an initiative at one of the Health Boards was to give the GPs an element of responsibility for waiting lists, by providing them with visibility of consultants' waiting lists. This allowed the GP to choose a consultant that would provide quickest access to the patient.

There are a whole series of issues, based on facts, perceptions, the lack of management skills and or processes, that relate to the current terms of the consultant contract and the engagement of consultants in management:

- Rostering/Monitoring of time input
- Service Planning
- Public Private Mix
- Clinical Audit
- Clinicians in Management

Rostering/Monitoring of Time Input

It is interesting that the Consultants' Contract in the Memorandum of Agreement sets out that hospital services need to be critically linked to consultants' working patterns to ensure that a cost effective quality service is provided to all patients in the hospital system. At one extreme, this reflects the difficulties faced in rostering as given the independent nature of consultants, the hospital has to try and best plan and manage its resources around the working patterns of consultants rather than consultants providing a service within the planned operating framework of the hospitals. The Consultants' Contract also states that it is the role of the employing authority to arrange appropriate rosters for the provision of clinical cover for emergencies arising within the hospital and for patients brought to the hospital for emergency treatment. There are a whole series of allowances and payments to cover the cost of such emergency services. In 2000, these costs were estimated at 20% of the overall consultants' salary cost.

The concepts of flexible working are fine as long as it does not prohibit the overall management of hospital services. The rigidities that exist within current contracts for all hospital staff can have significant overtime and pay cost implications if the resources required to manage the delivery of service are not co-ordinated. Therefore flexibility must be on a team basis and must provide flexibility for all stakeholders. This is a prime example of an area, which would benefit from clinicians' involvement in management.

There is a need to extend the hospital working day, which has implications for all hospital staff and will necessitate agreement on changing consultant working patterns to provide attendance on a non-emergency basis outside the hours of 9am to 5pm Monday to Friday.

Consultant numbers have increased by c.37% in the last 10 years (with half of that increase being in the last three years). The total number of consultants in the system as of Jan 2001 was 1,560. There is widespread view within the system that this increase in consultant numbers has not led to corresponding improvements in the delivery of out of hours hospitable services.

There are a number of issues relating to the monitoring of time input of consultants in the system. Firstly consultants are not subject to effective management from a non-clinical perspective. As indicated above there are issues in relation to; scheduling time inputs; managing cover; provision of locums; managing rest days etc. This is further exacerbated by the degree of delegation to NCHDs.

There is an appreciation that senior level clinical decision-making is not available within our system at all key times. At present a significant level of frontline services at Accident & Emergency are provided by NCHDs which has a consequential impact on requirements for additional tests, referrals to other NCHDs and waiting times. Whilst recognising that 24 hour cover is not only not feasible but not necessarily appropriate, there is a requirement to better understand the pattern of presentation at hospitals. Circa 80 % of presentation is covered in 10 DRGs. Hospitals need to resource senior clinical decision-making for these areas in Accident & Emergency, and should put in place the appropriate levels of support for this in areas such as Anaesthetics, Labs and Surgery. Having appropriately trained doctors available on site will necessitate changes in consultants' working patterns. This has significant consequences in terms of consultant numbers and in terms of a reduction in the ratio of NCHDs to consultants.

There is no question as to the consultants' rights in terms of clinical independence. However, the independent nature of consultants does provide other difficulties. A consultant must decide on what the balance in his practice will be between emergency and elective clinical work and between teaching, research or other work. The employing authority has little control over what that balance should be. In addition the preferences of a consultant for a particular type of work within his specialty can over time dictate what gets referred to him. This profile of work may not necessarily match the overall needs and priorities of the Employing Authority. The nature of the current role of the consultant, in addition to his clinical independence, means that once a patient and doctor come into contact, then the relationship is a personal one between the patient and the doctor.

Service Planning

The responsibility for service planning under the current contract lies with the Employing Authority. It is their responsibility to know and understand the resource implications of diagnosing and treating existing patients or planning for the care of future patients. Given the independent nature of consultants described above, this presents significant difficulties for service planning. Notwithstanding the consultants current role as advocate on behalf of his patients or patients waiting for consultation or treatment, and his role in terms of advocating more or better services for patients, the consultants should in our view be central to the service planning process, albeit within the prevalent resource constraints. They are the most appropriate body to determine the clinical priorities. This is why the development of clinicians in management structures is critical.

Public Private Mix

The current consultant contract accommodates consultants undertaking public and private activity in public hospitals. The total number of consultants in the system as of January 2001 is 1,560. According to the medial manpower report about 580 consultants from the public hospitals and 150 private specialists deliver care in private hospitals (supported by a very small number (c.35) of Non Consultant Hospital Doctors (NCHD). It is estimated that half of this private care is provided in public hospitals, though in terms of complexity a higher proportion of complex procedures are carried out in the public hospitals. There is no restriction on the level of private practice that can be carried out by a consultant. This has consequent implications for other resources, and the management thereof, in the health system.

In our discussions with Board managers and hospital managers, we found widespread concern that the private Health Care system is reducing the resources available for public Health Care. However, there is no evidence to support any widespread abuse of public sector responsibilities by consultants. Furthermore, there is no hard evidence on the amount of activity in the private hospitals carried out by individual consultants.

There is a need to measure and monitor the public/private practice issue routinely, and arguably to ring fence consultants' private & public practice. We are not aware of any formal processes, which account for each.

The Memorandum of Agreement of the Consultants' common contract includes the following statement: *"... a consultant's overall proportion of private to public patients should reflect the ratio of public to private stay beds designated...and that variations in the nature and extent of a consultants work as between his public and private practices will be subject to review under the terms of review of Section 6 of the Memorandum of Agreement".* The processes to monitor and evaluate this do not appear to be in place, and as such it is difficult to determine whether the co-existence of public and private practice impacts on equitable access of public patients. Improved data sharing would help resolve many of the public private mix issues.

The overall issues in relation to Public Private mix are discussed in Section 8.

Clinical Audit

There are fundamental requirements on Boards as discussed earlier in terms of corporate and clinical governance. Clinical audit is a prerequisite in this regard.

The current Consultants' Contract provides for clinical audit. This recognises that there is a basic need to ensure that there is a qualitative assessment of the work carried out by consultants. Clearly whilst hospital management can assess on a quantitative basis the work of a consultant, (for example numbers of admissions or activity levels), they are not equipped to provide a qualitative assessment of care given or ultimately a qualitative assessment of the outcomes of treatment. Under the current contract, the basis for this type of assessment is peer review, in which the confidentiality of the patient and doctor is preserved. It is evident that not all consultants participate in this type of audit. The pace of introduction of such clinical audit systems is slow. We are concerned that there is no great desire to introduce the system at consultant level. There is a need to create, develop and agree the appropriate evidence based clinical protocols and the appropriate audit processes to allow clinical audit to be an effective process for formal assessment against agreed criteria. It is our view that there must be an independent basis for this form of audit. At present clinical audit, to the extent it exists, does so in an ad hoc fashion in the system, and the audit process is not necessarily evidence based.

There are a number of valuable complementary initiatives to this whole concept of clinical governance:

- The proposals regarding accreditation of hospitals, a process which is due to be rolled out after the initial pilot stage in 2002. Accreditation is an internationally recognised process, which combines self-assessment and external peer review of an organisation's performance against a set of pre-determined standards, with an objective to encourage health agencies to continuously improve the Health Care delivery system. This should be viewed as a VFM initiative of fundamental importance. A pilot scheme for Ireland has been developed focusing initially on eight major acute hospitals in Dublin, Cork and Galway, with the first hospital survey targeted for early 2002 and the remaining seven hospitals within 6 months of that date. Each of the participating hospitals will or have established an accreditation steering group and are required to appoint a Hospital Accreditation Project manager to ensure that each hospital is prepared to participate in standards development and the overall implementation of the scheme. The development of this pilot provides for the establishment of an independent Accrediting Body to run the accreditation programme. We have a view that accreditation should over time be mandatory and that its focus should be on both clinical and non-clinical aspects of care, and on the management processes of the hospitals.

- In industry there are many accreditation processes. In some cases, accreditation has been seen as a marketing tool for companies. This has resulted in the implementation of systems and processes within companies designed to achieve success in terms of the accreditation process, but which fundamentally miss the purpose of accreditation, which is to strive to continuously improve the way organisations do their business. There is danger that the opportunity afforded by hospital accreditation could also be missed in the health environment. Accreditation is important, but what is critical is understanding what the implications of failing an accreditation process will be. There is a requirement to determine what if any sanctions should be in place if a hospital fails the accreditation process. There needs to be a clear view as to the impact on public perception and what the resulting implications might be in terms of resource allocation to the entity concerned.

- The concept of 'Revalidation/Re-Registration of Doctors; which puts in place a mechanism to evaluate whether the practise of consultants, specialists and GPs is current in terms of medical developments. Doctors can prove their continuing competence to practice in such a model. The Medical Council has proposed a system of competence assurance, based on Continuing Medical Education, Continuing Professional Development, peer review and performance review.

Clinicians in Management (CIM)

A key point to note within the organisation structure of the health system is the predominant absence of clinical staff, in particular consultants, from any formal reporting structures. This is central to why the clinicians in management initiatives are being promoted by The Department of Health & Children.

The current contract does provide for Consultants in Management. However, the phrasing of the contract is quite loose. As a concept, CIM is in its infancy. It has been agreed that the Employing Authority and the Consultants will work together, and will have the support of the Department, in identifying the most suitable management models for implementation in individual hospitals/hospital groupings. This has had a significant impact on the pace of implementation, and in our view there is limited emphasis in driving this process throughout the health system.

There are a number of pilot clinician in management structures in the health system at present. The key requirement of any model must be to provide a framework within which the activity of clinicians can be co-ordinated and prioritised in line with the needs of patients.

Ideally this framework allows the grouping of specialties in a coherent fashion to provide a more focused interface with hospital management. In our experience implementation has had its difficulties:

- Benefits not necessarily achieved
- Support for concept patchy
- Nurses not adequately involved

The absence of formal structures to involve consultants in management does represent a deficiency, given that they control the activity within hospitals and as a consequence this deficiency has a bearing on costs and VFM. There are of course interactions on an informal basis between the consultants and the hospital management to facilitate the running of hospitals. However, the issues resulting from this lack of involvement are:

- Limited co-ordination
- Perception of interference with clinical autonomy
- Poor communication
- No clear allocation of responsibility
- Limited accountability

The fundamental rationale for involving consultants in management is the devolution of decision-making to the point of service delivery. This, however, can only happen if real power and influence is devolved, if it is to have the commitment of consultants and the support of management.

A key issue therefore is whether it is better for clinical professionals to manage departments/specialities themselves, rather than being managed by others? Undoubtedly the answer to this question is yes, however putting this into practice has its own difficulties. It requires significant time commitment. Currently the management responsibility as defined above would not be seen as central to a consultant's practice. Associated with such clinician involvement in management is a perceived erosion of clinical autonomy. In addition there will inevitably be the clash of medical and management cultures, both of who will have different perspectives in relation to choices and conflicts.

In some quarters, the CIM concept is perceived as a means for clinicians to control the activity of other clinicians, rather than as a mechanism to provide necessary clinical input into management decision-making. This perception needs to be tackled and dealt with if CIM is to be successful.

If consultants are involved to the extent that decision-making is devolved to the point of service delivery then there are a number of issues that need to be considered/clarified;

- A realistic assessment of the adequacy of the Hospitals operational budget, as devolved, needs to be carried out. Transparency in terms of how the budget has been developed needs to be established.
- Funding the time involvement – this relates to how the time commitment associated with clinician involvement will be funded for example additional sessions/locums.

- Bed Allocation – a key part of the process must be the determination of a bed allocation strategy for consultants. In addition, better processes for bed management need to be developed. Particular needs are the development of admissions wards / medical assessment units and the need for intermediate/sub-acute facilities in terms of rehabilitation beds for the young chronic sick, or beds for the care of the elderly etc to free up acute beds.
- It is dependent on having the proper information systems in place.
- There is a requirement to support this structure to allow consultants optimise the time they have available to deal with management.

There appears to be broad acceptance that a move to a more consultant provided service would require changes to the current common contract and working practices of consultants, and increased numbers of consultants. There is a debate ongoing whether there is a requirement for either the introduction a new tier of doctor between the current registered doctor level and consultant level and or a different category of consultant with a different contract focusing on public patients, and/or focusing on addressing requirements in changed working patterns.

The Medical organisations appear opposed to both these concepts. A 'fulltime' public consultant contract would need to reflect the loss of earnings potential of being restricted in terms of private practice.

In conclusion, there are significant organisational issues in relation to the consultants and their interactions with the health systems. In our view the current contract does not serve the system well and it needs to be re-addressed particularly in terms of; managing consultant time input; addressing issues in relation to public/private mix and its specificity with respect to CIM and clinical governance.

Hospital Accreditation, Clinicians in Management and Clinical Audit are not going to radically reform the health system overnight, but they are important processes which need to be seen in the context of striving to improve health service delivery. They need to be planned for in terms of resourcing, training, change management and negotiating contracts. However, the time-scale for seeing real benefits as a result of their implementation is a medium term one, and on their own they should not be seen as an answer to the problems in the Health Care system. The task facing the Irish health system is complex and there are no short-term solutions. Changing culture, the provision of additional infrastructure and the provision of an integrated manpower planning system to ensure that the skills needs are being met, will not happen overnight. The delivery of necessary reform cannot be achieved within the time-scale of one government, hence the criticality of developing a widely accepted set of principles for the health system based on needs assessment.

6.2 HUMAN RESOURCES (HR)

There are HR issues to be dealt with in each element of the health system. There is a requirement for the Department of Health & Children to provide a context and framework through which issues at Board and other service provider levels can be dealt with. At present there is no national HR strategy in Health, and this is badly needed. A strategic approach to human resource management at all levels of the system is required. There is much work to be completed by the Department in this area. A Major investment in HR and Training is required throughout the system. Broadly the HR issues fit within the following categories:

- Role of HR
- Recruitment & Retention
- Skills usage/skills shortage

- Grade Structure
- Performance Measurement
- Structural Pay Cost Issues (legislation)
- Manpower Planning
- Industrial Relations

6.2.1 Role of HR

The role of HR is not well developed within the health system and consequently not well understood by those working within the system. HR is a critical organisational support function in all organisations. In organisations as complex as health service delivery organisations with their diversity of specialities and with the inherent split between clinical and non-clinical staff, the role of HR becomes even more significant.

The distinction needs to be made between personnel and HR functions. At a very general level the Personnel function relates primarily to the more administrative aspects associated with personnel, for example maintaining personnel records and staff establishments, providing payroll data and statistical information etc, and recruitment. The HR function on the other hand, is concerned with developing the human resources of an organisation and providing the policies and processes for managing the relationships with and measuring the performance of these resources. The HR function in the health services has been under resourced and under developed in the past.

The role of The Department of Health & Children in this regard is to provide a policy framework for the Employing Authorities.

There are major change management issues entailed in the above for both the people currently employed in these functions, and all the employees of the health system. There is a requirement to understand the skills and competencies required to achieve individual or team objectives. In terms of performance measurement there is a requirement to understand what are the performance indicators against which outcomes will be measured. This will entail consultation at all levels, detailed planning, the development of training and support programmes, and training and development.

A step change is required to support and develop line managers to take on the role of managing their resources and managing the local industrial relations. Traditionally this activity has been avoided by line managers, resulting in it being dealt with by personnel/HR managers.

6.2.2 Recruitment & Retention

As highlighted earlier c.20% of the approved positions within the Department are not filled and based on the 2001 Health Board service plans some Health Boards have up to a 1,000 positions to fill in each of their areas. Whilst the Health Boards have significant experience of large scale recruitment, and the associated time that it takes, the level of vacancies poses enormous difficulties on the health service in terms of carrying out its statutory role. This is also compounded by the withdrawal of the Local Appointments Commission from certain types of recruitment. This will necessitate further investment in resources at Health Board/hospital level to manage the recruitment process. The Department policy in terms of appointing staff, known as Circular 10/71, dates back to 1971 and is seen as being in need of revision to facilitate Employing Authorities in the current environment.

The numbers of vacancies are not directly related to new service developments, which ultimately causes difficulties for the staff currently in the system. The planning of recruitment to fill positions that are becoming vacant is poor. The majority of HR managers in the system have spoken to us of the increased levels of stress and burnout amongst staff members staff morale is also an issue from working in a pressurised environment suffering from a lack of resources.

Clinical roles, which have experienced increasing difficulties in terms of recruitment are nursing and paramedical services. Much work is currently being carried out to recruit these skill sets from overseas. Likewise there is recognition by the Department, (as evidenced by the Report of the Commission on Nursing and the Medical Manpower Report) of the real challenges that have to addressed in terms of providing a satisfactory working environment and training and career structures for clinicians. In addition the career structure for NCHDs is such that many seek further training and employment abroad, where they can avail of better research and post-graduate facilities.

The retention of women in the medical workforce is also problematic. C.60% of new entrants to medicine are female. Keeping women in the workforce and providing equity in terms of career advancement requires the introduction of more flexible training, career and employment structures.

On the non-clinical side the recruitment and retention of professional staff in areas such as IT, Finance, and HR is a major issue. The 'common recruitment pool' is seen as a major constraint in attracting the appropriate people to specific jobs. The current grading structure and operation of the common pool ignores the specific skill sets required of particular positions. The manner of appointments by the Local Appointments Commission in the past was not best suited to ensuring appropriate appointments were made, particularly as management had limited, if any, input into the decision (we understand this is likely to change – particularly in enforcing governance and accountability in Boards, management must have an appropriate input into appointments made).

The system by its nature does not provide particular "professional" skill sets in the areas of Finance, IT, Purchasing, and HR. This has a fundamental impact on the system in terms of sustaining an administration rather than a management culture within the system. It results in prohibiting easy access of new talent into management roles within the service, and leads to the phenomenon of people "growing up" within the system, which promotes a culture of "the old way of doing things is best". Given the importance of the health service and the significant scale of the organisations within the service, we have a view that in today's economy, remuneration levels do not attract the quality of people required for particular roles.

The structuring of remuneration also needs consideration, at present there is no real performance measurement of individuals within the system, which could support the incentivisation of individuals through performance related pay.

Throughout our consultation process, strong views have been expressed that the national pay deals have not provided for delivering VFM, that there has been too little focus on resolving particular working practice/productivity issues.

Furthermore, the impact of National Agreements on local implementation issues is not assessed during the negotiations at National level. These negotiations are carried out by the Health Services Employers Agency (HSEA). Whilst it may be fair to conclude that National Agreements by their nature could not afford to be involved in the specificity of each local issue, there appear to be limited alternative opportunities to deal with such issues.

Role of the HSEA

The HSEA is a representative body for health service employers. It is a statutory agency focused on promoting and supporting VFM in terms of employment practice. Given the need for all employers to focus on the pay costs in the system, the role of the HSEA will become increasingly significant. Employers will look to this agency for leadership in terms of tackling IR and change management issues. There are major issues from an employer / employee perspective discussed above and in the ensuing sections which will impact on employment practice, where employers on the ground will require significant levels of additional support. We would suggest that the HSEA needs to be properly resourced to allow it to be more proactive in terms of promoting and supporting VFM in employment practice at all levels in the system.

6.2.3 Skills usage/skills Shortage

We have discussed earlier the particular skill shortages within the Department, and at management levels within the Health Boards. There are more fundamental issues in terms of skills usage:

- A large proportion of work carried out by nurses is not appropriate to nurses. Nursing as a profession is promoting both a significant upskilling of and recognition of the skilled role of nursing, whilst at the same time, there seems to be a reluctance to relinquish some of the non-skilled tasks carried out by nurses.
- The Report of the Commission on Nursing discusses defining the new roles of Clinical Nurse Specialist and Advanced Nurse Practitioners, and discusses a number of guidelines for such roles which are relevant to any definition of the roles of doctors.
- 'Clinicians in Management' as a model does not just apply to the medical profession – it equally applies to the nursing and paramedical groups.
- According to a recent PA report there is a significant proportion of work carried out by NCHDs, which is not appropriate to NCHDs.
- The role of Public Health Nurses needs further consideration. There are suggestions that there is a skills mismatch between the skills of the highly trained public health nurse and the nature of work carried out in terms of delivering home care. Consideration should be given to making the public health nurse the nursing manager for a district rather than being hands on practitioners.

Given that there are difficulties in recruiting and retaining nurses, it seems appropriate that the role of nurse is much more clearly defined to avoid inappropriate unskilled tasks, thus allowing nurses to spend their time more effectively, which could have a consequent impact on the numbers required.

There is a requirement to clearly define and agree amongst the various stakeholders the roles and responsibilities of the various professions, and to determine the resource requirements associated with both de-skilling and up-skilling various roles.

6.2.4 Grade Structure

There are issues relating to the multiplicity of grades within the system, and also the level at which particular positions are graded. This is particularly evident when considering the senior management positions at Health Board or hospital level. The current grading structure as indicated above limits the attraction of new, skilled professional management resources into the system.

6.2.5 Structural Pay Cost Issues

There are a number of structural issues working their way through the system, which will lead to additional pay costs. The two main issues relate to the working time directive, and minimum wage legislation. The former will have the most impact on clinical staff, although its introduction for NCHDs is on a phased basis. The latter is more likely to impact on the cost of providing services in the area of community care.

NCHDs were excluded from the provisions of the original working time directive (91/104/EC). However as part of an agreement reached by member states in 2000, NCHDs will transition to a 48 hour working week by 2010. At present NCHDs work an average of 75 hours a week. Transitioning to 48 hours a week will be a difficult task given the limited availability of NCHDs in the system and the limited availability of promotional posts for them. In any event the employment of more junior doctors without a fundamental restructuring of hospital medical staffing is not considered a solution. The impact of this directive could be more significant in terms of:

- The requirement for additional consultant positions working appropriate shift patterns to support a consultant delivered service. This will entail significant changes in work practices for consultants requiring fundamental changes to the consultant contract as discussed earlier.
- The potential requirement to re-define the roles of hospitals or reconfigure service delivery. In addition hospitals will have to consider the volume of service to be provided over an extended hospital day and the requirements for emergency services staffed by consultants with the necessary support in attendance in such a fashion that does not reduce the level of care provided to patients.

The upward cost implications of the above are such that it is critical that there are appropriate structures, resources and systems in place to manage and minimise the cost impact.

6.2.6 Performance Measurement

At a system level, there are signs of system performance monitoring and evaluation being introduced. All service plans now set out the performance measures that will be assessed. However, despite the civil service SMI process, there has been limited success in introducing performance measurement at an individual level within the civil service. Even at the simplest level of monitoring absenteeism, there is insufficient information on a timely basis to support managing absenteeism.

Performance measurement is a critical part of delivering a quality VFM health service. Major changes are required to instil a performance management based culture within the health service. This is an issue not just within the health service but, within the whole public sector. In fact initiatives taken by The Department of Health & Children in terms of accruals accounting, service planning and the development of performance indicators within the health service would suggest that they have advanced further than other government departments.

6.2.7 Manpower Planning

The level of staff shortages in the health system is of particular concern. There needs to be a fundamental assessment of particular skill requirements in the system. This assessment should stem from needs assessment being carried out as part of service planning and resource allocation. The ongoing requirements for all clinical roles including nursing and paramedical should then be determined and assessed against what the education system is geared to deliver. This will determine the true gap in terms of specialist skill requirements, which will have to be met by either attracting people from overseas or gearing the education system to deliver the

appropriate balance of skills on an ongoing basis. Formal structures and processes need to be in place to support detailed manpower planning for the health system. In this regard co-ordinated workforce planning is urgently needed across the health sector.

6.2.8 Industrial Relations

Industrial relations have proven difficult in the health service over the last number of years. There are serious issues of inflexibility within the health service that need to be resolved. The work force is highly unionised and management of industrial relations at local level can be difficult. Professional barriers and structures can also hinder the integration of services for patients.

6.3 CHALLENGES FOR VFM ARISING FROM CURRENT STRUCTURE

This section summarises the key challenges for VFM arising from the current structure. They are grouped in the following categories:

- Governance & Accountability
- Strategy & Service Planning
- Service Delivery
- Organisation Structure/Resources
- Performance Measurement

6.3.1 Governance & Accountability

The introduction of "Accountability Legislation" provides a foundation for the development of accountability and governance at service provider level. In terms of implementation it is at an early stage. It requires the Health Boards to be accountable, and requires a culture of decision-making to develop. Local politics must not be allowed to get in the way of good rational planning. At present there are too many vested local interests, which prevent change and prohibit the delivery of a VFM health service. This is also reflected in an imbalance between national and local decision-making, with the Department still involved in determining priorities, whilst local political decisions can become national political decisions.

There is also an absence of a value system at national level to provide the context around which services should be provided. The principles of access, equity and accountability whilst important are not sufficient.

6.3.2 Strategy & Service Planning

The Department has been strong in terms of development of policy. Policy development has occurred in a funding vacuum, which has lead to issues in terms of policy implementation.

At Health Board/ hospital level comprehensive strategic planning is still under development. There is a certain element of lip service, namely that 'strategic plans' plans are developed, but with little evidence of robust processes for development of, measurement of, and delivery of the strategies. The role of service planning at unit, regional and national level is under developed. The introduction of the ERHA and the establishment of its role in terms of service planning is a positive development. Outside the ERHA the structure around how planning is carried out is varied. Service planning requires a multidisciplinary team effort.

The absence of clinicians in management hinders this effort. Service planning is vital, and there is further work to be done by the Department in developing a comprehensive standardised

template for strategic/ service plans. A consequence of this is the considerable inconsistency of service plans between the Health Boards.

Thorough strategic planning is in its infancy in the health service. There is a danger of spending money without appropriate needs assessment underpinning it. There is however a requirement to introduce multi annual plans to support this process. Multi-annual plans will set out the funding that would be available to a service provider over a number of years, which would allow the service provider to plan and implement medium to long term care strategies.

In the past there has been a lack of coherence in planning arising from different time frames around service development planning and NDP planning. The NDP plan provides an opportunity to address this issue. Each of the Health Boards has put in place a new management structure to manage NDP planning and investment. One of the difficulties within the system is the lack of revenue and capital relationships. It is evident that the full revenue consequences of capital expenditure have not always been considered, resulting in capital expenditure impacting negatively on core revenue funding. Given the significant additional level of capital expenditure now available within the system it is critical that the revenue consequences of any investment are recognised, understood and most importantly funded.

6.3.3 Service Delivery

Considerable work is required to integrate services within Health Boards, particularly integration with primary care sector. The move to care groups is a positive move to help focus on service integration, though there are many barriers to be overcome yet. The concept of care groups is not fully accepted within all areas and the current structure within the Department is seen as an inhibitor to service integration. Communication within Boards is also seen as a barrier to service integration.

6.3.4 Organisation Structure / Resources

There are a number of salient points in relation to the current organisation structure and level of resources:

- The system is not organised the same way across the country.
- There are variations in the level of decentralisation/devolution of functions from Health Board to agency level.
- The competitive relationship between Health Boards serves no purpose. The establishment of HeBE should help address this issue.
- There is a lack of structure to consult the public; this needs to be differentiated from the democratic, representative nature of Boards. In addition there is a requirement to further develop the evolving customer focus of organisations, and this should impact on the organisation structures.
- The underlying emphasis, from a non-clinical perspective, within the system is one of administration and not management.
- There is an absence of structure around the management of primary care (independence of GPs).
- The Consultants' Contract is flawed in terms of managing time input, public/private mix and specificity with respect to CIM and clinical governance.
- There are significant resourcing issues in terms of recruitment and retention in conjunction with significant staff and skill shortages.

- The availability of trained management resources to support implementation of strategy. We have concerns that there are insufficient people with the ability to manage change and implement change within the system.

Organisational development is one of the most significant challenges facing Boards.

6.3.5 Performance Measurement

The health system, not unlike the rest of the public sector, does not operate within a performance culture, and whilst progress has been made in terms of the important steps that have been taken on the development of service planning and performance indicators, there is an absence of performance measurement within the system. The introduction of clinical audit is slow with significant resistance to it. It is impossible to assess the effectiveness of the Health Care system without the means to demonstrate and assess clinical outcomes.

On the non-clinical side there is a lack of comparable audit based assessment of management actions.

6.4 OPPORTUNITIES - RECOMMENDATIONS

In this section we set out a number of recommendations designed to address some of the more fundamental VFM issues above.

1. There is a requirement to carry out a detailed review of the organisation structures within the Department. This needs to be mindful of the developments in Board structures and the need to provide cross programme and care group focus in a seamless fashion.
2. The values and associated principles for Health Care need to be clearly defined. We would expect the health strategy currently being developed to provide this. The principles of equity and access are not sufficient.
3. Structures to improve the planning, implementation and monitoring and evaluation of both core service delivery and national strategies need to be established.
4. Processes for multi-annual budgeting and planning need to be approved and implemented.
5. A review should be commissioned on the role of Health Boards. The terms of reference of this review should focus on:
   - The structures and roles of Boards. Regionalisation of services should be central to this assessment. Regionalisation needs to be appropriately defined (it does not mean all regions have equivalent services). The role of the Department in providing leadership to such a regionalisation strategy needs to be emphasised.
   - An assessment of alternative organisation structures for service delivery. There are trusts in the UK, which are bigger than the entire Irish Health System.
   - An assessment of whether the establishment of a smaller number of Health Authorities like the ERHA could eliminate the need for the current level of Health Boards, and whether the multiplicity of structures under the ERHA is the most appropriate to support service delivery.
   - Mechanisms to de-politicise the implementation of Health Strategy and service delivery. If this is not achievable there need to be mechanisms in place to make Boards accountable for the non-delivery of VFM associated with local political decision-making.
   - Identifying areas for conjoint working between Boards.

6. There needs to be a fundamental assessment of what is the core level of funding required for each Health Board. This needs to be considered from a zero-base taking into account requirements resulting from a clearly defined national value system for Health Care.

7. There needs to be detailed clarification of and separation of roles at Department, Regional Authority, Health Board, and agency level. The supporting resources then need to be clearly defined and a change management plan put in place to allow appropriate devolution. This should include an assessment of whether the Department should be involved in areas such as adult homelessness etc.

8. There is a need to develop Governance and accountability training programmes for Health Board members and management.

9. Robust processes for strategic planning, service planning, manpower planning and financial management need to be put in place. Some of these will require to be managed at both regional and national level. For example formal structures and processes need to be in place to support detailed manpower planning for the health system. Co-ordinated workforce planning is urgently needed across the health sector.

10. Reviews should to be carried out to assess the most appropriate way to deliver safe, high quality hospital services across the country. The terms of reference here should focus on:

    - Development of Regional Accident & Emergency centres of excellence (1/2 per region).
    - The rationalisation of Accident & Emergency facilities across country.
    - Re-designation of hospitals for different services for example acute elective care, etc.
    - Use of hospitals as 100% elective.

11. The concept of shared services should be promoted either through HEBE, the ERHA shared services platform or an alternative which would concentrate on providing at a minimum the following services:

    - ISIT provision.
    - Financial transaction processing.
    - Purchasing and Materials Management.

12. Further develop a performance measurement culture within the health systems to encompass:

    - Individual performance appraisal.
    - Development of a prescriptive approach to VFM, with the establishment of the appropriate processes for monitoring and evaluation. This should entail setting challenging cost reduction targets on an ongoing basis.
    - Service delivery performance measurement and evaluation.
    - Internal Audit.
    - Audit of management practices.
    - Clinical audit & governance.

- Processes and systems for measurement and evaluation of health outcomes.

13. Re-negotiation of the Consultants' Contract with regard to managing of time input, public/private mix and specificity with respect to CIM and clinical governance. In particular the revised contract needs to deal with:

    - Changing working patterns.
    - Flexible rostering arrangements in support of clinical need, and outside the current 9am to 5pm Monday to Friday arrangements.
    - Continuous updating of skills to include governance and clinical audit and accreditation.

14. The implementation of some of the above recommendations requires major investment in IT. A commitment to increased investment in IT is required, and a co-ordinated approach to procurement of systems and their implementation should be jointly agreed by Boards. The practice of Boards 'going it alone' on IT investment decisions must be stopped.

15. The Health services are continuously in the media. The Department needs to take a much more proactive approach to ensuring media representation of the health system is more balanced. How the Department interacts with the media needs to be reconsidered; there is a requirement for the Department to market itself in terms of the positives that are occurring in the system.

SECTION 7: MANAGEMENT INFORMATION & PERFORMANCE MANAGEMENT IN THE HEALTH SECTOR

7.1 SECTION FRAMEWORK & OBJECTIVES

Management information and performance management are two broad-ranging areas. In this section of the report we centre our discussion on these issues in the context of measuring and managing VFM in the health care sector *i.e. in terms of economy, efficiency and effectiveness.* Our core objective is to set out a framework that will provide management with the information they require to support decision-making, control, and the measurement and evaluation of performance against target objectives and goals.

The structure of this section is as follows:

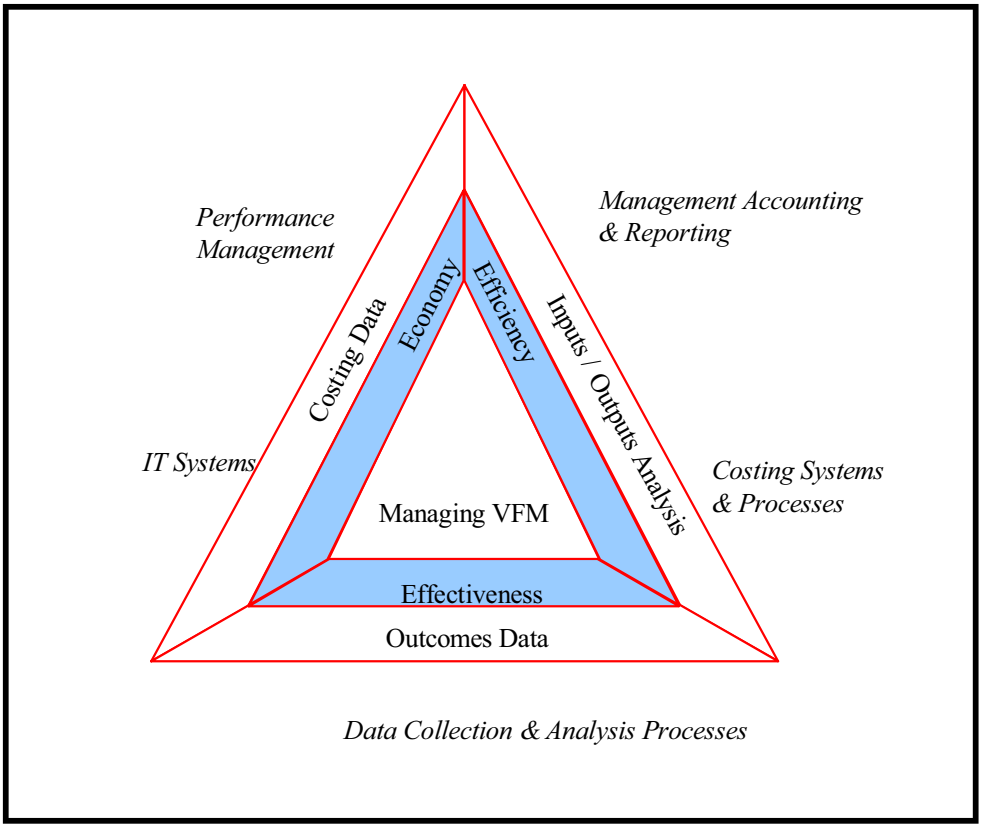
- Section 7.2 discusses the inter-relationship between VFM, management information and performance management.
- In Section 7.3 we present a high-level "As Is" overview of the state of development of management information, performance management, management accounting and reporting, and costing systems and processes in the health care sector. In doing so, we highlight key issues and recent initiatives undertaken.
- Section 7.4 outlines a future framework for defining priority information requirements and for measuring and managing key areas of performance that impact on VFM.
- Section 7.5 summarises our key conclusions and recommendations.
- Finally, Section 7.6 outlines the next steps to be taken by The Department of Health & Children to facilitate the implementation of the framework outlined.

7.2 VFM, PERFORMANCE MANAGEMENT & MANAGEMENT INFORMATION

Performance management as a generic term can be used to describe the following:

- Performance planning in terms of strategic / business planning and in particular the development of performance indicators to measure the extent by which objectives are met.
- Performance measurement / monitoring – measuring and monitoring performance against defined performance indicators.
- Performance evaluation – critically identifying the gaps that arise from performance measurement and taking corrective action to ensure that strategic objectives are achieved.

Throughout the health system, it is acknowledged that progress in managing VFM requires the establishment of consistent and comparable sets of performance indicators, and standardisation in the collection, monitoring and evaluation of data. This in turn creates the imperative for reliable, timely and relevant management information at Department, Board and agency level.



In developing core competencies in the above areas in the health sector, the following must also be sufficiently developed and resourced:

(a) Management reporting and analysis

(b) Costing systems & processes

Performance management occupies an intrinsic component of The Department of Health & Children's current strategy "Shaping a Healthier Future" and every indication suggests that greater attention and importance will be attached to this practice in the future. The CPMR document entitled "Performance Measurement in the Health Sector" states that "*Performance measurement has considerable potential in health services management in enabling national priorities for health reform to be translated into organisational and individual objectives, to provide a focus on results, and to enhance accountability*". More specifically, national policies and initiatives have clearly signalled the link between performance measurement and VFM:

- The SMI Working Group on Financial Management recently developed the Management Information Framework (i.e. Generic Model for Financial Management).

  The purpose of this framework is to provide enhanced financial management systems and practices to support the SMI process. In particular, these systems aim to provide quality management information to support value for money analysis, input/output measurement, planning, decision-making, control, etc.

- The Programme for Prosperity and Fairness (2000) links performance measurement to the strategic management approach.

- The Health (Amendment) Act 1996 in outlining the role of the service plan specifies that Health Boards must "secure the most beneficial, effective and efficient use of resources".

- The Comptroller and Auditor General (Amendment) Act 1993 provides for the review of whether and the extent to which resources were used, acquired or disposed of economically and efficiently.

- While it is accepted that there are inherent difficulties in measuring outputs and more especially outcomes in the health sector (a matter to which we refer later), it is widely acknowledged that performance management can potentially deliver improvements and benefits in managing VFM in terms of:
  - Planning – it supports the strategic management cycle.
  - Resource allocation – it provides a mechanism for reporting on performance thus enabling better management of resources.
  - Accountability – if used properly it facilitates devolved management and accountability, clarifying the outputs and outcomes that are achieved for the resources used.
  - Problem identification – problems, poor performance, etc., can be identified and corrective action taken when required.
  - Risk management – it can contribute to the better management and service delivery to customers.

The three key questions that we will address throughout the remainder of this section are:

(a) What needs to be measured and managed in the health sector in terms of economy, efficiency and effectiveness?

(b) What information is required to support this?

(c) What facilitates (a) and (b)?

7.3 CURRENT OVERVIEW

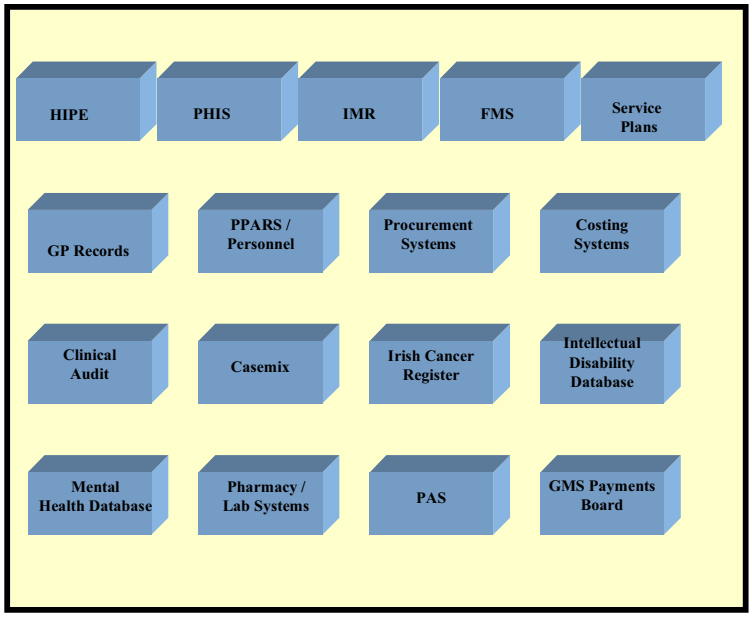
In this section, we provide an "as is" overview of the current state of development of MIS and performance management in the health sector. We consider the extent to which management accounting and costing systems and processes are in evidence in the sector. Once again, it is important to highlight that this assessment is focused on the key elements that link into and impact on VFM. It is not intended as a comprehensive review of MIS systems and strategies.

7.3.1 Management Information – An Overview

Data Systems

The primary suite of systems and sources of data that inform performance management and VFM in the Irish health care system are as listed below (this is not intended as a comprehensive list). A summary of the main characteristics of each of the principal systems operated by The Department of Health & Children for strategic planning purposes and as part of its role in monitoring and evaluation follows.

-Figure 7.1: Principal Data Sources for VFM In Irish Healthcare Sector



(a) Hospital Inpatient Enquiry System (HIPE)

In simple terms HIPE is the coding of activity to World Health Organisation standards for epidemiological (and management) purposes. Its focus is the acute hospital sector and it allows for inter-hospital, inter-Board and international comparisons of acute hospital activity. The current HIPE system only captures data from publicly funded acute hospitals and two private hospitals although other private hospitals are expected to follow.

Opportunities have been identified to achieve full coverage of the acute sector including the deployment of an anonymous HIPE database for the private sector and the substitution of HIPE for a less detailed system for private hospitals such as a health insurance risk utilisation scheme.

The HIPE system operates thus: data is inputted into the system at hospital level and is accumulated and subsequently transferred to the ESRI on a monthly basis. There are concerns that all data is not inputted on a timely basis and as such the system is not a true reflection of hospital activity. In turn, there is a six-month time lag in the reporting of data. There are other issues surrounding data quality in terms of who completes the coding i.e. practitioners or qualified coders, as well as issues associated with trapping case complexities. Accordingly, questions arise as to whether the system should be case based or patient based.

Internally within The Department of Health & Children, HIPE data in used in finance, planning, secondary care, the CMO's office and to address parliamentary questions. As such, it has links into Casemix, IMRs and costing systems. Our assessment is that while the HIPE system is advanced and provides a rich source of data, it is greatly under-utilised and is not integrated to the way the Department currently carries out its functions. Owing to the issues over data input and reporting, HIPE as it currently stands needs to be developed to be reliably used for accreditation and performance assessment.

(b) Casemix

The Casemix Measurement System was introduced by The Department of Health & Children in 1993 and is, in essence, a system to measure the relative cost efficiency of certain acute hospitals in the Irish system. Since the time of its establishment, the Casemix programme has been progressively enhanced to include an increased number of hospitals in the system and to extend coverage to a broader range of specialities in the hospitals concerned.

At present, the Casemix Programme covers some 32 hospitals, split into two groups. Group 1 covers the major acute hospitals in the system, namely Beaumont, Cork University, James Connolly, The Mater, St. James's, St. Vincent's, Tallaght and UCHG. These hospitals carry out a wide range of specialities, and have a higher Casemix intensity than other hospitals in the system.

The Casemix system brings together the discrete streams of activity and costs to arrive at a Casemix adjusted hospital base price per case. The activity data is captured through the HIPE system. Cost data is captured through the financial systems at hospital level, which is then subject to an allocation process to arrive at a cost per specialty in each hospital. A system of weighting cases (the Maryland Weighting System) is applied to determine the relative complexity of cases, which in turn is used to determine the appropriate utilisation of resources per case.

Once the Casemix adjusted hospital base price is determined for a particular hospital it is compared with the average for the Group of which it forms a part. To the extent that a particular hospital's Casemix adjusted hospital base price is less than the average of its group, it is rewarded for its efficient performance through an adjustment to its determination two years after the base year reviewed for casemix purposes i.e. the casemix adjustments for 1999 form part of the 2001 determination.

At present, the adjustment is made at the rate of 15% of the relative efficiency of the hospitals concerned (a 13% blend for activity and costs and 2% for workload adjustment to distribute historic costs on an output rather than an historic basis). A further adjustment is made for day cases at the rate of 5% of the relative efficiency involved. In overall terms, the casemix scheme operates on a budget neutral basis and serves to re-allocate funds to more efficient hospitals in the system from those least efficient.

The current Casemix system in operation in Ireland has to be seen as still in its development phase. In the years ahead, the system needs to build on the lessons learned and extend its coverage, which will include consideration of the following:

- Extending its operation into a wider number of hospitals in the system, including those providing maternity and geriatric care. A programme to include the three large Dublin maternity hospitals is underway.
- Extending the Casemix system to include costs of Accident & Emergency, and the refinement of day cases included in the Programme. One stand alone paediatric hospital (the National Children's Hospital in Tallaght) is included in casemix.
- Reviewing the Maryland Weighting System in line with international experience. We note that this is planned as part of the Casemix work programme for 2001.
- Developing more sophisticated costing systems at hospital level to reduce the level of arbitrary allocation in the specialty costing process.
- Ensuring the accuracy of coding practice in the system including consistent coding between hospitals. The appointment of HIPE Casemix co-ordinators in a number of hospitals in recent years is a significant advance in achieving these objectives.
- Promoting an acceptance by hospitals of the need for greater co-operation in the operation of the Casemix scheme. To date, particularly in the context of a resource constrained environment in the Irish health care sector, the Casemix programme has promoted a level of divisiveness amongst Boards.
- Ongoing and extensive audit of specialty costing and coding procedures at hospital level to ensure hospitals are in compliance with procedures and to promote maximum inter-hospital comparison going forward.

- Inclusion of an increased number of private hospitals, where possible, in the HIPE system to increase coverage across the whole of the Irish acute hospital system.
- Increasing the resources in The Department of Health & Children to develop and manage the Casemix system. Casemix measurement is potentially a very valuable tool, but must be robust if it is to be reliable and accepted by those applying it in the system. We understand that a comprehensive review of the Casemix model has commenced.

Careful consideration also needs to be given to the basis on which newly established hospitals are introduced into the Casemix scheme. Great care is needed to ensure that the Casemix system does not militate against providing high quality patient care in a modern environment, (which is clearly intended in any newly established hospital) but which may, because of the quality of the facility, equipment, etc. carry a higher inherent cost of service provision than some of the older facilities in the system. The balance to be struck is between absolute cost efficiency and quality of patient care.

The experience of AMINCH and Ardkeen, both new acute facilities, on their introduction into the Casemix programme was to reduce their allocations by virtue of relative cost inefficiency. It is essential that the Casemix programme, in promoting cost efficiency, does not make inappropriate comparisons between the cost base of modern new facilities with the older generation of facilities, particularly when the latter have come through a highly resource constrained environment in the past. None of this is to say that new hospitals should not be subject to cost efficiency measures; care, however, is required to ensure that the Casemix system does not militate against the quality of patient care.

(c) Integrated Management Returns (IMRs)

IMRs deliver financial, personnel and activity data from the Health Boards and acute hospital sector to The Department of Health & Children. Their key function is to provide the Department with a monthly flow of relevant data from the Health Boards to facilitate the monitoring of the Health Boards' budgets against the service plan. One of the most recognised value components of the IMRs is the written commentary provided by the CEOs of the Health Boards.

Presently, completed IMR forms are delivered in manual format to the Finance Unit of The Department of Health & Children. They are then copied by the unit and distributed to all other relevant internal units who have an interest in the data or commentary provided. Whether the current manual interface between the Health Boards and the Department is efficient needs to be further explored. In our view, IMR returns in electronic format would be more appropriate in the future.

There are a number of issues with the data provided through the IMRs. Firstly, the Department is not empowered to ensure that complete data is submitted in a timely manner. Secondly, different data definitions and standards are applied by Health Boards, particularly in relation to personnel data. Finally, there may be mismatches between reported expenditure and budget allocations that are not in fact real variances owing for example to factors such as the phasing in of pay awards.

(d) Public Health Information System (PHIS)

The principal function of PHIS is to report on the health status of the population on an annual basis. While the system is owned by The Department of Health & Children, its output is also used at Health Board and agency level. The key areas that it reports on are population mortality, fertility and morbidity. It has links into HIPE, the National Cancer Register and the CSO.

The system is recognised as still being at a relatively early stage of development but is unquestionably a significant step forward by the health sector in trying to measure the health status of the population. In moving forward, there are a number of key questions and issues that ought to be addressed to improve usage and benefit. These include the current time-lag in the reporting of data (up to two years), the extent to which the information contained in the database is sufficiently comprehensive (should such data as screening data, data on disabilities, drug prescribing patterns and mental health be included?) and the exclusion of the measurement of health gain.

(e) Service Plans

The Health (Amendment) Act 1996 sets out the requirement for Health Boards to submit a service plan to The Department of Health & Children on an annual basis as part of the process of implementing the principles of the Strategic Management Initiative (SMI) in Health Boards. The key components of the plan include a description of the services to be provided for the forthcoming year together with associated projections of income and expenditure. It is a requirement for Health Boards to plan their activities within the amount allocated to them in the Department's Letter of Determination. A Board which exceeds its Determination in any year is required to carry forward the excess as a first charge against the following year's Determination.

The overall functions of the service plan are generally recognised as followed:

- It is a means of improving the strategic planning process by providing a mechanism to assess the extent to which stated objectives are being met.
- It is a management tool that links national strategies and policies to regional programmes and investment.
- It provides for the improved control of expenditure against budgets at Health Board level.
- It is a mechanism that allows The Department of Health & Children devolve responsibility and accountability for operational issues to the Health Boards.

Throughout the consultation process it was widely accepted that the full benefits of the service planning process have not yet being achieved.

- Firstly, it would appear that the service planning process is more developed in some Health Boards than others.
- Secondly, a coherent approach to service planning has not been adopted across all Health Boards and there is inconsistency as to the level of detail provided and the balance struck between retrospective performance review and future programmes. In particular, there appear to be differences of opinion as to where the service plan sits in the overall planning process. Currently service plans are regarded as a one-year projection of funding and activity and do not form part of any multi-annual planning process, a process which is lacking in any integrated fashion in the Irish health system.
- It is also acknowledged that the monitoring of performance against the service plan needs to be more explicitly developed, both at Health Board and Department level particularly in the monitoring of non-financial areas.
- Finally, while Health Boards are requested as part of the Letter of Determination to define performance indicators, this has not been universally adhered to. Health Boards argue that they do not have the data to measure performance, nor are they clear on what should be measured. There is a clear need for a comprehensive set of performance indicators for the Irish health system, and that these are consistently applied and measured.

Service planning is still at a relatively early stage of development and as highlighted above there are a number of key areas that can be addressed as part of the process of managing performance and VFM. Despite the scope for improvement, we consider service planning to have been a major advancement in the Irish health system, linked as it is to a statutory accountability. The service plan has a potentially pivotal role to play in the future in ensuring that health services are planned, in enhancing accountability, in terms of managing VFM and also in establishing the principles of SMI in the health sector.

System / Data Gaps and Issues

The following is a *general list* of the key issues that were raised with respect to the management and organisation of information and systems in the health sector. All of these impact on the management and delivery of health services and as such directly or indirectly link into the management of VFM in the health sector.

- There has been a significant lack of investment in management information systems. The annual investment in IT for the entire health sector increased from £4m per annum in 1990 to £8m by 1997, in our view, a completely inadequate level of investment to provide for the system / information requirements of the sector. In 1998 and 1999, the investment in IT did increase to £14m and £20m respectively, and further increases are planned as part of the NDP. The legacy of this lack of investment in IT is an inadequate infrastructure to support information requirements, performance management and VFM.

- There is a clear need for the development of a co-ordinated approach to the selection and implementation of management information systems across the health sector. Information systems and the data collected through those systems is highly fragmented and not standardised. Consequently, the analysis and evaluation of data is also fragmented. This militates against benchmarking and the comparability of data and also against the sharing of information between various stakeholders and agencies. This deficiency is also representative of the general need for improved co-ordination between the various stakeholders in the health system.

- The lack of electronic records at GP level is a major impediment in achieving integration between primary and secondary care and in measuring, monitoring and controlling VFM. We are aware that grants have been made available to GPs to purchase computer systems. There are concerns however that GPs may not be obtaining the benefit of this investment in IT. An assessment is required of the effectiveness of the investment to date, including the requirement for GPs to receive training in the use of the systems and the establishment of standardised systems and procedures on a national / regional basis.

- Responsibility for the collection, analysis and interpretation of data is spread across several areas of responsibility (i.e. Finance, IT, Public Health, etc.,). A more centralised and co-ordinated approach to information management, at both regional and national levels is required.

- For effective decision-making and performance measurement, information should be as accurate, timely and as comprehensive as possible. It is perceived that there is generally too long a time-lag between when data is collected and produced. Secondly, the accuracy of data is also questioned. For example, specific concerns were raised about the accuracy of waiting list data and when patients are eligible to be included on lists. In some respects, the issue is not so much a lack of data, rather that the data available is not subject to meaningful use.

- There is also evidence of system capabilities being under-utilised or indeed inadequately understood in the sector. There is a lack of a clear definition of data requirements to support strategic priorities. This could also be a function of the general lack of commitment to use information to inform policy and strategy in health care.

- We have concerns that there is a lack of appropriate skills at all levels to analyse and interpret data. Certainly the lack of sufficient numbers of qualified finance personnel and analysts in the health system militates against the effective use of data and the development of systems to use data to inform the decision-making process. Questions arise as to whether adequate training has been provided to staff in the system.

- There is a concern that systems are being implemented in the absence of clear strategy, objectives and business case. Furthermore, systems development and implementation does not always involve service managers (i.e. end users) and implications for existing processes and procedures are not necessarily fully considered.

- Following from the above, there is a concern that funding is approved on specific IT projects rather than funding overall IT strategies. The funding model for IT development needs to be reviewed and considered, to ensure funding is provided for an overall coherent and co-ordinated IT strategy for the development of management information.

- The Conference Report on the National Health Information Strategy identified the following data gaps in current health information systems:

  – Health inequalities
  – Morbidity
  – Health status of the population
  – Primary care
  – Health services research database

  In addition to those listed above, we identified a general lack of data and systems at community level. This is particularly important if one considers the focus of key policies, for example for the elderly and the intellectually disabled, where a concentrated effort is now being made to keep people in a community setting as opposed to institutions. Other system gaps identified arise in:

  – Asset management / utilisation
  – Vaccinations / childcare health
  – Strategy related systems
  – Screening
  – Theatre management

Current Initiatives

It is important to point out that a number of positive initiatives have and are in the process of being developed and implemented, to improve the availability and quality of data in the health system. Over the last ten years we have seen the establishment of the National Intellectual Disability Database and the National Cancer Register among others. Details of the more recent significant development are described in the sections that follow.

(a) The National Health Information Strategy

Probably the most significant development in recent times has been the development of the National Health Information Strategy (NHIS).

The strategy gives recognition to the fact that accurate, timely and relevant information are critical elements for assessing population health, guiding service planning, measuring effectiveness and informing health policy. In order to move the process forward a National Health Information Strategy Steering Committee was established the functions of which are set out below. It is anticipated that the strategy will be fully developed by Autumn 2001.

The main issues being considered in the NHIS strategy are:

(i) To review current arrangements for the collection, reporting and use of health information for health service management and population health.

(ii) To examine the approaches adopted by other countries in the provision of an integrated health information system.

(iii) To review some of the issues identified above including data quality, data definitions, data integration and data timeliness.

(iv) To identify data gaps in addition to assessing the requirement for the development and use of performance indicators and outcome measures for monitoring and evaluating health and the effectiveness of health services.

(v) To examine the issues surrounding data access including protocols for confidentiality and the distribution of data to third parties.

(vi) To investigate ICT solutions for the improved storage, updating, collection, analysis, dissemination and standardisation of health and health-related data in order to optimise data integration, management and delivery.

(vii) To define the resource (human and technical) requirements to develop and implement a national integrated health information model.

A critical issue that must be tackled by the Steering Committee in the immediate future is the perception that the NHIS is focused on public health promotion / "e-health" promotion. This view has evolved primarily because the genesis for the concept originated through the Department and the Public Health Department of the Royal College of Physicians. The scope of the strategy is in fact much broader and includes knowledge management, telemedicine, information for policy makers, managers and the public. The consultation process to date on the NHIS shows the increasing recognition of the role of management information/systems in the delivery of efficient and effective health systems. Central to the successful implementation of the strategy will be a required change in the way that information is currently developed and used in the health system.

(b) Unique Patient Identifier

One of the areas to which the NHIS will be giving consideration is the Unique Patient Identifier (UPI). While the potential value of such a system was widely acknowledged at the National Health Information Conference held in November 2000, particularly in terms of the provision of an integrated and seamless health service, the potential negative aspects were also highlighted:

- The significant amount of resources required to implement the initiative at a national level.
- The inadequacies of the current IT infrastructure.
- The general lack of staff training on information systems.
- The measures that will be required to ensure confidentiality are maintained.

In addition to the above, there is the fundamental practical problem of ensuring that all individuals are assigned an RSI number. For people who are members of the travelling community and those in the poorer strands of society this does not automatically occur with the present system i.e. an RSI number is allocated at birth registration and not when a birth takes place. It is anticipated that the National Drugs Payment Scheme will provide an additional mechanism to capture a more comprehensive set of patient data.

We understand that the General Medical Services (GMS) Payments Board is currently in discussions with the Department of Social Welfare on issues concerning the development of a UPI system for Ireland i.e. based on the adoption of the PPSN as the GMS client identifier for their schemes. If this approach is used in the wider context, one of the biggest issues is data protection and legislation. There is strong resistance to the development of the scheme from the Data Protection Commissioner in Ireland and in addition, a recent EU Directive could potentially curtail the key benefits that could be achieved by the system. The Directive essentially prevents the collection of data for one purpose to be used for any other purpose. However, these potential constraints could be overcome by the Data Collection Commissioner clearly defining what constitutes public service use.

(c) CHIPS

The Information Management Unit within The Department of Health & Children is currently working on the development of CHIPS – Casemix, HIPE, IMRs and the population system. The objective of the system is to bring together all the various sources of data for the acute hospital system into a single windows-based computer application to allow at least 80% of all routine data requirements and enquiries to be addressed. A secondary objective is to facilitate an integrated view of acute hospital activity using a range of indicators. Among the key benefits that the systems are expected to accrue are:

- Access to all relevant acute hospital indicators in a single application.
- The provision of an essential tool in the implementation of service planning.
- Speed of access, report production, mapping and graphics.
- Automated updating of files.
- Rapid production of hospital profiles across all areas of hospital activity.
- Efficiency in responding to queries.
- Effective monitoring of trends and performance indicators.
- The routine provision of executive summary accounts.
- Data / sides for speeches and presentations.
- Systems or sub-sets of the system that can be made available both in-house and via the web.

(d) Other Initiatives

It is also worth mentioning a number of other initiatives that are ongoing which are likely to inform future MIS strategies and policies.

- The e-Government Initiative: The objective of this initiative is to establish closer links between government and the public as well as between government agencies and departments.

- The REACH initiative, a public sector initiative within the framework of SMI/Delivering Better Government, which is aimed at improving the efficiency and effectiveness of services to the public. It promotes the use of the Personal Public Services Number and the introduction of a Public Services Card.
- Health e-Procurement: This forms part of a wider government initiative to try and establish more cost effective and efficient purchasing processes throughout the public sector. It remains at an early stage of development in the health sector where it is hoped that a pilot project will be implemented this year, which will be used to prove the strategy developed.
- A national Virtual Private Network for voice and data is being developed across the public sector. This is an important element of the overall IT infrastructure which will enable and support data collection and sharing.

7.3.2 Performance Management – An Overview

Performance management is at a comparatively early stage of development in the Irish health care system. Within the current health system, performance planning is probably perceived to be the most advanced (except perhaps at community care level) through the strategic and operational planning processes. The fundamental weaknesses in the system are largely attributed to the lack of performance measurement and performance evaluation. However, as identified below there are still a number of important issues to be resolved around performance planning particularly in terms of the dominance of financial and activity measures vis-à-vis output and outcome measures. Our review of initiatives completed to date also indicates that while there is certainly a growing acceptance of the need to undertake performance management and indeed many organisations have attempted to do so, there is no clear framework or vision in place that is driving this process forward.

It is fair to acknowledge that good progress has been made by a group chaired by the CEO of the North Western Health Board in defining, for the first time, a set of performance indicators for the health system.

Key Issues

Among the specific issues identified were:

- Standardisation of data and data definitions is required at national, regional and local levels.
- Health care is essentially a service to the public. However, because it is a service there are difficulties associated with defining what exactly is produced and to what quality. Debate in the system centres around whether outputs or outcomes should be measured and to what extent they can accurately be assessed. In particular, the quality and efficiency of a service are also impacted by factors outside of the control of the health system. These include the policies and strategies of other organisations as well as individual decisions and behaviours.
- A review of the different performance indicator sets produced across the health system to date has highlighted:
  - Health Boards have not focused on developing the same framework for the implementation of services against national policies and strategies. This has serious implications in terms of the generation of comparable data.

- There has until recently been a lack of co-ordination in producing and monitoring performance indicators between regions and even within Health Board regions. More recently, some good work has been done on developing a suite of performance indicators for the Boards. Ideally, 50 to 70 indicators are needed to focus on measurement in the sector.
- There have been marked differences in the level of advancement and sophistication in developing and monitoring performance indicators across regions and sectors. For example, the focus of development to date has very much centred around the acute sector whereas performance management in the community has not been adequately addressed.
- There is a lack of emphasis on systems and data to monitor and evaluate performance indicators.
- Considerable attention has been afforded to financial and activity measures; similar attention must be given to patient focused measures. Overall a more balanced approach is required.
- The measurement of performance has tended to focus on managing compliance with budgetary processes as opposed to the achievement of targeted strategic objectives.
- Performance management at an individual and organisational level tends to be largely underdeveloped.
- There appears to be some confusion as to the requirement for, and use of consistent performance indicators. This is reflected in the lack of correlation between different sets of performance indicators in consecutive service plans of Health Boards, for example. Nor is it always clear how indicators integrate into key policy measures.
- The degree to which performance indicators are achieved is not always explicitly reported in consecutive service plans / annual reports of Health Boards.

- Previous research highlighted the concerns of Health Boards with regard to the Department's role in monitoring and evaluating service plans. The view was expressed that the Department's focus is primarily on meeting budgetary constraints. It was felt that greater emphasis was required on the monitoring of the effectiveness and appropriateness of the services delivered and the quality of those services. However, questions must also be asked regarding the extent to which Health Boards are delivering on service plans and meeting service targets in the absence of a coherent set of balanced indicators.

- Concerns about the Department's performance measures included as part of its Letter of Determination were also raised. In particular, issues were raised surrounding the availability of information to measure a number of the indicators, data definitions and the relevance of certain indicators.

- Managerial capability and capacity to manage performance does not appear to have been sufficiently addressed. In particular, a structured approach to defining key resource and training requirements needs to be undertaken. Equally important, a cultural change in the way organisations and individuals view performance management needs to be initiated. The rewards and benefits of the process need to be fully understood and appreciated and more especially any fears and misunderstandings about the objectives of performance management should be eliminated.

- Effective performance management requires that the appropriate reporting structures and processes are in place at all levels throughout the system. The CPMR discussion paper on performance measurement in the health sector found that "…structures are developed most at Department / Health Board level. Currently, performance management does not explicitly extend to the individual level and, outside the acute hospitals area, reporting structures are not so well developed. The community area is probably the area where most work is required …". In general greater clarity is required in the definition of roles and performance expectations. Our own discussions highlighted that even within the acute sector no significant progress has been made in implementing clinical audit or clinical governance.

- Building on the previous point, the systems to measure individual performance are by and large not in place. In particular, it was brought to our attention that a lack of data exists on staff productivity, rates of absenteeism, etc. The full implementation of PPARS could go some way to improving information for management purposes on these issues.

- Generally, management reporting within the health care system is under-developed and primarily focuses on statutory reporting and financial accounting requirements. There is little reporting of financial performance by activity, for example, by service group or care group. This results in a lack of meaningful management information to report and evaluate financial performance by key areas of activity.

- Following from the previous point, activity based costing is underdeveloped throughout the Irish health care system. Specialty costing has been developed in the acute sector to facilitate Casemix measurement in 32 acute hospitals (as outlined above) and requires financial data to be reported and analysed by specialty across ten main cost centres (theatre, nursing, laboratory, etc.). The process requires careful review and audit to ensure costs have been correctly attributed to specialties. With regard to costing of community care activities, there are significant gaps in relevant management information and costing systems in this area are virtually non-existent.

What Has Been Achieved?

- The various information systems such as HIPE and PHIS have been set up to monitor and evaluate progress against objectives. Systems have also been established at programme / service level such as the National Cancer Register and the Intellectual Disability Database.

- An initial set of joint performance indicators has been agreed between the Joint Department / Health Board Service Planning Group as part of the service planning process for the Health Boards. 2000 was the first year that specific performance indicators were developed and it is recognised that much more work needs to be done in the future.

- A number of sites in Dublin, Cork and Galway have piloted the National Teaching Hospitals Accreditation Programme. The Programme, which has been adopted from the Canadian model, aims to improve the quality of care provided to patients through systems of clinical audit.

- As outlined, the Casemix Measurement System was introduced in 1993 by The Department of Health & Children. With regard to the ongoing measurement of value for money, the Casemix programme provides some relevant management information enabling the measurement of the relative cost efficiency of acute hospitals participating in the programme. The principle behind the Casemix programme is undoubtedly right, namely, that more efficient hospitals in the system should be rewarded at the expense of the least efficient, thus rewarding superior performance and emphasising cost efficiency.

However, the Casemix programme is only one element of the measurement process. In this regard, it is important that Casemix performance is not viewed in isolation (i.e. it is also important to measure the outcomes of patient care, such as quality, etc., to enable a full view of effectiveness and value for money).

- A comprehensive document on "Performance Measurement in the Health Sector" was produced by the Committee for Public Management Research in 2000. The document addresses the use of performance indicators in the Irish Health System and reviews key elements from other international systems. It also outlines a proposed framework for the sector.

- The National Health Information Strategy has adopted performance management as a key element in the overall strategy. Delegates at the conference in November proposed that the following considerations should be addressed as part of any performance indicator set:

  - Closely linked to health outcome measures.
  - Linked to patient identifier.
  - Multi-dimensional to address issues in relation to equity, effectiveness, efficiency and responsiveness to patients.
  - Compare performance at national, regional and local levels.
  - Differentiate between measuring activity and effectiveness.
  - Measure client satisfaction with services.
  - Measure access and responsiveness of health services.
  - Base on client groups, for example, children, older people, etc.

7.4 FRAMEWORK FOR THE FUTURE

At the outset of this section of the report, we identified three key questions to be addressed in managing VFM. In this section, we set out a framework to address these.

(a) What needs to be measured and managed in the health sector in terms of economy, efficiency and effectiveness?

(b) What information is required to support this?

(c) What facilitates (a) and (b)?

Before proceeding, it is important to emphasise that the framework we are proposing is only the first step in moving from the current situation. All of the issues and deficiencies identified cannot be addressed in the short term, although there maybe a number of potential "quick win" opportunities.

The difficulties associated with the measurement of outcomes across the health sector have been referenced throughout this report. In conjunction with this, it was also established that a balanced approach to performance measurement requires the availability of processes and systems to track outcomes and assess the relationship with inputs. We already highlighted in Section 7.3.2 a number of recent and on-going initiatives that are being implemented across various areas of the health system to measure outcomes and service quality such as those for persons with an intellectual disability. Undoubtedly, issues and difficulties will remain owing to the level of subjectivity that characterises outcomes.

However, this does not preclude the development of a more co-ordinated approach right across the sector through the agreement of a priority set of core outcomes / quality measures and the development of processes and systems to support the measurement and evaluation of these. Central to this is the development of compatible systems that permits the analysis of health status and outcome measures and provides for the identification of future care needs that form the basis for service planning.

The implementation of the framework will need to be achieved on a phased basis in line with resource availability. The ultimate objective is to ensure consistency, quality and relevance in the information that is produced and the areas where performance are managed. In the interim, there needs to be a realisation and acceptance on the part of all stakeholders that data will be imperfect, but that a continuous effort will be made to improve this, which will in turn require their input and co-operation. Critically, the vision and framework for the broadening of performance indicators in the future must be developed. Otherwise, there is a serious risk that the effort will be discredited by agencies who will argue that they cannot meaningfully measure or evaluate the indicators.

Our starting point for the development of a framework is the strategic plan and the objectives contained within it. In simple terms, the effective management of that plan requires that:

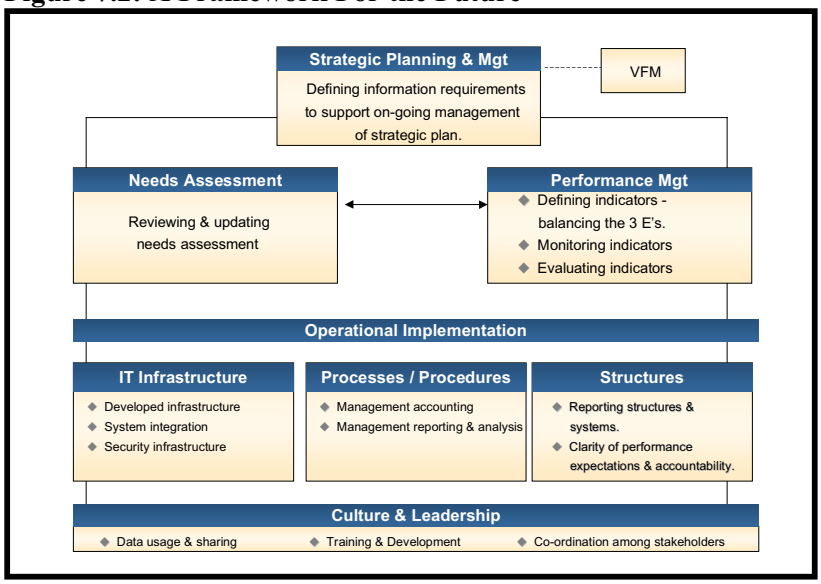
(a) Objectives are continuously reviewed to ensure that they remain relevant to the health needs of the population.

(b) That performance against objectives is monitored and evaluated on a regular basis to ensure objectives are being met and that the appropriate balance between economy, efficiency and effectiveness is achieved.

VFM forms a key component of the strategic management process in the health sector.

Operationally, there are a number of factors that will impact on the ability of the health system to manage the above. In our framework we have brought together a number of the recommendations and findings of the CPMR report (Performance Measurement in the Health System) and the Report of the Commission on Health Funding 1989 (Section Ten: The Role of Information and Evaluation in the Planning, Management and Delivery of Services) which addresses these operational factors. We consider it important to highlight and recognise the significant amount of work and research that has already been completed in this area.

Figure 7.2: A Framework For the Future



In essence, the framework recognises that effective strategic management requires:

- Developed information systems that provide relevant, timely and reliable data, together with the integration of systems and adequate system security.
- Processes and procedures that facilitate management accounting and costing together with standardised procedures for data collection, etc.
- The appropriate reporting and organisational structures at all levels of the health care system.
- A culture that is supportive of strategic management, performance review and evaluation and the utilisation and sharing of data.
- Suitably trained personnel to collate, analyse and report on the information gathered.

7.4.1 What needs to be measured and managed in the health sector in terms of economy, efficiency and effectiveness?

From a VFM perspective, it is generally acknowledged that the focus of performance management in the Irish health care system must include both financial and non-financial measures. Internationally, quite a significant amount of work has been completed on performance management in the health system particularly in the UK, Australia and the US and we understand that The Department of Health & Children has examined a number of these models. The *approach and ethos* adopted by the NHS in England offers some useful insights.

The NHS Performance Assessment Framework

The NHS Performance Assessment Framework was set out in April 1999 with the objective of focusing on those areas that mattered most to the public in the delivery of a quality and cost-effective service. The six inter-dependent areas identified were:

- Health improvement
- Fair access
- Effective delivery of appropriate health care
- Efficiency
- Patient / carer experience
- Health outcomes.

Subsequent to launching the framework, the NHS held consultations with key stakeholders to define a co-ordinated set of high-level performance and clinical indicators for each of the six areas. The initial set of indicators were primarily applied to Health Authorities with the goal of further rolling these out to all NHS trusts and primary care trusts providing community services. The addition and amendment to the initial set of indicators is ongoing. It was also recognised and acknowledged by the NHS that performance measures would be of variable quality and that improvements would be made along the way.

For each indicator a standard data template has been developed, which includes a data definition; the area that the indicator is intended to cover; the rationale for the indicator; notes with respect to the interpretation of the information produced; the source of data; the years / times to which the data source applies; numerator data descriptions; denominator data descriptions; notes with respect to data calculation and other general notes as applicable.

As part of the framework, the NHS set out how it would like the various agencies to use the information contained in the indicators set. This includes:

- Reviewing the performance of local services against the six areas of performance.
- Comparing local performance with that of other agencies.
- Sharing information about achieving good results for patients.
- Using the information to assist work in Clinical Governance.
- Strengthening the emphasis on quality and outcomes in local health improvement programmes and local service and accountability agreements.
- Involving the users of services.
- Securing improvements in the quality and accuracy of routine data collection.

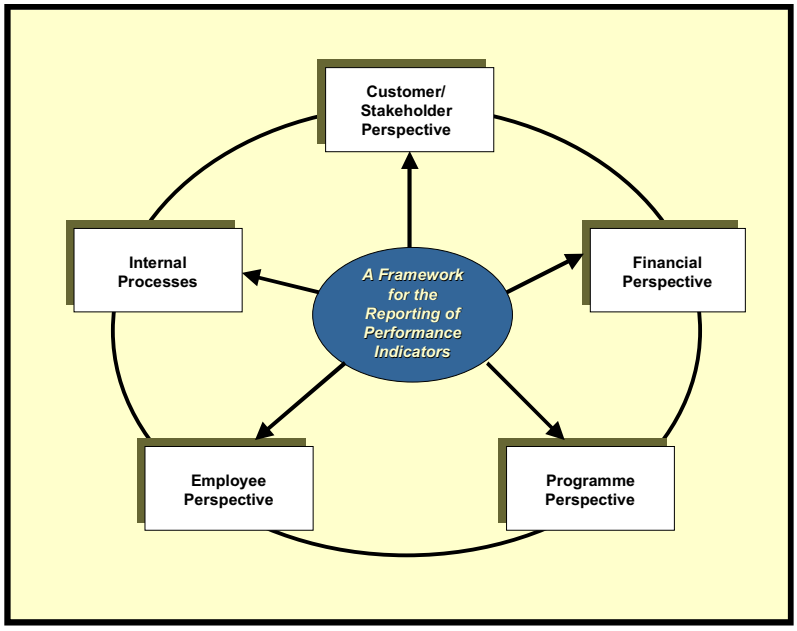
There are a number of key points from the NHS approach:

- A balanced set of indicators in delivery of a quality patient service was developed.
- A phased approach to performance measurement was implemented with a continuous focus on improving the quality of data produced over time.
- There is a process in place to continually amend and expand the original performance indicator set based on the feedback from stakeholders and from the general experience of using the indicators.
- There is an alignment of performance measures across the various levels of the health system all linked back into the NHS's corporate strategy.
- Data definitions and guidelines in interpreting and using data have been defined.

The Balanced Scorecard

The Balanced Scorecard is another tool that is being increasingly used by public sector organisations to develop a balanced set of performance measures which also fits with the NHS's Performance Assessment Framework. A modified version of the original model developed by Kaplan and Norton is presented below for the health sector. This is only intended as a guideline.

Figure 7.3: Proposed Balanced Scorecard Framework



As highlighted previously, a considerable amount of work has been completed internationally in developing performance indicators for the health sector. There is obvious merit in The Department of Health & Children adopting and modifying these indicators to suit the Irish situation in terms of what is applicable and also in terms of what is achievable with available infrastructure and resources. This process also allows for the analysis of mistakes and lessons learnt by other countries that can be automatically built into any Irish model. There are also opportunities to inform this process through the on-going work of the National Health Information Strategy, the Department's and other key stakeholders' experience as part of the Joint Department / Health Board Service Planning Group in addition to the work completed by the ERHA in this area.

The fundamental point is that consultation between the Department and key stakeholders is required in defining an initial set of high-level / strategic performance indicators and this should be driven by the Department as part of its role in monitoring and evaluation. Subsequently, more detailed indicators can be developed for the various other levels in the health system.

To facilitate the above, the following sections set out:

- Characteristics of good performance indicators.
- Recommendations to facilitate the performance management development process.

(a) Characteristics of Good Performance Indicators

We have set out below what we believe are the key characteristics to focus the development and selection of performance indicators for the health care sector. Ideally, any indicators developed should be scored and ranked according to these characteristics. Consequently, the best-fit indicators should be selected.

- Definable – can the indicator be clearly defined to ensure consistent data is collected and measured?
- Clear intent – is the intent of the indicator easily understood and interpretable by all users?

- Relevance – Does the indicator measure aspects of performance that are relevant and significant i.e. do the measures relate to the objectives and policies of The Department of Health & Children?
- Accessible – Is data accessible?
- Reliable – Is there demonstrated reliability of data? (This will to a large part depend on standard definitions and the rigour of data collection methods).
- Valid – Does the indicator measure what is intended and point to issues of quality?
- Useful – Does the indicator provide useful information to inform quality programmes and stakeholders?
- Practical benefit – Does the indicator have a strong cost / utility ratio, i.e. the costs of collection should not outweigh the usefulness of the indicator?
- Time bound – The indicator should apply to a specific period of time.
- Responsive – Can managers influence the performance measured by the indicator?

(b) Recommendations to Facilitate the Performance Management Development Process

- A national co-ordinated performance management system should be introduced, championed and promoted by The Department of Health & Children. The finalisation of the National Health Information Strategy creates a potential platform to achieve this.
- It should be ensured that the approach to developing performance indicators is logically linked to structures as well as objectives and goals. Performance measurement is hierarchical and as such measures must firstly be developed at a strategic Departmental level and subsequently cascaded down throughout the structure. There should be a clear linkage between all performance measures developed, recognising that more strategic and high level indicators will be required at Department level and further down the system more detailed performance information is likely to be required.
- Indicators should be developed which target key areas of performance in the health sector using the Balanced Scorecard framework / or another conceptual framework.
- Effective communication with all stakeholders in the system including customers is essential to successful development and deployment.
- At a minimum the following information should be provided for each indicator: data definition, source of data, data input and analysis guidelines, for what purpose the indicator will be used and reporting procedures.
- Accountability for results must be clearly assigned and understood.
- The reliability of data collection mechanisms should be fully assessed by clearly identifying key issues and constraints with existing systems and resources.
- Processes for the sharing of information should be established.
- A process for the periodic review of indicators to ensure on-going relevance is also required.

7.4.2 What Information is Required to Support the Strategic Management Process & VFM?

As highlighted by Figure 7.2 there are two inter-connecting strands of information that support the strategic management process, the first is information on health needs and the second is information to measure performance across inputs, outputs and outcomes.

Within the framework of this section of the report we have not reviewed in detail the extent to which information is available to support needs assessment. However, it is a critical element of the strategic management and planning processes and therefore it should be fully considered as part of any MIS strategy or performance indicator framework developed by The Department of Health & Children. There are a number of key points that are worth noting:

- The measurement of population health is largely dependent on mortality data. This only includes information on fatal diseases, to the exclusion of non-fatal diseases and therefore does not represent a full and true assessment.
- The key components of a comprehensive population health surveillance system should include information on:
  - Demographics
  - Health status measurement - positive health measures, ill health measures, mortality data and equity of health status
  - Health risk measurement – biological, environmental and behavioural
  - Health systems – health service utilisation, efficiency and effectiveness measures and health care resources

By way of a concluding remark the Commission on Health Funding made an interesting observation *"...most data required for the measurement of service needs are already being routinely collected by public agents or by health and social service professionals in the course of their work. The difficulty lies in drawing together this information and using it effectively"*.

With respect to the information that is required to support VFM, this should be in line with the set of performance indicators produced as part of the conceptual framework and the information that is needed to monitor and evaluate these. While all of the information may not be available in the short term, initiatives to address key constraints and weaknesses should be assessed particularly in terms of:

- Improved coding / data entry practices and procedures.
- The implementation of processes and practices that routinely assess data quality and reliability.

7.4.3 Other Considerations

IT Infrastructure

As identified in previous sections of this report, investment in IT infrastructure and systems in the Irish health sector has been inadequate. However, it is important to recognise that some significant advances have been made (for example, that such a sophisticated system as HIPE exists) and there is a continuous effort to develop others to bridge information gaps and deficiencies.

If a concerted effort is to be made in the future to manage VFM in the health sector proactively, it has to be accepted that the current IT infrastructure will need to be developed and enhanced. This will require a commitment to IT investment well in excess of historical levels. In conjunction with this, improved co-ordination of system development / selection is required across stakeholders to facilitate data sharing, data integration and benchmarking.

Investment in IT will serve to support the policies and objectives of The Department of Health & Children and the health sector at large. There are a wide range of areas where IT can bring about significant improvements and benefits which include, but are not limited to:

- The implementation of a more patient focused approach to service planning and delivery through the development of a UPI system and also through the improved use and integration of systems at community and primary levels and in the acute sector.
- The provision of a more comprehensive set of data, for example on health status and future health needs, that goes beyond mortality data.
- The provision of management information and costings that support the planning, monitoring and evaluation of services and business plans.
- Facilitating improved control, accountability and empowerment in the use, monitoring and management of resources.
- Facilitating the improved identification and prioritisation of issues.

Following on from the above and the issues discussed previously, we recommend that the key principles that should underpin any IT strategy and vision for the Irish health care sector should include:

- Promoting greater use of IT systems and data across all levels of the health sector.
- An integrated approach to service management and delivery incorporating improvements in the sharing of data and in the co-ordination of systems selection and development. Conjoint working by Boards will be essential to future IT selection and procurement.
- The provision of accurate, timely and comparable information. This in turn requires standardised data definitions and processes in the collection, analysis and presentation of information.
- The empowerment of service users and health professionals through improved access to, and training in, IT systems.
- A framework for data security and privacy particularly if a decision is made to implement a UPI system. In many other countries this has been incorporated directly into legislation.
- Clear guidelines and standards to govern the wider release of information and the use of data.

There are a number of priority areas where we believe investment needs to be targeted (as set out below). However, these recommendations should be further assessed and incorporated as part of a detailed MIS strategy for the Irish health care system. To this end, we understand that the ERHA is in the process of finalising its MIS strategy and it is recommended that the opportunities to dovetail with the output and recommendations of the strategy are fully explored to minimise duplication of effort. The ERHA strategy will provide the health care sector with a better indication and quantification of the types of deficiencies that exist and the investment that may be required to bring the systems up to the required standard. Priority areas include:

(a) The development of systems for the acute sector. These include management systems for Accident & Emergency (primarily in Dublin), theatre scheduling and waiting lists. In line

with national proposals to implement a UPI system, the acute sector needs to strive towards the development of a fully integrated electronic patient record system.

(b) The development of a suite of systems and / or the upgrading of systems at primary care level - an area that requires urgent attention. In particular, the requirement for electronic records at GP level was previously identified as essential to realising improvements in service integration. Likewise, public health nurses require access to systems and data to support patient care and health promotion.

(c) At Health Board level, a focus on developing integrated systems for primary and community care that link into health needs assessment and service planning. In turn, acute hospital systems need to be aligned to ensure the development of integrated management information systems throughout the health care system.

(d) At National level, an assessment of the IT infrastructure and the level of investment to implement a UPI system, whether delivered by REACH or developed specifically within the health sector.

We also recommend that full consideration is given towards a more co-ordinated approach to organising and managing IT systems across the Health Boards. Systems are currently duplicated and the approach taken to date has not facilitated national data comparisons or analysis. Future investment requirements in IT will be very significant but these costs are likely to be inflated if systems are replicated across each of the Health Boards. Although, HeBE is at an early stage of development, it may provide a suitable structure of governance to move the process forward within the context of a national MIS strategy. This point needs to be further explored by The Department of Health & Children and HeBE.

Processes & Procedures

Traditionally, the health service in Ireland has focused on financial accounting and reporting, ensuring that there are adequate levels of financial control in place. Until recent years, there has been little focus on the development of management accounting (i.e. management reporting, budgeting, costing, performance measurement, etc.).

The development of management accounting has been gradual and slow. Initial efforts have primarily focused on the development of integrated financial management systems, however, management accounting processes are still not sufficiently developed to support the provision of relevant, timely and accurate management information. Management accounting procedures and processes need to be developed in the following areas to support the provision of management information for planning, resources allocation, decision-making and control:

- Budgeting - the development of effective medium term budgetary control processes and mechanisms to support the devolution of budgets.

- Management Reporting - involves reporting organisational performance, both financial and non-financial, against budgets and targets. It is essential that management information provision is aligned with organisation segmentation and accountability assignment.

- Costing – supports planning, budgeting and performance measurement identifying the resources (i.e. staff, materials, equipment, etc.) consumed in delivering a particular activity. Costing facilitates informed decision-making, provides a basis upon which cost control measures can be instigated, and supports comparative analysis.

In particular, the areas of management reporting and costing need to be developed at both a national and regional level to ensure the provision of relevant, timely and accurate management information throughout the health care system. In this regard, consideration should be given to the development of national policies that set out the minimum requirements and standards for the development of management reporting and costing. National policies should set out guidelines for their development and highlight future information requirements at a national level (i.e. including common performance information). The Department should consider the following requirements to support development of management information:

- Management Reporting – The current process for submitting returns to the Department should be reviewed, ensuring the optimal use of available technology to support management reporting and analysis. In particular, the content of IMRs should be reviewed and developed to facilitate ongoing monitoring and review of performance. Where possible, financial data should be reported across service or care groups enabling better analysis of performance, and non-financial information improved through the incorporation of national performance indicators.

- Costing – It is important that a co-ordinated and consistent approach is adopted to the development of costing throughout the Irish health care system. At a national level, the requirement for a standardised approach to costing should be considered. In particular, a costing framework should be developed that encompasses all activity (i.e. including community care) in the Irish health care system.

Structures

We alluded in earlier sections of the report to the requirement to have in place appropriate reporting structures to facilitate the regular and timely reporting of information. The need for this is most evident at community and primary care level. However, issues still remain at Health Board and secondary care level. The roles and responsibilities for information management and provision should be clearly defined and aligned throughout the health care system, thereby ensuring responsibility for on-going performance measurement and reporting within the system and into The Department of Health & Children.

At secondary care level greater emphasis and effort is required to develop clinical audit and clinical governance, ensuring measures of service quality are clearly defined and incorporated into the system. Throughout the system, the potential role of accreditation schemes in clarifying performance expectations should be assessed.

There is also a clear need to re-enforce the service plan as the key accountability document between the Health Boards and The Department of Health & Children. While the ERHA is presently the only health agency that is required by legislation to monitor and evaluate performance, there is an implicit requirement for all Health Boards to do so both for its own service units and the third party agencies it funds (for example Section 65 agencies). Greater effort must be made to report on the achievement of objectives and also on the extent to which new programmes lend themselves to the attainment of targets and goals.

In addition to having the appropriate structures and systems in place, it is equally important that the appropriate resources are in place to translate data into meaningful and usable information. The view was expressed that there are insufficient resources and skills in the system presently to address this. In particular, the difficulties of attracting professional personnel (IT, Statisticians, etc) were highlighted given the rates of pay that are available in the private sector for comparable posts.

The loss of staff in the IT area was another issue highlighted. It may be that more flexible recruitment and pay policies are needed if these areas are to be properly resourced. Indeed, the Commission on Health Funding recommended the establishment of a central function staffed by personnel with the appropriate qualifications and resources which would have specific responsibility for information management and monitoring service performance.

This may again be worth revisiting and in particular, consideration should be given to establishing a separate agency (i.e. Health Information and Evaluation Agency) outside of The Department of Health & Children which would be resourced with a range of expertise (accounting, health economics, etc.,) to develop the appropriate framework for performance measurement and to ensure the ongoing development of management information in the system. Part of the remit of this Agency would be to ensure, on an ongoing basis, that value for money objectives were set and were achieved across the three areas of economy, efficiency and effectiveness. As such, the agency would represent a fundamental change in ensuring that VFM was integrated into the operation of the system.

The establishment of such an agency is not intended to centralise all information monitoring and performance monitoring; we clearly expect a significant level of local evaluation in managing the services. Such local evaluation will need to mobilise and co-ordinate input form the Directors of Public Health, GP units etc. particular to evaluate primary care more effectively.

Culture & Leadership

The role and function of performance management in the health sector must be properly understood by all concerned. In particular, any misconceptions that exist that performance management has been developed to identify and / or discipline organisations and individuals or that it will have a negative impact on decision-making and service provision must be eliminated. Central to this process is the need to engage all key stakeholders and ensure that they have a sense of ownership and responsibility for performance in their areas. In turn, those involved in the system need to be encouraged to make greater use of the data available (even allowing for its short-comings in the short to medium term) and to share more information. The Department will need to take a lead role in this process. The linkage of performance indicators to funding and / or incentive schemes will require careful consideration and in particular the reliability and validity of indicators would need to be assured. If incentives are created, they must be designed so that they support quality improvement.

7.5 KEY FINDINGS AND RECOMMENDATIONS

7.5.1 Key Findings

- Performance management has become increasingly recognised as a critical component of the Irish health care system and every indication suggests that greater attention and importance will be attached to this practice in the future. While some progress has been made in developing performance indicators, significant gaps remain to be addressed in performance measurement and evaluation. Equally important, there is a need for the better co-ordination of indicators as part a national framework of indicators linked to national strategy and policies.

- There has been a general lack of investment in management information systems in the Irish health care system over the last decade. Particular gaps exist at primary and community care levels. The impact of this is an inadequate infrastructure to support information requirements, performance management and VFM. Progress has, however, been made in implementing a number of systems that input into the strategic planning and performance management processes. These include HIPE, Casemix, IMRs, PHIS and the service planning process.

- It is important to recognise that initiatives have or are in the process of being developed and implemented, to improve the availability and quality of data in the health system and to manage performance including VFM. These include the National Intellectual Disability Database and the National Cancer Register. More recent initiatives and projects include the National Health Information Strategy (NHIS), CHIPS, the proposed development of a UPI system, the REACH project, Health e-Procurement and the development of an initial set of joint performance indicators by the Joint Department / Health Board Service Planning Group.

- There is evidence to support the view that IT systems are being implemented in the absence of clear objectives and procedures and performance indicators have been developed in the absence of a national framework or vision.

- There is a need to improve the level of confidence and usage of management information in the health care system. This is due in part to a lack of standardisation in data and data definitions at national, regional and local levels. It is also a function of the absence of common procedures to govern data collection, analysis and presentation. As a result of these deficiencies, it is generally not possible to compare data and benchmark performance.

- There is a clear need for the development of a more co-ordinated approach to the selection and implementation of management information systems and performance management across the health sector.

- There is a lack of appropriate skills and capacity at all levels to analyse and interpret data and to manage performance. In tandem with this, a cultural change in the way organisations and individuals view performance management and management information needs to be initiated in terms of its uses and benefits.

- Management reporting and costing is underdeveloped throughout the system. Specifically, there is a lack of integration between financial and non-financial reporting of performance.

7.5.2 Key Recommendations

- A framework is required to more structurally define what needs to be measured and managed in the health sector in terms of economy, efficiency and effectiveness, what information is required to support this and what facilitates the latter two points. The framework we are proposing recognises that effective strategic management requires:

  - Developed information systems that provide relevant, timely and reliable data, together with the integration of systems and adequate system security.
  - Processes and procedures that facilitate management accounting and costing together with standardised procedures for data collection, etc.
  - The appropriate reporting and organisational structures at all levels of the health care system.
  - A culture that is supportive of strategic management, performance review and evaluation and the utilisation and sharing of data.
  - Suitably trained personnel to collate, analyse and report on the information gathered.

- A balanced set of performance indicators need to be developed for the Irish health care system that takes accounts of outcomes as well as outputs and financial performance. As part of this we recommend that The Department of Health & Children review the work

completed in this area internationally, of which there has been a considerable amount, and adapt this to the Irish situation. There are also opportunities to inform this process through the on-going work of the National Health Information Strategy, the Department's and other key stakeholders' experience as part of the Joint Department / Health Board Service Planning Group in addition to the work completed by the ERHA in this area.

- The key proposals to facilitate the performance management development process include:
  - A national co-ordinated performance management system should be introduced, championed and promoted by The Department of Health & Children. The finalisation of the National Health Information Strategy creates a potential platform to achieve this.
  - The approach to developing performance indicators should be logically linked to structures as well as objectives and goals. Performance measurement is hierarchical and as such measures must firstly be developed at Departmental level and subsequently for each level in the structure underneath that. There should be a clear linkage between all performance measures developed, recognising that more strategic and high level indicators will be required at Department level and further down the system more detailed performance information is likely to be required.
  - Indicators should be developed which target key areas of performance in the health sector using the Balanced Scorecard framework / or another conceptual framework.
  - Effective communication with all stakeholders in the system including customers is essential to successful development and deployment.
  - At a minimum the following information should be provided for each indicator: Data definition, source of data, data input and analysis guidelines, for what purpose the indicator will be used and reporting procedures.
  - Accountability for results must be clearly assigned and understood.
  - The reliability of data collection mechanisms should be fully assessed by clearly identifying key issues and constraints with existing systems and resources.
  - Processes for the sharing of information should be established.
  - A process for the periodic review of indicators to ensure on-going relevance is also required.

- Two inter-connecting strands of information are required to support the strategic management process, the first is information on health needs and the second is information to measure performance across inputs, outputs and outcomes.

- A concentrated effort in managing VFM in the health sector for the future requires significant investment in IT infrastructure and training. The priority areas to be addressed should include:
  - The development of systems for the acute sector including management systems for A&E (primarily in Dublin), theatre scheduling and waiting lists in conjunction with the development of an electronic patient record system.
  - The development of a suite of systems and / or the upgrading of systems at primary care level including electronic records at GP level and improved access to information for public health nurses.
  - Integrated systems for primary and community care at Health Board level that links into health needs assessment and service planning. In turn, management accounting and costing systems need to be reviewed.

  - At National level, an assessment of the IT infrastructure and investment to implement a UPI system is required.

- A structure of governance is required to manage future developments in IT in the context of a developed strategic plan and to provide for a co-ordinated approach across all the Health Boards. Consideration should be given to the use of HeBE for this purpose. However, this option needs to be further explored and developed.

- The principles that should underpin an IT strategy for the health sector should include the following:

  - Promoting greater use of IT systems and data across all levels of the health sector.
  - An integrated approach to service management and delivery incorporating improvements in the sharing of data and in the co-ordination of systems selection and development.
  - The provision of accurate, timely and comparable information. This in turn requires standardised data definitions and processes in the collection, analysis and presentation of information.
  - The empowerment of service users and health professionals through improved access to, and training in, IT systems
  - A framework for data security and privacy particularly if a decision is made to implement a UPI system. In many other countries this has been incorporated directly into legislation.
  - Clear guidelines and standards to govern the wider release of information and the use of data.

  The output and recommendations of the ERHA's final MIS strategy should be reviewed in the context of developing a national strategy.

- The roles and responsibilities for information management and provision should be clearly defined and aligned throughout the health care system, thereby ensuring responsibility for on-going performance measurement and reporting within the system and into The Department of Health & Children. Ideally, this would fall under the remit of an information unit in each Health Board, although the measurement of service quality could require specialist health care knowledge.

- The role and function of performance management and management information in the health sector must be properly understood and any misconceptions addressed.

- Management reporting and costing processes should be developed and where applicable strengthened to ensure the provision of integrated management information.

- Consideration should be given to establishing a separate agency (i.e. Health Information and Evaluation Agency) outside of The Department of Health & Children, which would be resourced with a range of expertise (accounting, health economics, etc.,). The remit of this Agency would include responsibility for information management in the health care system and ensuring, on an ongoing basis, that value for money objectives were set and were achieved across the three areas of economy, efficiency and effectiveness.

  As such, the agency would represent a fundamental change in ensuring that VFM was integrated into the operation of the system. The role and remit of the Agency can be more precisely defined having regard to the outcome of work on the NHIS and by the Quality subgroup of the new Health strategy.

7.6 NEXT STEPS

The output of the National Health Information Strategy is likely to highlight broad information requirements across the health sector, including the information status on health needs. However, it is not clear at this stage to what extent it will examine in detail management information and performance management in the context of VFM. It is highly improbable that this can be comprehensively developed within the existing terms of reference of the Committee.

We recognise that VFM is a component of the National Health Information Strategy but consider it an issue that needs to be looked at in more detail. Therefore, the Department should consider the extent to which the opportunities identified in this section of the report for the development of management information are being addressed by the National Health Information Strategy.

Specifically, we recommend that a Steering Committee be established to ensure that opportunities identified are achieved and also to facilitate the co-ordination of any work in this area with other key developments including the National Health Information Strategy.

In terms of going forward, we envisage a phased approach to the implementation of the overall framework in consideration of resource constraints and system deficiencies. Clear leadership and commitment are required.

7.6.1 Short Term Actions

In the short term (i.e. over the next 12 months) the Department should set out a strategy for the development of management information and the following actions should be completed:

- Clear leadership and commitment to the development of a co-ordinated approach to managing VFM across the health care sector must be established. To this end, we recommend that a Steering Committee is set up to ensure that short term actions are achieved and also to facilitate the co-ordination of any work in this area with other key developments including the National Health Information Strategy.

- One of the first tasks of the Committee will be to secure agreement on a credible framework for developing a balanced set of performance indicators. This should involve the in-put of key stakeholders and should in turn be driven by the key objectives and policies set out in the Department's new strategy which is expected mid-2000.

- Subsequent to agreeing the framework, performance indicators across each of the key measures will need to be established. This will necessitate working within the current deficiencies of the health information systems while establishing what deficiencies actually exist and what steps if any can be taken to address these in the short term. To this extent the indicators that can be developed may be somewhat constrained by the available infrastructure in the immediate future but there should be a clear vision as to future development. Clear data definitions and standards should also be established for each indicator.

- Standardised procedures and processes will be necessary to support a co-ordinated and consistent approach. This will include:
  - The development of a template along the lines of that drawn up by the NHS to guide performance measurement, as previously outlined.
  - The development of costing to support planning, decision-making and control at all levels of the health care system including acute and community care.

  - Recommending appropriate structures and procedures for sharing and reporting of data.

- As highlighted previously, roles and responsibilities for measuring and reporting on performance measures should be established in each Health Board.

- In turn, the recommendation to establish a separate agency outside of The Department of Health & Children to develop the appropriate framework for performance measurement and to ensure the consistent development of management information needs to be developed and costed.

- The resource requirements to support the allocation of clear roles and responsibilities for information management and provision and performance measurement and reporting should be initiated throughout the various levels in the health care system.

- An IT strategy review should be initiated across the system. The strategy should define the IT systems, resources and investment that is required to meet the information needs of the health sector. To reiterate, the work currently being completed by the ERHA should be assessed as a basis for strategy development. Critically, we would argue that a co-ordinated approach to systems development is implemented across all Health Boards. Systems that are developed in isolation will not support performance management and VFM, nor will they account for the reality of patient flows. The structures and objectives that unpin HeBE should be looked at as a potentially suitable framework in this regard.

7.6.2 Medium to Long Term Actions

A longer term approach is required to:

- Enhancing and developing the current IT infrastructure arising out of the recommendations of the IT strategy.

- Enhancing management capability across:

  - IT

  - Performance measurement and evaluation

  - Management accounting

  - Costing

The key themes that should underpin all actions in the short and medium term are:

- Clear leadership and governance.

- The co-ordination and evaluation of activities.

- The continuous review and updating of performance measures and IT systems.

- Communication between all key stakeholders.

PART 5
SERVICE PROVISION

SECTION 8: ACUTE HOSPITAL SERVICES AND URGENT CARE

8.1 INTRODUCTION

Acute hospitals are a major component of expenditure on health services in Ireland. In 2000 the acute hospitals programme, including the voluntary hospitals, absorbed approximately 46% per cent of non capital expenditure by government. Acute hospitals are also the part of the health care system with which people have contact when they are most affected by urgent and serious health problems. They therefore attract media and consumer attention on a scale that may be to the detriment of other services, which also have a need for resources. However, acute hospitals remain a large, important and highly visible component of public health care in Ireland.

In this section of the report, we examine issues of value for money as they affect the acute hospital services in Ireland. Because of the particular importance attached to it by those interviewed in our study, we also include in this section a review of value for money and emergency services, including some provided outside hospital.

The provision of acute hospital health care is determined by:

- The total hospital capacity planned for Ireland;
- The distribution of that capacity between geographic areas;
- The distribution of capacity according to its suitability for general, acute or specialist care.

The Value for Money achieved by the acute hospital system can be measured by activities or by outcomes. Relative to hospitals systems in other countries, the Irish hospital system has relatively lower costs and fewer clinical staff (see Section 3 on International Health Care Systems). It also has fewer acute hospital beds than many countries (though more than the UK and the USA). Measured by activities, the system appears to offer value for money in that hospitals are heavily utilised, broadly, across the system. However, the ultimate value for money of the Irish acute hospitals depends on the outcomes achieved for patients. Currently, there is no systematic assessment of outcomes and so the extent to which the hospital system is improving health cannot be demonstrated. This is a problem common to all health systems internationally.

8.2 POLICY BACKGROUND

The key principle, which should underpin the recent development of acute hospitals in Ireland, was set out in Shaping a Healthy Future. This strategic plan for health care proposed that:

The role of each hospital should be defined as part of a co-ordinated network of services delivering high quality care in the appropriate setting, in an equitable and cost-effective manner.

This continues the policy developed in the 1970s, which aimed to build up a network of regional hospitals across Ireland. It is envisaged that the development of hospital services will continue, and will be directed towards a hierarchy of secondary care, where appropriate care is provided in the most appropriate location. While there has been no recent acute sector policy (a major gap) key components of the policy background in the acute sector are:

- A focus on strong network of local and general hospitals, serving defined catchment areas and providing various medical and surgical facilities;
- A number of larger regional hospitals, offering more specialised services and providing a broad range of regional specialties to their local regional population;

- A small number of highly specialised tertiary or supra-regional units, serving larger catchment areas, such that resources are used to the best effect;
- An objective of self-sufficiency for each Health Board, in community and regional specialties;
- Hospital networks which operate as co-ordinated groups so that total comprehensive services are not provided on each hospital site. This was seen as potentially requiring some re-definition of the role of some hospitals;
- A hospital service that is more responsive to the needs of primary care, with the development in primary settings of care currently provided in secondary settings;
- An improved ambulance service, supporting acute hospitals, through the implementation of the 1993 Review Group recommendations on ambulance services.

The issue of self-sufficiency requires definition; it does not mean all regions are totally self-sufficient across the full range of specialities. The best patient outcome is the core objective, which may mean, particularly for more complex procedures, treatment outside a particular Board or region.

A related issue in "Shaping a Healthy Future" concerns the development of technological enhancements to services and their use in ways which improve the effectiveness of services. This is linked to clearer priority setting and the involvement of a wider range of stakeholders in priority setting. This is particularly important for acute hospitals because they are the major user of advanced and high cost technologies. (In practice, this more explicit approach to priorities has not been developed.) The key aspect of Shaping a Healthy Future for acute hospitals was the proposal that hospitals in future would work as more co-ordinated groups so that a comprehensive service could be provided without all such services being available on a single hospital site. Linked to this is the concept that each region should be self-sufficient in community and regional services. The concept of self-sufficiency is likely to require further development and is considered in more detail in Section 8.6 below.

8.3 RESOURCE BACKGROUND

The analysis in Section 5 of this report pointed to a stagnation in investment in all aspects of the health services in the late 1980s and early 1990s, which many involved in managing the delivery of hospital believe adversely affected the achievement of high standards of hospital care. A number of issues arise;

- Until about 1997, hospital managers saw financial restraint as the main agenda, with service developments as a secondary consideration. Managers in the system have been conditioned to think on how not to spend money, rather than strategically plan investment. We have concerns that while significant additional funding has been made available to the health services in recent years (and more including capital investment will arise under the NDP), clear criteria for investment of the increased funding are lacking, the structures to effectively manage the increased expenditures at Board and hospital level are underdeveloped, and managers, because their experience and training was gained in a resource constrained environment, lack the skills to strategically plan and manage the increased resources. The large increase in funding has been a major culture shock to the health system.
- The lack of investment has meant that physical facilities and clinical equipment are in need of further investment, in spite of substantial investments over the last four years.

- The majority of facilities in use for acute hospital care are relatively old, though many have been upgraded in part or in full, which may introduce both clinical and organisational inefficiencies and risks.
- The manner in which the Casemix Programme handles new, more modern and better resourced facilities merits review. Older acute hospitals which carry high occupancy rates (arguably too high) and which may be under-resourced for the work they are carrying out, both in terms of personnel and investment in medical equipment may gain relative to new facilities under the Programme. Casemix is a valuable tool to promote efficiency in the system, but it is vital the system does not act to impair effectiveness.

Specific areas where additional investment is a priority include:

- Day case facilities;
- Intermediate facilities for elderly and other patients no longer requiring acute care;
- Rehabilitation facilities for patients not able to return to the community immediately.
- The development of Medical Assessment units in hospitals on an 18-hour basis per day.

The level of day case activity in Ireland, while increasing, is still low by best international standards**.** Furthermore, as pointed out in Section 5, there are variations in the levels of day surgery practised in different Boards. This may be impacted by distances between home and hospital in some parts of the country; however again the lack of appropriate infrastructure for day care is a factor militating against further expansion of day care activity. The level of day case activity in the Eastern region is relatively high and is in all probability likely to peak at current levels unless further infrastructural investment is made. The overall low level nationally probably results from constraints on investment in the late 1980s and early 1990s, when day surgery had begun to spread as a highly cost-effective means of providing surgery of minor and intermediate complexity. Day surgery is typically delivered in dedicated units, which ensure that a key component of hospital waiting lists is addressed regularly, without competing for theatre time with cases requiring a hospital stay.

Access to intermediate and rehabilitation facilities offer the potential benefit of speeding up discharge from acute wards and releasing acute beds for other patients. Elderly patients are likely to remain in acute beds in some areas because of the lack of appropriate places for rehabilitation, in hospital or in the community. The level of the subvention for nursing homes over the 1990s has also potentially limited discharges from acute hospitals, given that the full cost of nursing home accommodation is not met. (We understand that a separate study of long term care funding is being undertaken.)

In spite of comments on the shortage of resources in the past and the recent high level of spending, some of those interviewed during the study noted that recent levels of expenditure might themselves pose problems of value for money. This was seen as arising from:

- The sheer pace at which additional funding has been injected into the hospital system;
- Financial rules such as pressure to spend resources, for example, before the end of the financial year or on a specific clinical initiative, which encourage rapid spending rather than the most effective spending. (In the absence of detailed and regular reviews of value for money in the health service, it is not possible to test this with published data);
- A tendency for a first shot of investment to lack follow-up investment so that, for example, the cancer strategy has led to the appointment of consultant oncologists but not sufficient funding for their subsequent expenditure on drugs.

8.4 THE CULTURE OF "VALUE FOR MONEY" IN ACUTE HOSPITALS

There is general acceptance throughout the Irish health system that the achievement of value for money is a key factor in the use of health care resources. This point was particularly made by those interviewed in acute hospitals. This attitude stems from the period of financial restraint in the late 1980s and early 1990s. However, there are risks that a culture of financial restraint will lead to a tendency to not spend money, rather than to spend it where an investment could bring about future savings or significant improvements in services. In addition, although we were repeatedly told that concerns with value for money entered every spending decision, there is no systematic approach to the explicit achievement of value for money in hospitals. For example, there is no culture of routinely producing an investment appraisal of significant spending decisions, in which alternatives are explicitly assessed on benefits and costs. Specific investment criteria are also required.

The introduction of guidelines for investment appraisal could potentially improve the value for money gained from significant new expenditures. At present, while managers argue that it is a factor in decision-making, there is little concrete evidence so support this.

8.5 HOSPITAL PLANNING AND SERVICE DELIVERY

A key element in Shaping a Healthy Future was the proposal that, in future, hospitals would work as co-ordinated networks, with some redefinition of hospitals' roles.

A modern acute hospital provides a range of highly technical diagnostic and treatment interventions. It is expensive to duplicate all of this technology in all hospitals and potentially inconsistent with achievement of value for money. While it is desirable, for example, that patients have short journeys for use of major diagnostic facilities, it is not cost-effective to provide, for example complex imaging technology in every hospital, where capacity would be substantially under-used. Medical students and junior doctors are increasingly trained with such equipment, in the teaching hospitals and other centres of excellence. In consequence, both patients and doctors require good access to a range of complex facilities in order to deliver high quality, cost-effective care. However, patient care must be an overriding factor, and it may be unacceptable to ask certain categories of the sick to travel long distances.

Development of shared services between hospitals is the approach most likely to achieve improved services without the cost of replacing large amounts of existing hospital capacity. This kind of development was proposed in "Shaping a Healthier Future". But in the acute hospital sector, there is concern from managers that the required degree of planning and integration of services is not happening consistently.

Ireland has a large number of smaller acute hospitals in rural areas. These hospitals are typically not used by Irish junior hospital doctors for their professional training and are often staffed by doctors from overseas.

Such hospitals may lack the facilities needed for the delivery of the full range of technical services which Irish junior doctors are being trained (often outside Ireland) to provide. Again the solution is for networks to develop so that both doctors and patients have access to high quality facilities, within the network if not within the local hospital.

In the UK, smaller hospitals have become less viable due to the increased difficulty of recruiting both consultants and junior medical staff. Consultant recruitment to hospitals in rural Ireland remains relatively good, with applicants from outside Ireland often attracted to apply. Junior doctor recruitment, by comparison, is more difficult, and some Health Board staff have travelled overseas in an effort to recruit junior medical staff.

Ultimately, a failure to attract sufficient junior medical staff is likely to undermine recruitment of consultants because of the need for them to work more on-call shifts or support the service in other ways. There is some concern currently about the quality of facilities for training and for delivery of care. Combined with the moves to meet working time directives, this is likely to lead to substantial change in junior doctor recruitment in a number of European countries. Irish hospitals are likely to need a strategy that can respond to this difficulty.

A number of factors are potentially limiting the development of co-ordinated networks of services across Ireland:

- Hospital staff are concerned about the viability of their local hospital and so may seek to retain part of their caseload that might be more appropriately treated in larger hospitals;
- There is a lack of coherent management of clinical services across a geographic area. That is, while Boards have staff responsible for the management of the acute hospitals, there is no specific management for the delivery of individual service components, for example the area orthopaedic service.

There is widespread acknowledgement that integrated services had not developed sufficiently between hospitals.

A recent example arises from the investment in cancer services. Cancer services are widely recognised as best provided through specialist centres linked to smaller units following clear protocols. The implementation of the cancer strategy requires the designation of some hospitals as cancer centres. These hospitals will therefore be expected to provide cancer services for some time to come and can expect appropriate investments. But this kind of investment and the effective commitment to future continuity of services is attractive to many hospitals. Also, hospitals, which already treat cancer on a limited scale, might aspire to go on doing so and all hospitals and clinicians can reasonably aspire to do more and better things for their patients. The result, however, is competition for designation as a unit, which is likely to frustrate the smooth development of an integrated network of cancer services.

Currently, there is a lack of sufficiently strong internal management of a clinical service within individual hospitals. The role of clinicians in management is discussed in more detail in Section 6 of this report. If integrated services are to develop across a number of hospitals, there is a need for a clearly identified clinical lead and management structure to take forward the co-ordinated planning and delivery of services for an area, rather than for an individual hospital. While the planning function for this can be partly provided by Board Public Health Departments and Acute Programme planners and managers, a more coherent framework is needed to deliver on the plans.

The strong links between staff and their place of work may be undermining the development of care pathways, which should cut across a number of hospitals. This was illustrated in a number of comments from those interviewed:

- Examples where new consultants appointed to a hospital wished to develop state-of-the-art facilities locally, in competition with those in the surrounding hospitals rather than as part of a network of services. For example, in paediatrics, consultants trained in neonatal intensive care may have a consequent desire to build up this service in their hospital rather than serving a wider network with a specialist centre;
- Health Boards report having paediatric and obstetric units that are duplicated, with each one being significantly under-utilised. This is clearly not compatible with achieving good value for money unless the value of local access is seen as predominant. Managers perceive that, politically, access may be more important than quality of care or cost-effectiveness;

- The lack of guidance on specific networks for care or on the appropriateness of particular technologies was seen as limiting local integrated hospital service planning. Managers would welcome a national health technology appraisal process and development of integrated service guidelines. Some of those interviewed noted that it would be relatively easy for Ireland to draw on advice developed in other countries and customise it to the Irish health care context.

Potentially the way forward to achieve better integration is to develop:

- Regional services more effectively and concretely linked to regional plans;
- Moves to a more integrated approach to clinician appointments. Where services are provided across a range of hospitals under a network arrangement, consultants could be more explicitly appointed to a network team rather than to an individual site and be encouraged to see their contribution to the network of services as their prime commitment.

Developments of this kind could in future be linked more tightly to the development of broad strategies such as the cancer and heart disease strategies. These envisage a set of national services to achieve improved health outcomes and reduce premature death from these conditions. But it is difficult to identify clearly the local leads responsible for implementing the strategy across an area. In cancer, for example, it appears that treatments are developing to a considerable degree along the lines of individual clinical practice, rather than regionally developed protocols.

Further development of integrated planning of hospitals is likely to lead to changes in the role of some hospitals, as has already occurred in a number of places. However, achieving change in the role of hospitals is seen as difficult by Health Board managers, due to public and Health Board member support for the status quo. Changing this is one of the major challenges facing the health system, which can only be done by presenting an acceptable and logical regionalisation strategy.

There is a widely held perception in acute hospitals that any reduction in the level of acuity of patients treated in a hospital or the range of services offered is likely to be strongly resisted by local groups. There is a gap between the man and woman in the street and those planning and managing hospitals regarding the appropriateness of local acute services of various kinds. The public tends to see an acute hospital, of almost any size, as an appropriate place of care for a wide range of acute health problems. Yet one Health Board study suggested that in practice patients, as opposed to the healthy local population and politicians, preferred treatment in larger hospitals, presumably because of the perceived higher quality of care available.

Smaller hospitals inevitably raise questions of quality of care and value for money. In practice, at night and at weekends, a small local hospital is likely to have a very small number of junior medical staff available immediately to care for patients. It may also not have a range of requisite equipment if a problem becomes more acute or is in practice different from the original assessment. The time taken to bring in more staff from home should be compared routinely with the time taken to transfer the patient to a hospital with a wider range of staff on-call and with additional facilities, in any assessment of the time taken to get appropriate care.

There is little research evidence to show that an increase in the time taken to get to hospital, once skilled medical or paramedic help has arrived, has a major adverse impact on outcome (largely because of the ethical problems of carrying out this research). The benefits of access to better-equipped hospitals may therefore be difficult to demonstrate and policies for integrated services across sites may continue to face problems of public resistance to change.

It was clear throughout our programme of interviews that many of those involved in the planning and management of acute hospitals are concerned that:

- The number of hospitals and the limits on their integration pose difficulties for provision of effective and cost-effective services;
- Staffing of smaller hospitals, particularly with NCHDs, was likely to continue to be a challenge for the hospital system;
- Because of restraints on capacity and new investment in the late 1980s and early 1990s, the capacity provided in smaller hospitals is an important component of hospital capacity that is required, in some perhaps redefined role, to meet the demand for hospital care;
- While the role of some hospitals may need to be redefined, they will remain important parts of local and regional capacity for the foreseeable future.

8.6 REGIONAL SELF-SUFFICIENCY

As discussed earlier in this section, the national strategy stated that each Health Board locality is to be self-sufficient in community and regional services. Whilst the objective is universally supported by the Health Boards, there is concern at the method of implementation and the implicit definition of 'self-sufficiency'. Issues include:

- The range of specialties to be included in the definition of self-sufficiency? This raises questions of the appropriate distribution of high cost MRI or cardiac catheterisation facilities in an area. There needs to be a clear cut standard on what is or is not a part of the regional self-sufficient service.
- Health Boards also want to provide local radiotherapy services (see also cancer strategy). Again it raises the question of whether such a service forms part of local self-sufficiency;
- Health Boards are concerned that there is a tension between self-sufficiency and critical mass and quality of care. For example, it is possible that a single consultant could provide sufficient service for an area. But it is increasingly difficult to develop services around only one consultant, because of the need for more cover and support for junior medical staff. That is, one may be the right number for the quantity of the service but not the right number for quality;
- Self-sufficiency is seen as lacking because of the dominance in a national context of the acute services in the ERHA region. The Department needs to develop a coherent regionalisation policy for all services, including acute care;
- Consultants outside Dublin are seen as working in less specialised ways so that their current focus and skills may limit the further development of more specialised regional services. It will be vital in any increased regional self-sufficiency of services that consistent quality of care can be demonstrated across the regions, particularly in view of the historical dominance of the Eastern region in acute care, and the patient perception in some Boards that they need to travel to Dublin for the best treatment.

Clearly, if the principle of self-sufficiency of hospital services is to be sustained by the Department, there is a need for more planning and prioritisation to determine what comprises the regional service that should be available. Redefined self-sufficiency in this context needs to be unambiguously defined.

Again this would link with the development of clearer regional networks for service delivery.

8.7 THE PUBLIC PRIVATE MIX AND VALUE FOR MONEY IN IRISH HEALTH CARE

The public-private mix of funding and services in Ireland is a long established way of delivering health care. It covers many aspects of health care provision in Ireland, but is most frequently associated with acute hospital services, the area receiving the greatest share of private insurance payouts, and where most controversy arises on the impact of private provision on the public system. For this reason, the public private mix issue is included in this section.

8.7.1 Private Insurance for Health Care in Ireland

The starting point is to consider the rationale for private health insurance in Ireland, and the issues which go with the existence of private insurance.

Private insurance was originally developed by the VHI to provide insurance against charges for public health care. That is, it was a response to charges imposed on some groups and a lack of willingness to fund free health care for all. It has grown into an insurance system which provides a significant proportion of the population with insurance against the need for acute health care and provides rapid access to care when needed.

Private health insurance in Ireland was reviewed by the Government in 1999 and a White Paper was published. The White Paper concluded that the current system should continue but that reforms to improve the resilience and operation of the private insurance system should be put in place to strengthen private insurance.

Private health insurance raises several equity issues:

- It has grown from simple protection against some modest public charges;
- It now provides those with insurance with faster access to health care, particularly hospital admission with less waiting;
- There is a widely held view that a two tier system now exists, for access to care as well as quality of care;
- In the absence of shared data between public and private sectors, it is a difficult to demonstrate the differences between the two services.

Private insurance in Ireland avoids discriminating against the sick, from among those able to pay for private insurance, by charging the same premium for all. However, in practice, only a small minority of disabled people have health insurance, probably because of the link between chronic ill health and employment. Similarly, a lower proportion of the elderly have private insurance, probably because of the drop in income on retirement. The small numbers of these groups in private insurance helps to reduce the premiums but it also reduces the burden taken off the public health care system.

The underlying fairness principles of the system are not clear. If charging for hospital care (now no longer an issue) or failure to provide universal GMS membership are not seen as unfair on higher income groups who are seriously ill, it is not clear why it should be unfair for private insurance premiums to be income related.

Linking premiums to earnings is more likely to be a practical problem, arising from the sale of private insurance in a market. Tax and social insurance can be levied on incomes but voluntary payments cannot be easily and compulsorily income related. The inequity of higher and lower income groups paying similar premiums may therefore be unavoidable.

The aim of private health insurance in Ireland is not only to offer some protection for those not eligible for free public services, particularly public hospital services at the time VHI was established, but also to obtain some funding for health care from private sources rather than higher taxes.

- The problem this poses for value for money for the system as a whole is that the additional funding generated by private insurance is used to benefit a minority of the population;
- That is, at any time there may be more severely ill patients waiting for treatment in the public sector than those being treated in the private sector. (Again there is no shared data to analyse this possibility.)

If private health insurance was abolished, and the contributions paid raised in taxation on middle and higher income groups, it could raise the same revenue for health care. However, if this revenue was used to treat current public sector priorities, currently insured individuals may lose some of their current services and would almost certainly lose their preferential access to services. This makes it less likely that they would accept the tax payments required to keep total health care funding constant. This in turn means that, where these formerly insured people received care from the public system, the amounts raised in taxes may not cover the additional costs of treating them. In short, if current private insurance was abolished, it could easily cost the public system more.

Private health insurance may also be vulnerable to future economic downturns, which may change the age composition of membership. This would push up the premiums of those staying insured, unless government subsidies were provided.

Private insurance under community rating with equal premiums for all members is effectively a form of long term health insurance:

- Younger age groups are being encouraged to join and stay in, to subsidise the costs of older, sicker age groups, in the expectation that they will benefit from similar access to insurance at controlled premiums and private health care in future;
- Governments can only guarantee this if they are prepared to consider the need to subsidise private health insurance under adverse economic circumstances in future;
- If insurance is seen as a purely market product, with the better off sick paying higher premiums than the better off healthy, then the market can be left to its own devices, as premiums will balance expenditure annually or for each age cohort;
- Once attempts are made to share inter-generational health risks within a market insurance product, governments are likely to need to intervene continually to maintain the balance of premiums required. A market is being used to achieve a social gain, community rated premiums. Markets are typically not effective ways to achieve social goals and are likely to need to be controlled. This is clearly the case in Australia, where interventions include controls on premiums, tax subsidies and tax levies on better off people who do not take out private insurance;
- Continued intervention and dispute, potentially with a larger group of insurers and with the European Union involved, is likely as long as current arrangements are in place.

Risk equalisation, the sharing of premium income between insurers, is one such market intervention, which is likely to involve the government in continuing debate and negotiation with insurers. Ireland operates a Risk Equalisation Scheme in the health insurance market. More generally, as private insurance on preferential terms grows, the constituency supporting its retention will also grow, making change in the future difficult to achieve.

A shift to insurance for all, giving public patients similar access to fee-for-service, responsive private practice is an appealing alternative. However, this would be likely to lead to very substantial increases in total spending and potentially substantial elements of health care driven by providers rather than by population needs and public priorities. It is not clear how, without additional expenditure, private standards of access could be readily achieved for all.

From a pragmatic perspective, private health insurance on the current terms is likely to be a feature of health care finance in Ireland for at least the medium term. It can be judged pragmatically on its impact on the public health care system. However, it should be noted that there is a lack of published data on the overlapping aspects of private and public health care. As a result, it is difficult to assess many aspects of its wider impact on the health care system as a whole.

In the sections that follow, we concentrate in particular on the impact of private health insurance on the value for money of the Irish health care system.

8.7.2 Value for Money and Private Health Insurance

The existence of a private health care system may impact on the public health care system in several practical ways, apart from providing a source of funding for some health care which then no longer falls on the public system:

- Private health care may draw resources away from public health care, reducing is effectiveness;
- Private health care may reduce demands on public health care, increasing what can be achieved with the available public resources;
- Private health care in Ireland may act to attract additional resources, particularly doctors, to Ireland.

8.7.3 Private Health Care and Public Health Care – The Consultants

In our discussions with Board managers and hospital managers, we found widespread concern that the private health care system is reducing the resources available for public health care. This is particularly seen as being due to consultants spending more time on private health care than is appropriate within their contract.

However, we have identified no systematic evidence to support any widespread abuse of public sector responsibilities by consultants. The lack of hard evidence on the amount of activity in the private sector carried out by individual consultants does however hinder the making of informed judgements on the issue.
In the public sector, approximately 20% of the beds are designated as private beds. Based on 1999 data approximately 23% of cases in public hospitals (21% of bed days) are accounted for by private patients. This indicates prima facie that the private workload in public hospitals is being contained closely in line with the level of beds designated to this area.

There is however an element of cross utilisation of private beds by public patients and vice versa. The ESRI (Nolan & Wiley -2000) found that if public beds were entirely occupied by public patients, the number of hospital nights available would be increased by 6%, assuming public patients currently accommodated in designated private beds continued in such facilities. If public patients were exclusively accommodated in public beds, an increase of only 1.7% in total public bed nights would arise. Neither approach points to a significant increase in public bed nights from a completely streamlined approach; furthermore nobody has suggested to us during this study that private patients occupying public beds are elective admissions-the consistently held view is that such patients were emergency cases, admitted through Accident & Emergency. Whether a patient is public or private in these circumstances hardly matters from an equity point of view.

Shared data would be very valuable, at one level as part of wider integration of health records. Currently, there is no systematic and shared record keeping between private and public systems. At the level of the individual patient, this means that there is no systematic record of past treatments for patients crossing between the private and public sector.

It is potentially in the interests of both public and private sectors to pool data:

- The private sector could benefit from data on public health care provided by consultants as this could help to identify the degree of specialisation and the frequency with which a consultant carries out a particular procedure;
- The public sector could benefit from data on private health care provided by consultants as this could help with the management of consultants, particularly their time input to public services;
- Both sides, and consultants too, could benefit from an open and transparent system, which could help dispel the current climate of suspicion in which consultants are widely believed to be under-performing in the public system without any significant documented evidence to support this.

More generally, we believe that improvements in the consultant contract and in the management of consultant inputs to the public sector should develop in parallel with improved monitoring of activity in each sector (see Section 6).

It is also a widely held view among those interviewed that:

- The work of a consultant in the private sector is a legitimate area for public sector inquiry and data collection;
- It is disingenuous to argue that what consultants do in their uncontracted time is their own affair;
- It is arguable that an employer has the right to ensure that employees do not work in their own time in ways, which affect performance of their main job.

Suspicion is reinforced because, in their private practice, consultants may well be operating on patients who would otherwise be on the bottom of their waiting lists, as newly referred and assessed patients. This suggests a conflict of interest between public and private work However, it is important to stress that we received no data to suggest that waiting lists are associated with private practice or that any manipulation of waiting times occurs in practice. Again the absence of any reliable data is potentially creating the suspicion of a problem that may not exist.

One potential way to reduce tension in this aspect of the service provided to public and private patients would be to agree some standards for waiting list management and new referrals with consultants, to prevent long waiting lists building up. Consultants with well-managed waiting lists would be less open to criticism of their private practice.

8.7.4 Private Health Care and Public Health Care - Private Beds and Charges

A further concern, widely felt in the public health care system, is that currently private patients do not pay a sufficiently high price for access to private beds in public hospitals. The ESRI (Nolan &Wiley –2000) found that the cost of provision of private care in public hospitals substantially exceeds the current level of charges for such care. This view highlights the changes that have occurred as a result of the growth in private health insurance and the market for private services:

- When VHI was first introduced, it was intended, to a considerable degree, to help those not eligible for free public care to meet the charges levied for treatment in a public hospital;
- Private health insurance has become a means of accessing faster treatment and a range of services, including more private beds in private hospitals.

The level of charges for private beds in public hospitals could in principle be anything up to the daily cost of providing a hospital bed and associated care. Full economic changing has been proposed by the Department, to be achieved progressively over a period of time. However, if the aim of charges is to recoup some of the cost of public health care from those able to pay such charges, there is no reason why the charge should necessarily equal the full cost of care. Charges are a co-payment and not a payment in full, so, charges would not cover the cost of private beds in public hospitals in these circumstances.

The issue of charging for private beds in public hospitals was examined in the recent study by Nolan and Wiley, Private Practice in Irish Public Hospitals. Their report includes some important qualifications on the issue of charges for private beds, which are worth restating:

- The concept of the "full economic cost" of a hospital bed is not unambiguous. It may depend on costing methods but also on the extent to which private health care in public hospitals leads to other changes, for example investment in additional facilities for private patients;
- The price charged for a private patient in a public hospital should not be set independent of the prices in the surrounding private hospital market;
- Prices or charges must also have some regard for the position of the health insurer, particularly if a large rise in charges is contemplated. For example, doubling of charges for private beds in public hospitals could have a major impact on the uptake of health insurance.

There are several implications from this analysis.

Firstly, prices or charges cannot be set in isolation. Secondly, if the Irish government is committed to retaining private health insurance, as an important contribution to national health spending that avoids the need for higher taxes, the optimum charge for a private bed in a public hospital may not be the full cost, however defined.

If charges for the use of private beds in public hospitals are seen, as above, as a form of co-payment, the issue is what level of co-payment would maximise the contribution from private insurance to the costs of public hospitals. There is no reason to believe that this figure should be 100 per cent of the cost per bed day:

- It might well be lower, given the possible loss of members in health insurance plans with cover limited to private beds in public hospitals. Higher charges may force such individuals to leave private insurance or encourage them to move up to a plan giving access to private hospitals (though this would also remove the cost of their care from the public system);
- It might be higher, depending on the state of the demand for private health insurance and the cost of surrounding private hospitals.

However, in the current environment, any strategic pricing of hospital bed days by the public sector could be seen as anti-competitive.

The importance of the private insurance sector to its members, and therefore the potential difficulty of changing the system, is probably much greater than its real value to the health care system, because of its small effective contribution. It covers lower rather than higher users of health care and they do not use it for all procedures and treatments, for example major trauma. The weight of complex procedures lies in the public system. However, as noted in the 1999 White Paper, it is likely to prove difficult to move away from the current system, though the interventions that may be required to support community rated private insurance should be reviewed.

8.7.5 Private Health Insurance and Consultant Recruitment

Private health care is a substantial source of income for consultants who wish to take up the opportunity to treat private patients. In an environment where private health insurance is held by c.45% of the population, these opportunities are potentially much greater than for example in the UK, where membership is much lower.

Access to a substantial private sector market is likely to increase the attractiveness of posts in the Irish public health system. Therefore, recruitment may be easier in the current environment. If consultant numbers grow rapidly, in line with some manpower projections under discussion recently, then private practice would have to be shared by a larger pool of consultants. This could make the private income of consultants lower and reduce the attractiveness of posts in Ireland. That is, attempting to recruit more consultants could become counter-productive at some point.

An alternative model, which could be developed, would see consultants contracted exclusively to the public system. The public system, through conferring of consultant status, provides most doctors carrying out private practice with their entry to that market. If the differential salary issue could be resolved, the public sector could employ doctors full time and sell their services to the private sector, potentially for fees that would be shared by the public employer and the individual doctor. This would also allow the public hospital system to consider changing the balance of a doctor's private work, from time to time, in order to address waiting list or other problems in the public system. For example, at a time of high waiting lists, the charge for private sector services for a public consultant might be raised.

8.7.6 Summary of Public /Private Mix issues

Private health insurance has developed from a simple approach to charging for public care to a major consumer product with relatively high membership. The very high membership is likely to lead to considerable resistance to change in the operation of private insurance in Ireland. It is essential that the public policy position on the existence of private insurance is clearly articulated. Health insurance is now held predominantly for certainty and speed of access. It is supported by tax relief on premia. Yet it is seen as driving a two tier system accentuating inequity in the system.

There is no evidence of abuse of the private system opportunities by consultants but this is because of the lack of data from the private system in the public domain. Issues of consistent patient records and transparency of monitoring would justify greater sharing of data between the two sectors and do much to diffuse the current climate of suspicion about the private sector.

Currently, private health insurance makes only a limited contribution to the cost of public health care, as well as taking some demand for services off the public system. (Potentially, some of this demand would not in practice be met by the public system, for example private patients may receive treatment for minor conditions that would not reach the top of the public waiting list because of more severe cases waiting.)

There is scope for raising the cost of public beds used by private patients but this should be seen as a basis for charging and raising revenue rather than an issue of fairness and the correct economic cost. Raising the price of public beds to the point where local private hospitals were cheaper, for example, would reduce the contribution paid to public hospitals from private insurance. If the work did shift to private hospitals, so would the cost of care so in principle the public hospitals would still be financially better off. But in practice, if private patients are treated at the margin, public hospitals could be left with staff and facilities overhead costs that remain, so that overall public hospitals lost out.

Private practice is probably stimulating recruitment of doctors to consultant posts in Ireland. If consultant numbers are set to grow, this may mean dilution of private practice earnings and could reduce the attractiveness of posts in Ireland, unless public sector pay rose.

Overall, private health insurance makes a limited financial contribution to the cost of health care and provides a large minority of the population with better access to health care if they need it. Because of the age profile, income and health of those with private insurance, the take up of this better access is in practice limited. As in other aspects of this issue, the sharing of data would again help to dispel suspicions about the diversion of resources from public to private cases. For example, data on elective surgery in the private sector would indicate the relative size of this activity, which may actually be small in relation to the level of waiting lists. But the tension over the inequity of the current system, which is widespread in the public health care system, remains a source of difficulty for the future in the absence of an factual analysis based on shared data.

In the final analysis, it is vital that any informed debate on the Irish healthcare system properly analyses the causes of the core problems. The public/private mix issue comes in for frequent criticism. We do not doubt that inequities do arise from the current system, but to point to the existence of private practice in public hospitals as the reason for the problems in the acute sector is a facile analysis. In any informed debate on the future of Irish health system, the policy for the existence of private insurance needs to be clearly articulated, and the cost/benefits of private practice assessed. The public/private mix issue, while a fair issue for debate, should not be used to mask the more fundamental issue creating pressures and inequities in the hospital system, namely the recurring lack of investment and inadequate physical capacity of the public health system.

8.8 CAPACITY

No discussion on the acute services would be complete without consideration of capacity issues. Elsewhere in this report, we point out:

- The significant reduction in bed capacity in the acute system in the latter part of the 1980s, which has remained to the current day. A significant part of this capacity reduction arose in the former Eastern Health Board region.
- The below average numbers of consultants and doctors in the Irish system relative to other countries.

Particularly, when one considers the high level of occupancy in acute hospitals (many would argue the levels are too high for a high quality of patient care), it is difficult to come to any conclusion other than that the acute system has for at least 15 years being operating in a highly capacity constrained environment. The pressures are not relenting; a higher proportion of patients presenting at Accident & Emergency are being admitted as in-patients.

Our examination of the acute hospital sector within the context of this study convinces us that fundamentally the lack of capacity lies behind the principal problems in the acute sector. Waiting lists, cancellations, pressures in A&E Departments are, in essence, a symptom of this lack of capacity. Limitations on further extending day case activity are, to some extent at least, related to lack of appropriate infrastructure. The limitations on capacity have resulted in the high occupancy rates in our acute hospitals. In Dublin, occupancy rates in the major acute hospitals frequently exceed 100%. Hospitals working at such levels of activity will invariably compromise service quality, suffer form huge pressures on diagnostic facilities, and potentially cause consultants to protect beds (this last point inhibits VFM, as patient length of stay is likely to be longer). Capacity mismatches adversely affect patient streamlining and processing in the acute system.

It is only fair to acknowledge that these issues are being openly considered at the present time. The Department has commissioned a study of bed capacity, the results of which are due to be published shortly. The ERHA has prepared its own analysis of the requirements in its region. Work to date confirms the need for significant additional capacity both now and into the future, particularly in the light of the impact of an increasing number of elderly within the total population.

It is vital that in addressing the bed capacity issues that:

(i) any additional capacity is planned having regard to not only current/prospective needs, but also in the context of a policy of greater regionalisation of services. A comprehensive acute sector policy needs to be developed first. Simply to put beds into areas which may currently be experiencing shortages will reinforce the existing system, which is not well developed regionally.

(ii) the capacity requirements should also focus on specialist beds (e.g. ICU,HDU, Coronary Care, Medical assessment ,Geriatric Assessment).

(iii) the need for an increased number of general medical and surgical beds is addressed.

(iv) the need for an increased number of protected elective beds is addressed. The constraints in the current system have brought a culture of using elective beds as and when needed for emergency admissions, albeit out of necessity in an under provided system.

The Medical Manpower report has identified the need for an increased complement of consultants in the system. Further work is required to define the requirements, and the attendant costs. On any analysis, it is reasonable to conclude that to implement a consultant delivered service, a significant number of additional consultants are needed. Again, the planning of any increase should have regard to the need to meet the objective of increased regionalisation of services.

8.9 INTEGRATED NETWORKS AND SPECIALISED CARE

There are significant inflows of patients into the ERHA region from other Boards to receive acute hospital care. In part this can be explained by the scale and range of specialties performed in the major Dublin hospitals and areas of niche expertise. No discussion on regional self-sufficiency can be undertaken without explicitly defining the roles of the large Dublin hospitals in the national context. The existence of significant cross boundary flows into the ERHA region (estimated to account for 20% of all admissions in the region) is a contentious issue for a number of reasons:

- Cross boundary flows are not recognised in any explicit funding formula for Boards, and there are no arrangements for Boards to pay for services rendered to their resident population by other Boards. In the context of the current system of incremental funding of the Irish system, this risks inequity in the funding to different Boards.
- Outside of Dublin, hospital managers see patient flows as potentially open to manipulation and disruption due to what some perceive as a lack of explicit support for the regions offered by Dublin hospitals. For example, it is felt in the regions that Dublin hospitals frequently fail to admit such patients, or discharge them inappropriately, causing disruption to hospital services in other Boards;
- On the other hand, Dublin hospital managers believe that they receive too large a level of referrals from outside hospitals and that the level of acuity of patients is higher than is reflected in the available data, for example, in the Department's Casemix system for allocating some resources to hospitals. The level of routine referrals to the Dublin hospitals from other Boards is also a concern, particularly as many could be treated in their own areas. This issue needs to be tackled going forward through referral protocols to ensure referrals to Dublin hospitals are made on the basis of need rather than preferences of referring practitioners. The position is particularly acute in the Eastern region because of the shortage of intermediate and long-term care beds.

As part of the tighter planning and management of particular groups of patients, there is scope for much clearer planning agreements between Dublin hospitals and out-of-Dublin Health Boards to resolve the claims for additional funding, which may or may not be wholly justified. Similarly, it will be important for services, which form part of local self-sufficiency, to be seen over time to be moving out of Dublin. There is currently a predominance of some specialist services, for example for cancer, that does not seem compatible with a genuine attempt to develop regional services. The development of a comprehensive acute sector policy is badly needed to tackle these issues.

8.10 SERVICE INTEGRATION BEYOND THE HOSPITAL

Patients spend only a small amount of their lives in acute hospitals. While the acute hospital can deal with the most urgent and most complex threats to health, it cannot provide a complete cure to every patient. Rather, it can help patients survive or resolve major threats to health but most of the patient's life will have to be spent outside hospital, with the appropriate level of support for their condition.

It is almost universally the case in all health care systems that hospital staff complain about the lack of an integrated approach between the hospital, the GP and community services. (Similar complaints about the hospitals can be found in primary and community care, typically.)

It is also striking that a number of initiatives in extended health care, going beyond the hospital, have developed through the use of hospital-employed outreach staff, rather then retraining of community staff. While this may reflect issues of skills and experience, it may reflect concern that the management of activities in the community is best carried out when staff are accountable to the management responsible for the service.

Currently, integration of community nursing with hospital activities is limited. The staff report to different management structures and may visit the hospital relatively rarely. Attempts have been made to resolve this issue, particularly for children, where the aim is to keep patients out of hospital as much as possible. The development of the community paediatrician and of close links between children's nurses treating patients in hospital and at home have done a great deal to increase continuity of care, where it has occurred.

One solution, which to a degree reflects the model for children, is to reshape hospital and community services around patient groups. For example, an elderly care service could be developed for each Board, which focused on integrated services for elderly people, provided by staff that might be based in the hospital, the community or both. If community-based staff were more accountable to a client group manager, it may be possible to improve integration and service delivery. Under such a model:

- Elderly care would have a programme management approach;
- This would cover both hospital and community services;
- Staff in community or hospital care would have a common management and common objectives;
- Community-based staff would concentrate on their care group (for example elderly with chronic physical diseases, diabetics, and cancer patients).

One drawback of this approach is that it might be difficult, in very rural areas, to provide different types of community worker for different patient groups. This difficulty can occur now in the most rural areas but anything which tended to break up the community nursing and related workforce could increase the problems in less remote areas.

A less radical approach, which could achieve some improvements in integration of services would be to make the link between hospital and community services the specific responsibility of a member of staff. This approach has been tried for discharge planning for elderly people:

- Extended stays in hospital by elderly people are a major contributor to short term problems of bed availability for emergencies;
- Increased emphasis on discharge co-ordination could improve available bed capacity at any time; certainly there is an opportunity to introduce consistent discharge planning and management arrangements across the acute system to minimise lengths of stay and the effects of bed blocking;
- Supporting investment will be required in the community so that home care services could be available for a longer period of the day and better able to support discharges at short notice;

- Intermediate, sub-acute and long-term facilities to deal with patients discharged from an acute setting but not yet ready for home are lacking, although it is recognised that some improvements have been made in this area in recent years.

A second area of difficulty is the interface between these extended client group services and the generic GP services. GPs and practice nurses provide treatment for a range of patients and continuity of care for the individual and family is seen as an important principle of care. GPs provide care both for those presenting for the first time and those with chronic conditions that do not need hospital care. They consequently have a key role in chronic disease management.

If the health service is to provide an effective, integrated service for patients such as the elderly or those with chronic diseases, closer integration of GPs and hospital care is required. This could include:

- Shared protocols;
- Joint clinics;
- Shared training and development.

But this has to take place in an environment in which GPs are self-employed, frequently working single-handed and where many of their patients are not being funded by the public health care system. (This is less likely to be the case for many of those with chronic diseases, whose medication may well be funded under various schemes operated by GMS. Also, the proposed extension of GMS membership to all the elderly will reduce the number of patients with recurring problems who are not seen by a GP at public expense.)

A third difficulty is the current lack of shared records between different parts of the health service. An integrated service is likely to work best with integrated records. Increased scope for sharing of information, with appropriate protection for confidentiality and patient consent, potentially through electronic records in the future, will be an important element in the development of integrated services that cut across traditional institution boundaries.

There was clear support in our interview programme for further development of service integration between hospitals, GPs and community services. This could be through shared protocols and shared audit, where the development of an integrated approach to chronic disease management may be particularly effective in reducing avoidable referrals and admissions to hospital and in improving patient care.

The development of GP units in Health Boards is clearly a first step in the development of:

- A more coherent local strategy for primary care;
- Improved integration and co-ordination of services across the hospital and community.

GP units have considerable potential to develop improvements in services and value for money. However, they are likely to need significant resources to do this in the early stages and may warrant increased investment and staffing now.

8.11 OUTCOMES AND VALUE FOR MONEY

The Irish hospital system currently has a serious lack of well-developed and widely shared clinical audit. Recent clinical enquiries in the UK have shown that it is possible for local clinical standards to depart from the acceptable level, over a period of time, without sufficient information being available and without sufficient knowledge of the situation being shared. (In practice, these enquiries also show that information may have been available but effective action was not taken early enough.) The level of malpractice suits and the cost of claims is also rising in health care systems generally. Ireland is no exception.

It widely held that clinical audit remains under-developed in Irish hospitals. It is accepted that this may reflect:

- Availability of resources for audit activities;
- Willingness by consultants to undertake audit;
- A funding system in which payments are not based directly on each patient treated so that the financial need to obtain data on every patient is more limited than in other systems. (For example, some European and American insurance schemes are potentially best placed to assess outcomes because they receive comprehensive claims data on individual patients and can spot, for example readmission at another hospital following initial treatment or return for treatment some time after an initial negative screening test.)

To safeguard standards and to improve value for money, wider development of clinical audit, through local and national data collection and sharing of outcomes information, is an essential prerequisite. Without data on the outcome of interventions for cancer, for example, the return in health gains from the current investment in cancer services cannot be readily assessed.

Some of those interviewed in our study expressed concerns that, while the recent investment in cancer reflects a laudable desire to meet the needs of patients with a very serious illness, the actual improvements in outcomes and the cost of achieving them may be questionable:

- Investment in a wide range of cancer services may, for some conditions, be a relatively a poor investment of public funds, compared to alternatives in treatment and prevention of other cancers;
- There is little routinely and widely collected data to judge the value for money of this or other clinical initiatives.

Associated with concerns about clinical audit, there are also concerns in the hospital system about the quality and availability of other clinical information needed for the management of patients. Outcome measurement in general is poorly developed in Ireland as elsewhere. An evidence-based approach is required supported by a core of performance indicators focussing on the major illness categories. Information systems to facilitate population surveillance and improved risk management of disease and illness are required. A Unique Patient Identifier is central to the achievement of these objectives. This is considered in Section 7 on information systems as a whole.

8.12 INNOVATIONS IN HOSPITAL SERVICES

Although our programme of interviews identified many managers concerned about the appropriateness of current services and the feasibility of developing more effective local networks of services, we also encountered a range of innovations in hospital services. These include:

- One Health Board reported a risk management project in obstetrics in conjunction with the Medical Protection Society;
- One Health Board is having its local pathology service assessed under an accreditation programme;
- One Health Board has piloted direct access to surgery, which removes the need for outpatient visits;
- One Health Board has a full-time nurse in each hospital responsible for liaison with other services;
- Patient advisory initiatives being undertaken;
- Risk Management projects being undertaken in Dublin hospitals;
- Pre-admission screening has been developed in at least one hospital. This reduces length of stay in hospital and delays awaiting test results;
- One Health Board is developing new roles and services for one of its smaller hospitals including a medical assessment unit and more closely integrated accident unit with strong links to larger local units;
- One Health Board reported on a pilot study in orthopaedics, prioritising those who need a hip replacement. This can help with waiting list management but also raises issues about the appropriate wait for lower priority cases;
- One Health Board reported a review of the scope for rationalisation of laboratories. This will develop a local strategy and look at the location of labs to avoid duplication. In practice this may also be driven by a shortage of pathologists in Ireland and the UK.

These initiatives are all of interest and have the potential to contribute to improved value for money. But what is lacking is a more consistent national strategy, backed up by appropriate review systems, to ensure that efficient practice develops more widely and that lessons from innovations are more generally learned and implemented.

8.13 HOSPITAL AUDIT AND ACCREDITATION

A number of those interviewed during the project noted the lack of a comprehensive system of hospital accreditation in Ireland.

Hospitals are complex institutions with a wide range of services and facilities. Some of these can only be adequately assessed by specialist audits while others are controlled by similar processes across a range of departments and activities. Hospital accreditation schemes exist to check and confirm the existence and operation of appropriate standards across hospitals and have become a key feature of the governance of hospitals in several countries.

Accreditation is not of itself a solution to a hospital's problems but an external assessment of standards and methods of working can highlight difficulties, which can then potentially be more clearly understood and more readily dealt with. Ireland has lacked an accrediting body focused on the delivery of health care as a whole or on the quality of services across hospitals. Rather,

where hospitals are assessed, it is often from the perspective of the professionals and to assess suitability for training staff. (For example, hospitals are assessed for approved training posts in each medical specialisation.). A comprehensive system of accreditation needs to be introduced. building on the pilot schemes already in place.

More generally, it is of concern that the resources of the Comptroller and Auditor General, and the demands upon them, limit the ability of the C&AG to devote any substantial amount of time to the audit of value for money in health care. Relatively few reports on value for money of current services exist.
A substantial investment in a regular programme of value for money appraisal, whether carried out by public sector auditors or outsourced, has the potential to achieve a significant payback in improved value for money in health services. This is likely to require the establishment of a significant group of specialist health service auditors within the C&AG.

A further source of potential payback from improved accreditation should arise from medical negligence claims and insurance. Under enterprise liability arrangements, any systematic attempt by hospitals to review their systems and approaches to key risks could contribute to reduced claims and reduced costs for insurance (or financial provision for future claims). Medical negligence claims grew substantially over the 1990s and so the sums of money involved in future claims may become more than large enough to justify a significant investment in audit and accreditation.

8.14 WAITING LISTS

The public health system offers free eligibility to all the population and health services are provided through regional Health Boards funded substantially through annual allocations from the Department. Boards are responsible for the planning and delivery of acute and special hospital programmes, and community care services. Voluntary hospitals play an important part in the provision of acute hospital services, particularly in the ERHA region. These have historically been funded primarily by allocations from the Department supplemented by income from the Voluntary Health Insurance Board. Funding in the future will be through regional Authorities/Boards. Private hospitals, although a relatively small part of the overall acute hospital system, nevertheless play an important role in the provision of service and are dependent to a very high degree on income from the VHI.

The relationship between public and private medicine in Ireland is not one between two separate parallel systems, rather one in which both private and public elements are closely intertwined.

The interaction of the two systems is a continuing source of debate, on issues such as the true economic cost of private beds in public hospitals, comparative waiting lists between the two streams, and the balancing of the public and private patient case loads of consultants engaged under public common contracts etc.

The existence of waiting lists is not peculiar to the Irish Health System. They exist for numerous reasons including, acute hospital system capacity, structural capacity issues outside the acute hospital system, ever increasing demands for health care and the possible incentive that waiting lists can force people to opt for private treatment.

Perceived problems in relation to waiting lists get significant coverage in the media at present. Undoubtedly there are problems managing waiting lists, but arguably the debate should centre on how long people wait for treatment as opposed to the numbers that are actually on waiting lists. The numbers on waiting lists in fact represent a small percentage of the overall numbers treated in the system. Focusing on the relative numbers waiting for treatment obscures the real nature of the problem. Significant additional investment has gone into dealing with waiting lists and while there may be a correlation between additional funding and reductions in numbers awaiting treatment, this does not necessarily equate to a simple input output rule. This

questions whether investment in waiting lists equates to VFM. Certainly many of the stakeholders in the system do not view waiting list investments in their specialties as investment in reducing the numbers waiting. Rather it is viewed as the investment required to deliver the planned for level of service i.e. it is seen as meeting perceived or actual deficits in core funding.

The Report of the Review Group on the Waiting List Initiative made a number of valuable short medium and long term recommendations. These recommendations included the following organisational initiatives, which could be implemented quickly:

- Carry out a study on hospital capacity as matter of urgency.
- Ensure agencies review their management information systems to check that waiting list data was accurate and up to date, and that the data could be maintained in such condition.
- Hospitals were asked to carry out a postal review of patients on their waiting lists and put in place an agreed protocol for periodic further review.
- Improvements in terms of the operation of waiting lists at hospitals, including improved flow of information between primary and hospital care, continuing the move to day case, the appointment of bed managers and bed utilisation committees etc.

It can be seen that the recommendations cover capacity, validation, operational and information issues. In our view, these are the issues.

Within the Irish system, the utilisation of the bed capacity is running at an average of 85%. In some cases, occupancy levels frequently exceed 100%. Best practice internationally recommends a maximum level of utilisation of c.80%. On this basis it is easy to understand why waiting lists exist. The current infrastructure is beyond capacity, its activity year on year is increasing significantly, and hence it stands to reason that this limits the ability to significantly reduce the numbers on waiting lists.

Validation of waiting lists, a process which really only began in earnest in recent years, is important and has to happen on an ongoing basis. There are many reasons why patients are crossed off waiting lists including at the request of the patient; duplicate records for the same patient; non attendance at pre-booked admission dates; the patient being on different agencies waiting lists for the same treatment; the patient having had the treatment completed elsewhere; the patient has died; the patient having changed address; the patient no longer needing the treatment; or the consultant deciding to take the patient off the list for medical reasons.

It is believed that the validation exercise was responsible for a significant reduction in waiting list numbers. The postal review was an important part of this, and there was some reactionary fallout from a media perspective, when people were surveyed who were deceased or had moved address.

Whilst the extent to which each measure contributed to a reduction in waiting lists, the fact is that the numbers now are much more accurate, and as such provide a basis for more focused targeting and/or prioritisation.

Further steps recommended for implementation in 1999 entailed focusing waiting list initiative funding on a limited number of specialties, the development of protocols for the assessment, validation and prioritisation of cases, and the development of measures to reduce the pressure from Accident & Emergency services on acute beds. A further medium term measure was for the Department to incentivise hospitals to improve their waiting list performance. It was noted that the existing system of allocating waiting list funding had the potential to act as a disincentive to improve waiting list performance.

In addressing the problem in the longer term, the main focus is based on changing and/or increasing the overall infrastructure, in particular in terms of bed capacity, and in meeting some of the current gaps in terms of service provision.

The principal gaps are in the areas of day investigation facilities for the elderly, rehabilitation facilities, community based support services and long-term residential care places. This requires an evaluation of the gaps in service provision at a regional level such that a planned programme of investment in appropriate facilities can be established. The main objective is to eliminate/reduce the level of inappropriate use of acute hospital facilities. In addition, to this consideration needs to be given to:

- the development of Geriatric Day hospitals on the site of acute hospitals
- the development of rehabilitation facilities on acute hospital sites where they do not already exist

The Report of the Review Group on Waiting List Initiatives was published in June 1998. Data relating to the period since the report, in terms of numbers on waiting lists and investment in waiting list initiatives, is set out in table 8.1 below.

The significant reduction in waiting lists in 2000 also needs to be considered in the wider context of what has been achieved within the health system given that it is estimated that the hospital system treated 868,000 patients in that year, up c.5% on the previous year. Given that the validation process has been running since 1998, it is unlikely that validation has contributed to this significant drop. Undoubtedly validation will account for part of the reduction, as the reasons described above for validation require ongoing validation processes.

Table 8.1: Investment in Waiting List Initiatives, and Numbers on Waiting Lists between 1997 and 2000

Year	Investment £m	No.s on Waiting List (figures are based on end of December Data)
1997	8.0	32,206
1998	12.0	36,883
1999	20.0	36,855
2000	34.6	27,857

The figures do, however, hide the fact that a significant number of people are on the waiting lists for periods of time longer than the national maximum time targets (no longer than 12 months for adults and 6 months for children)

Table 8.2: Percentage of patients on Target Specialties' Waiting Lists longer than the accepted norm as of 31 December 2000

Specialty	% of adults over 12 months on waiting list	% of Children over 6 months on waiting list
Cardiac Surgery	53.78	67.44
E.N.T	61.53	80.32
Gynaecology	32.71	N/A
Ophthalmology	26.82	69.26
Orthopaedics	47.26	35.98
Plastic Surgery	67.59	84.50
Surgery	34.43	45.39
Urology	57.33	47.37
Vascular	65.03	100.00
Weighted Average of these Specialties	49%	74%
Actual number of Cases	10,337	2,146
Comparable figures for 1999		
Weighted Average of these Specialties	51%	75%
Actual number of Cases	14,833	2,719

Waiting times for adults and children have only improved in less than half of these specialties. However, the percentages hide an overall improvement, given that in all the specialty categories the actual number on waiting lists has reduced i.e. in the table above the overall number on the waiting lists in these categories has reduced by 29%.

Waiting lists are major areas for concern, particularly if you are actually on one, however they need to be seen in the wider context. The current waiting list as a percentage of the total number of people treated in the public hospital annually system is of the order of 3%. Waiting lists (relating as they do to elective procedures) represent 20% of annual elective cases, (public & private) in public hospitals, and 25% of the annual public elective caseload in public hospitals. Unless there is excess capacity in a health system, it is difficult to see how waiting lists will not arise for elective work. Excess capacity brings with it a cost which would not be justifiable in VFM terms. The issue is how one balances demand for elective services against capacity, and in the Irish system this relationship is out of equilibrium. Furthermore, it should be recognised that as consultant manpower is increased, it is possible that activity and associated waiting lists will in fact increase; the issue will be how long patients are waiting for care.

Access is one of the primary reasons why people take out private insurance. One suggestion to provide greater equity of access to publicly funded services, has been the introduction of a common waiting list. Under such an approach, elective admissions would be prioritised in order of medical need, irrespective of whether the patient is seeking to avail of public or private accommodation. The introduction of such arrangements may indeed improve equity of access. However, we believe it would be difficult to monitor such a system, which would require co-operation of the medical profession in agreeing to and applying admission protocols, and significantly improving data collection. The obvious risk is the classification of an increasing number of patients as urgent to move up the list. The introduction of a common waiting list would also mean that beds currently designated as private would be available for public patients – effectively the availability of a dedicated stock of private beds in public hospitals would reduce, and even in time could disappear. This could adversely impair private medicine, reduce the attractiveness of the public health system to consultants and make insurance less attractive.
The adverse consequences of these issues needs to be understood and accepted before any discussion on a common waiting list is taken, including the likely increase in public patients (as private insurance membership potentially drops) and the negative impact on the development of the health insurance market.

Whilst there has been an enormous focus on waiting lists in the Irish health system, arguably more attention should be given to additional ways of addressing the waiting list problems. Apart from completion of the measures indicated above, particularly those related to increasing the capacity in the system, others are through;

- Clinical governance
- Better relationships with GPs
- Entitlement to service measures that provide parity of access – it may be appropriate to manage waiting lists at a national level rather than at a unit level to ensure parity of access to treatment across the country. This has its own difficulties in terms of the independent relationship between the consultant and the patient, and difficulties in relation to patients having to travel greater distances etc. The development of a national waiting list would be greatly facilitated by the development of a patient index system, which would uniquely identify each patient in the system.
- Reallocation and protection of surgical beds
- Providing better management of waiting lists
- Assisting Boards to search out more efficient and innovative ways of delivering services.
- Development further opportunities for day cases, for example:
  - better pain management
  - use of new anaesthetic agents
  - improved management of post operative nausea
  - use of minimal access surgery
  - changes in patients' selection criteria
  - longer opening hours or use of hotel facilities
  - widening of the role of the GP in treating patients

In summary, it is our view that the full implementation of the recommendations arising from the Report of the Review Group on the Waiting List Initiative will have a significant impact on waiting lists in this country.

8.15 URGENT CARE - AMBULANCES

Urgent care is care provided for medical and surgical emergencies. It includes services provided by emergency ambulances and Accident & Emergency departments.

The period of the 1990s was one in which increased investment in urgent care was accompanied by continuing concern that services were not sufficiently well developed to achieve maximum effectiveness. In 1993 the Review Group on Ambulance Services:

- Defined the main functions of ambulance services and the role of Health Boards in managing service quality;
- Expressed concern at the variability in approach, including the use of ward nurses in some areas to crew ambulances;
- Recommended the establishment of a National Ambulance Advisory Council;

- Recognised the need for modernisation and reorganisation of command and control centres.

The national health strategy, "Shaping a Healthier Future", in 1994 included proposals for:

- A significant improvement in the quality of ambulance services through the implementation of the 1993 report;
- Development of the ambulance service as a pre-hospital service with strong ties to acute hospitals.

In 1997, the Comptroller and Auditor General (C&AG) carried out a review of ambulance services. This noted:

- Concern with the slow pace of implementation of the 1993 report;
- Concern with the effectiveness and efficiency of existing services;
- Concern with a lack of agreed standards of service or mechanisms for the audit of services against those standards.

Building Healthier Hearts, in 1999, also considered ambulance services since these can play a significant part in early treatment of heart attacks and related conditions. This latest policy document noted:

- Continuing concern with the variable progress in the implementation of the 1993 review of ambulance services;
- The need to improve and to standardise quality of services and indicators of the quality of service across the whole ambulance service nationally.

In our review of pre-hospital services with a range of stakeholders in the health service, we identified several issues, which suggest that difficulties dating back to 1993 have yet to be fully addressed.

There was a perceived need for improved protocols that would link different types of patient to specific types of hospital. Benefits are anticipated from use of the correct hospital for each type of patient, including improved quality of clinical care and improved management of patients in Accident & Emergency departments.

Several Health Boards noted that nurses were still used to crew ambulances, for example for maternity cases. This means that ambulances have to spend time collecting the nurse en route to collection of the patient. This is seen as inappropriate in that it delays the arrival of the ambulance with the patient and subsequent arrival at hospital. It may also misuse nurses' time. Potential and actual conflicts between ambulance staff and nurses were noted, which may reflect historic divisions in training and perceived standards of care provided between nurses and emergency medical technicians.

Several staff at Health Boards noted the advantages of improving training for Emergency Medical Technicians (EMTs) so that they could undertake more activities, including stabilising patients prior to arrival at Accident & Emergency. This could improve quality of care and would reduce pressure on Accident & Emergency departments. There are, however, both training and, potentially, legal issues to be addressed before this can happen.

Several Health Boards indicated that continuing industrial relations problems are affecting the development of ambulance services. In some areas, the implementation of the standard data collection form is still proving difficult.

Health Boards are concerned at the poor information that they are able to obtain on ambulance services. All those interviewed indicated a desire to improve infrastructure, particularly information systems. However, some local political issues, for example the desire to telephone a local base, were seen as limiting the rationalisation of command and control centres for ambulances.

Currently, the separation of emergency services and patient transport is seen as inadequate in some areas. Staffing of patient transport services with EMTs who also respond to emergency calls means that regular transport of outpatients can be seriously disrupted by emergency calls. Where patient transport services were more clearly separated, a number of Health Board staff noted large overspends on taxi services and inadequate funding allocated for patient transport. The fact that patient transport is chargeable to non-GMS patients was seen as unhelpful and likely to discourage some patients from using the service.

Overall, the impression gained from the current study of value for money is that many of the issues seen by the C&AG in 1997 as potentially improving services and contributing to greater value for money have not been addressed. One Health Board, for example, reported that its Ambulance Control Executive Group had been in abeyance for some time.

Ambulance services make up a relatively small part of the health care budget but can have an important impact on:

- The outcome of urgent health problems;
- The experience of patients having to travel for routine care.

Currently, the shortcomings of the ambulance services identified by earlier reviews have not been fully addressed. This may reflect the limited resources and substantial management agenda of Health Boards but it remains a serious concern after close to a decade of review and repeated review.

8.16 ACCIDENT & EMERGENCY SERVICES

A fundamental issue with particular relevance to Ireland is the size of accident departments. There is a move in the UK and in Europe to provide urgent care for seriously ill patients by:

- Having fewer major providers of services for serious illness and accidents;
- Treating minor injuries in less specialised facilities or through GPs;
- Sharing less serious work between doctors and nurses so that the most skilled resources can be kept free for the most serious cases;
- Establishing a network of centres to deal with major trauma.

The evidence on the contribution of service organisation to outcomes is limited. Some studies have found that minor hospitals are reasonably effective in dealing with urgent care. US studies support the advantages of major trauma centres, which have less frequent procedural mistakes and fewer avoidable deaths. Rapid access to an emergency operating facility and observation wards for monitoring of elderly and head-injured patients are also seen as key facilities for optimum patient management.

A particularly important feature to emerge from several reviews of the evidence and performance of accident departments is the need for senior medical input. Junior doctors in accident departments are often very junior and require skilled and experienced support. This is best provided by consultants. However, unless there is a team of about six to eight consultants, it is not possible to offer such support round the clock.

Many Accident & Emergency departments in Ireland continue to have no consultant staff, in spite of recent initiatives to recruit more. Some Board staff expressed a concern that additional consultants would not on their own resolve local service problems:

- One consultant is not of great value because he can only cover a department for a limited amount of time;
- Three consultants, for example, (due to additional recent recruitment) could cause other problems, in the absence of a clear strategy for Accident & Emergency, since their location in three departments could cause problems of competition for resources while provision of one per department would do little to raise standards.

Health Board staff also raised concerns about the quality of service available from NCHDs in Accident & Emergency departments at busy times where there is no consultant supervision. In the future, failure to provide sufficient consultant cover could lead to loss of accreditation of junior doctor jobs in smaller Accident & Emergency departments.

Ireland has recently attempted to recruit a substantial number of Accident & Emergency consultants to improve services. Although the number of posts to be filled was relatively large for a single round, many smaller acute hospitals in Ireland will remain without adequate consultant staffing in Accident & Emergency.

In the course of the present study, a range of factors, which may reduce the value for money of Accident & Emergency units, were noted.

- Some Health Boards currently operate several Accident & Emergency departments, which could ideally be rationalised and restructured;
- Frequent reference is made to local political factors, including the views of local clinicians, that militated against change in Accident & Emergency services;
- The lack of a national strategy for Accident & Emergency is a barrier to change locally.

There is scope to improve Accident & Emergency services through the development of trauma units, which could stimulate further change in the system. Services could be run in future on hub-and-spoke models with a central Accident & Emergency service, with two consultants, providing support for a local network of Accident & Emergency departments.

There are a number of concerns on aspects of management of Accident & Emergency services which arise in some (but not all) areas of the system:

- The lack of application of effective systems supported by evidence, for example triage and associated streaming of major and minor cases;
- The lack of agreed standards against which Accident & Emergency services could be benchmarked;
- The management of follow-up patients;
- The slow introduction of Medical Admissions Units.
- The lack of consistent, timely, reliable information on Accident & Emergency activity across the health sector.

Concerns also arose in our interview programme about the management of less serious illness in accident departments. Accident & Emergency departments in hospital see patients presenting with urgent conditions. However, since these departments are open to the public, this includes

patients who may see their problem as requiring more rapid treatment than can be provided by a GP, even when the problem itself would not be classified medically as an urgent problem. Self-referring patients may therefore attend an accident department as long as they expect to be seen more rapidly than by the GP. If a GP is not available until the following day, for example, a patient concerned that they might be seriously ill may be prepared to wait a long time. Non-GMS cardholders also pay a fee for attending the Accident & Emergency department.

The consequence of the "walk-in" access of Accident & Emergency departments is that there may always be a queue for non-urgent care. If additional resources are used to reduce waiting times, this would make the department even more accessible than the GP and potentially lower the threshold at which patients self-refer. That is, faster service could reduce waiting times, push up demand and lead in turn to the same wait but with more patients! To try to reduce this element of demand on Accident & Emergency departments, health care systems in Europe are encouraging use of telephone advice services and improved access to primary care as an alternative to attendance at Accident & Emergency. There is also scope for introducing nurse practitioners to deal with less urgent problems, though for legal reasons it may be difficult to deny attendees some access to a doctor.

There was also concern about the potential impact of the lack of integration of hospital and GP services. Many Health Board staff indicated that they believed too great a number of attendances at Accident & Emergency were "inappropriate". One Board has interviewed attendees to find the reasons why people attended an Accident & Emergency department. The reasons include:

- A belief that it is a more appropriate place to attend than a GP surgery;
- Because of the nature of their medical condition;
- That they had to attend outside normal GP working hours;
- That the cost (or perceived cost) of attending Accident & Emergency was less than the cost of seeing a GP for non-GMS cardholders.

In our programme of interviews, Board staff also raised a number of important issues about non-consultant staffing of accident departments, linked to the management of less serious illness. These concerned in particular:

- Extended nurse practitioners;
- The role of GPs.

There is undoubtedly value in developing an extended role for nurse practitioners in Accident & Emergency; we recognise that industrial relations issues may arise in trying to achieve this objective.

GPs are now widely employed in the UK to treat minor illness in Accident & Emergency departments. We understand that they are not so widely used in Ireland although there are some initiatives in this area. Some Board staff suggested that patients attending Accident & Emergency might regard GP care as inappropriate, given their perception of the severity of their problem. However, it should be noted that GPs are typically more experienced than the grade of staff normally seeing patients in Accident & Emergency, the junior hospital doctor.

8.17 OUTPATIENTS

Outpatient departments carry out several specific functions:

- New patients, referred by GPs for diagnosis and assessment, are examined by consultants and decisions are made on their future treatment;
- In surgical specialties, the key decision is whether to operate on the patient or not;
  - patients requiring surgery will be added to a waiting list;
  - patients unsuitable or not needing surgery will be discharged or referred to other clinicians, for example physicians, therapists;
  - Some patients may be kept under regular surveillance to see if their condition changes so that they need surgery in future;
- In medical specialties, the key decision is the treatment plan for the patient. This may involve:
  - Repeat attendances for the patient at outpatients for ongoing review and management of their condition, which may include further diagnostic tests and procedures;
  - Referral back to the GP for ongoing review and management, with or without periodic review by consultants or junior doctors as outpatients;
  - Discharge, as no ongoing management is needed for the patient;
  - Referral to surgeons for cases assessed as most suitable for surgery.

The greatest difficulties and delays usually occur for returning review patients. The separate problem of waiting for an appointment for a new problem is, comparatively, a simple capacity problem where the number of new patient clinic slots does not match the number of referrals per week. Extending the hours within which out-patient clinics are operated should be considered. There is also scope in the Irish system to apply significantly improved management and validation processes to out-patient waiting lists, in line with the processes already being implemented on inpatient waiting lists. The establishment and measurement of agreed performance indicators for outpatient activities is essential.

Ongoing review of patients may require a large number of patients to return to hospital regularly. Experience suggests that they may wait a long time to be seen and then be seen briefly, by a junior doctor, who may spend a short time with them and tell them to carry on with their current treatment. This means a long wait for a short consultation. It occurs for several reasons:

- Consultants are reluctant to discharge continuing care patients to GPs for longer term monitoring and management, or GPs are reluctant to take them on, so that the number of patients returning for regular review is large and can only be accommodated in large clinics with a short time slot per person. If a patient has deteriorated and needs more time, this disrupts the clinic schedule;
- Because of the number of patients and the need for many to continue with current therapy, it is appropriate for junior doctors to carry out some consultations. But patients may feel they are getting an inadequate service, particularly if they have waited a long time.
- Inadequate management of the out-patients timetable.

We understand that problems of this kind occur in many hospitals in Ireland. A key factor in resolving this is the future of integrated care, in which GPs and hospital specialists share a protocol for care of chronic disease patients such as asthmatics or diabetics. This may require GPs to set up specialist clinics in their practices, for example monthly clinics when the patients in question attend. It also requires broad agreement between the GPs and hospital specialists on how the service will function.

Integrated care is, in our view, relatively underdeveloped in Ireland, though the lack of detailed research and evaluation makes it difficult to validate this view.

A key issue in the introduction and development of integration is the status of general practitioners. GPs are self-employed professionals. As such, they cannot be given directives of the kind that might characterise for example a national curriculum in schools. In addition, for a large number of Irish citizens, their general practice treatment is not funded by the State. In our assessment, while we cannot document specific difficulties caused by this, it does not appear to be a framework in which shared care is likely to develop strongly. GPs may also resent the intrusion of the State, through for example shared care protocols, into a private transaction between doctor and patient.

The more general issue of self employment of GPs, even when wholly serving public patients, (as in the UK), remains a barrier to the rapid development of integrated care in many places (though not the only barrier). It is accepted that the future employment status of GPs in Ireland is not likely to change without considerable negotiation and so it may have to be accepted that some elements of integrated care will only develop slowly.

SECTION 9: PRIMARY AND COMMUNITY CARE

9.1 INTRODUCTION

In this section, we examine the organisation and management of primary and community within the Irish health care system. These areas cover a broad of activities which span (but are by no means limited to):

- General Practitioner Services (GPs)
- Public Health Nursing
- Community Pharmacies
- Community Drug Schemes
- Childcare
- The Elderly
- Physical, Sensory and Intellectually Disabled Persons
- Psychiatric Services
- Ophthalmic Services
- Women's Health
- The Travelling Community
- Services for the Homeless
- Palliative Care
- Asylum Seekers
- Environmental Health

This section is intended to give a high level overview of the main issues at hand.

We start off this section by focusing particular attention on GP services owing to the pivotal role they play in primary health care and also because of the gatekeeper role they have in relation to many acute/specialist services.

The points raised in this section should also considered in conjunction with Section 5 which examines expenditure on GMS services and related payments, and Section 8 which examines acute hospital services.

In Section 10, "Other Welfare and Care Group Issues" we review in greater depth how primary and community care issues have impacted on the range of services provided to a number of specific care groups.

9.2 GP SERVICES

9.2.1 Policy on GP Services

The development of GP services and their role in the Irish health care system has been informed by a number of key policy documents:

- In the mid-1980s, a Working Party was established to carry out an examination of the GMS system. As part of this, it defined the factors that contribute to a quality GP service:
  - Ready and immediate access to services by patients, regardless of means;
  - A close personal relationship between the GP and a constant group of patients, through registration of practice populations;
  - A holistic approach to care;
  - A focus on prevention and anticipatory care, as well as treatment;
  - An ability to reach fully rounded diagnoses.

- Shaping a Health Future, which noted that GPs are the first contact of patients with the health care system (though of course Accident & Emergency and ambulance services also perform this function), and play a key role in the diagnosis and treatment of diseases and in the provision of continuing care for persistent and chronic conditions through the monitoring and management of medication. This strategy document did propose that GP services should be better organised and supported in fulfilling a wider and more integrated role in the health care system. In particular, 'Shaping a Healthier Future' noted that:
  - GPs are self-employed and are separate from both hospital and community care services.
  - Health services are relatively compartmentalised with insufficient sharing of information and patient management.

These policy documents emphasised the influential role of the GP in the provision of an efficient and effective health care service, and the relative importance that is attached to linkages with other primary, community and acute services. 'Shaping a Healthier Future' highlights the difficulties that exist around service integration and organisation of GP services, both of which are considered below.

9.2.2 Service Overview

It is estimated that there are currently 2,500 GPs in Ireland, of which 2,250 are active in practice. Of these, it is estimated that almost half are self-employed, single practitioners, although this number is falling i.e. in 1984 they represented 59% of active practitioners, compared to 42% today. The GMS choice of doctor scheme has over 1600 participating doctors.

As discussed elsewhere in the report, the Health Vote has since 1993 included an allocation for the development of general practice. This gave rise to the General Practice Development Fund and the General Practice Capital Fund. The purpose of the latter was initially to provide funds for GP practice investment pending the coming on stream of drugs savings monies. The fund has continued to provide monies to target particular development areas such as practice nurses, secretarial subsidies and vocational training.

Funding has also been provided for the GP/primary care units and for pilot initiatives. While the benefits of the initiative have been acknowledged, some issues arise in relation to the impact on the quality of prescribing decisions. Monies have also been made available to GP practices under the Indicative Drugs Target Saving Schemes as discussed in Section 5.

Among the key changes which have taken place in recent times is the establishment of GP Units in each Health Board. These units have already developed a range of initiatives to improve local GP services, examples of which are set out below:

- Incentives for the improved organisation of general practice such as GP co-operative arrangements.
- Assistance to practices to develop a wider range of services.
- GP participation in reviewing Accident & Emergency services / arrangements in regional hospitals to improve services and liaison between GPs and Accident & Emergency.
- The introduction of a regional system to inform GPs of the outcome of referrals or self-referrals to Accident & Emergency.
- Improved data collection and data sharing, linked to electronic data collection through the GMS scheme.
- A review by GPs of their patients on hospital waiting lists.
- The development of medical protocols for homeless persons.
- The recent development of performance indicators including the percentage of GPs employing practice nurses, the percentage of GP practices with two or more doctors, the rate of computerisation, the number of female practitioners, etc.

Our review of Health Board service plans has indicated that increasing emphasis is being placed on supporting the role of the GP through efforts to provide a more interactive process between all providers of care in the community. In many cases, this has been formalised through the preparation of a primary care strategy and related action plan. Objectives under these plans include a census of GPs and their services, piloting of out-of-hours co-operatives, increased computerisation of practices and the development of practice interface with the acute and community services.

Many GP Units in Health Boards have developed into Primary Care Units reflecting the Department's objective to develop GP services as an element of a Primary Care team. Primary Care Units are now also regarded as having a pivotal role in service integration and in the implementation of primary care strategies (where developed). We identified a number of on-going initiatives that these units are administering, including the organisation of regular meetings with Consultants and the inclusion of GPs on Committees such as Hospital Advisory Committees and Laboratory User Groups. Some Primary Care Units are also providing advice and information to GPs on general prescribing costs and an assessment of the effectiveness of various treatment options. Finally, we understand that Primary Care Units are in the process of establishing GP databases the purpose of which is to collate relevant information pertaining to GP practices within each Board.

Other positive changes that have taken place include:

- The development of a national drugs information unit to support GPs.
- Support for the Irish College of GPs in their development of quality assurance measures for primary care.
- The development of shared protocols for services, which can be provided across hospital and primary care.
- The development of screening programmes for vulnerable children.

9.2.3 Issues

- Single practitioners are increasingly viewed as being less conducive to effective working owing to the risks of professional isolation, inadequate infrastructure and the absence of a team approach to providing primary care. In more recent years there has been a trend towards the development of co-operative type arrangements between GPs serving a particular area / region. In some instances, a regional base has been established to receive patients and address telephone calls. Among the key benefits attributable to such arrangements include improved management and organisation of out-of-hours services, and the provision of services that are determined by population needs rather than the preferences of the practitioner(s) concerned.

  Other key improvements arising from the co-operative approach relate to improvements in the working conditions of GPs through the sharing of work between a wider pool of doctors. This is especially true of rural practices and is perceived as being a very important factor in attracting more students to GP practices and to rural locations.

  It was not surprising to find there may be an initial level of resistance to a regional service by local communities. Further work and definition is also required around funding particularly in relation to how private doctors get paid for GMS patients.

- Overall, the self-employed status of GPs is well-established in Ireland and it is likely to be difficult to change. However, we feel it noteworthy that in such a situation, it is unlikely that a high level of service integration can be achieved with acute or community services regarding shared services, shared records or other activities. This model also effectively leaves much of primary care to the market and to the decisions of individuals to seek care, or not seek it, as they see fit. The inclusion of a charge to attend GPs could be a disincentive to patients to seek effective care at an early stage, as shown by research in other countries on health care pricing. Likewise, it must also be considered that there is a general lack of incentives available to encourage GPs to become involved in co-operative arrangements. The level of investment required in infrastructure, etc is quite frequently prohibitive for many younger doctors forcing them to set up a single practice at home. One possible solution that has been put forward to overcome this (discussed below) is the development of polyclinics/medical centres.

- Policies on GP practices primarily support continuity of care and registration of patients with a particular GP. However, in the non-GMS sector where individuals are free to visit any GP, there is an absence of a formal registration process, although in practice it is widely believed that relationships are well developed, especially in local communities. There is a fear that in the absence of reliable registers of the practice population, there may be deficiencies in services such as screening and vaccination.

  While scope exists to extend the current GMS system, the cost benefit associated with this approach would have to be comprehensively defined and analysed in the context of future Departmental strategy. A comprehensive patient register would require the co-operation of private practitioners to make available details of their patient register.

  In our view, any consideration of extending eligibility to a range of free GP services should be selective, for example to promote health preventative measures, and for specific groups, for example, the elderly (to reduce inappropriate acute hospital admissions). We do not however advocate a free GP service, and to achieve this may in any event be complex given the self- employed nature of general practitioners and the financial rewards associated with private patient income.

- Another issue that arises under continuity of care is the requirement for the Health Boards to negotiate on a fee-per-item basis each new initiative that is introduced. There are strong arguments to support the broadening of GP services particularly in the areas of health promotion and preventative care on a fee per item basis. There is a view that there needs to be a greater focus on funding the implementation of national strategies at GP level, particularly with regard to preventative measures.

- Throughout the public and private sectors, there has been a lack of a concentrated effort to transfer manual files into an electronic format. The level of computerisation in General Practice is currently estimated at circa 70%. Whilst this figure is relatively high, there is a widespread view that the level of quality computerisation is no more than 20%, despite the grant assistance in IT training provided by the primary care units in each Health Board. The poor state of IT in general practice is a major concern and will, unless addressed, inhibit integration between general practice and other areas of the health sector. In conjunction with this, there needs to be a review of hospital patient record systems, of which we understand there are currently at least seven different versions, none of which marry or inter-link with GP systems. Some Health Board GP Units are now starting to more proactively track the application of computers in practices.

  The Department of Health & Children has also established the National GP IT Group to promote and co-ordinate better use of IT. The Group has also organised training and is addressing technical issues such as coding standards, quality standards, etc.

  Among the areas that have been identified as requiring attention in the future are patient appointment and recall systems, payment systems (GMS and private patients) and patients' medical records.

  In summary, the overall lack of information in the primary care system militates against planning, monitoring and evaluation and while steps are being taken to address key issues, it is too early to assess the impact of these.

- Significant scope exists to develop stronger links between GPs and the community care sector. One difficulty however, is that the number of public health nurses is potentially too low to allow for the linking of a GP with a public health nurse in every practice.

- There are opportunities for GPs to support the more efficient and effective use of hospital resources, and efforts are ongoing at Health Board level to realise some of these potential benefits. Examples where further improvements could be made include the facilitation of patient records to hospitals, so that patients would not have to be assessed a second time by a hospital specialist. In addition, there is a view that, too frequently, GPs inappropriately send patients requiring admission to hospitals via the Accident & Emergency department. Improved communication and the definition of clear standards and procedures may assist in addressing this issue.

- A view was expressed during the consultation process that the facilities in which some GPs operate are often inappropriate, using consulting rooms in private houses rather than well-equipped surgeries.

- The numbers of support staff employed by GPs (outside of clerical and administrative staff) remains, for the most part, low. As greater importance is placed on the provision of a comprehensive set of services, further emphasis will need to be placed on the skills mix required and linkages with other community services to meet these needs. For many single practitioners, the GMS allowances are insufficient to cover such costs.

- A further concern relates to the small number of practice nurses operating in GP Practices. Data from the GMS Payments Board indicates the number of practices with practice nurses to be less than 400 within the GMS scheme. Generally, it is considered that practitioners outside the scheme are unlikely to have nurses. There is a clear need to extend the number of practice nurses, particularly in light of the opportunities they offer to provide a more cost-effective service.

- The output from our consultation process highlighted that there is a general requirement for a programme of continuous training and development for GPs. GPs are expected to be able to deal with a range of issues, both medical and personal, and specific training is required to support them in their work. This is recognised as becoming increasingly important in light of public demand for improved accountability and the increasing emphasis now being placed on risk management and evidence based practice. Likewise, it is argued that GPs should receive formal training as part of the graduate programme across key business areas such as employment contracts, PRSI, tax, budgeting, etc.

- There is a concern that GPs are to a significant extent only routinely available between 9.00am and 5.00pm, and as such are not meeting the full range of needs that emerge in the community. This undoubtedly impacts on inappropriate admissions to Accident & Emergency departments and contributes to a significant requirement for out-of-hours calls. It also raises issues with regard to service accessibility, service quality and the availability of local emergency services.

  The co-operative structures discussed above have generally been viewed as a positive improvement in better service in those areas where they have been implemented. These include DUBDOC, a Dublin initiative where a number of GPs operate an out-of-hours facility from the campus of St. James's Hospitals, CAREDOC, a GP co-operative in Carlow/Kilkenny and a region-wide out-of-hours GP project that has been developed in the North Eastern Health Board area. Pilots have also been initiated in other Health Boards. There are some concerns about establishing GP services on hospital sites, in so far as it associates service provision with the hospital.

  Incentives for the development of Medical Centres in which a basket of primary care services (physiotherapy, counselling, dietary advice) in addition to general practice are provided needs to be further analysed and reviewed. This could be through taxation incentives for investment in such facilities, and State provision of facilities on a selective basis to GPs entering into co-operative arrangements in such centres. Under the NDP, some provision has been made to enable Health Boards undertake a programme of development for new and existing health centres.

- There are no mechanisms in place to facilitate a regular and meaningful evaluation of GP services. It has been widely argued that there is a greater requirement for service user involvement and feedback into this process. Part of the difficulty associated with measuring performance is the lack of defined quality standards in terms of service efficiency, service outcomes, service accessibility, service equity and infrastructure. However, the ongoing work of the Irish College of GPs, as referenced above, should assist in this regard.

In conclusion, there is a perceived lack of good management practice in the primary care sector, in many instances reflecting the self-employed status of GPs. Many of the issues and concerns centre on the lack of electronic records and the lack of integration with other services. The establishment of the GP Units and the development of Primary Care Strategies should assist in addressing some of the gaps and concerns that exist. However, cultural difficulties exist that may impede the implementation and rate of change in some regions.

In this regard, the proposed introduction of the Unique Patient Identifier (UPI), (discussed in Section 7) could have a key role to play in service integration and in the realisation of improvements in the provision of a more efficient and effective service. Another key benefit of this system is that it links health and personal social services, which are strongly inter-connected in the provision of health services and health promotion.

9.3 COMMUNITY CARE

During the 1990s growing emphasis was placed on moving care away from institutional based settings to a community environment. This has obvious implications on the demands that are likely to be placed on community services against a background of low investment in community infrastructure over much of the same period. In turn, effective community care requires a multi-disciplinary approach to the delivery of services that cuts across primary care and acute care as well as non-health services such as housing and transport. It also requires linkages and co-operation between the statutory sector and the voluntary agencies.

The many deficiencies and issues surrounding the organisation and delivery of community care are continually brought to the attention of the public through media reports on such prominent issues as childcare, drug abuse and the elderly.

While these issues are certainly real and need to be addressed, The Department of Health & Children and the Health Boards are now in many respects unrealistically expected to have a quality service in place despite having only recently received the funds to do so. The progress that has been made should be acknowledged especially in terms of:

- Significant investment in respite, residential and day care services.
- The development of home-help services.
- The creation of additional posts across key professions.
- The establishment of regional co-ordinating committee structures and project managers to progress service delivery and define service issues for specific care groups.
- The implementation of care group structures.
- Strengthening relationships with the voluntary sector and further clarification of roles and responsibilities with other Government Departments.
- The development of performance indicators.

9.3.1 Key Issues & Challenges

Among the main issues and challenges to be addressed are:

- Community nursing services have developed under separate Board management arrangements from primary care. To a degree this is inevitable due to:
  - The independent contract status of GPs, which makes it less likely they will take on a wider range of staff who work on services planned by the Health Boards
  - The potential for community nurses to compete with GPs for fees for private patients

  Overall, there is a perceived lack of a clear strategy for public health nursing, particularly given the difficult links with general practice. As part of this, it is argued that too many different grades of community nurses arise, i.e. public health nurses, mental health nurses, palliative care nurses, etc. There is also some concern that community nursing and

related services currently lack the infrastructure to manage additional spending if it was to be directed towards them.

- Integration between community services is a further issue that warrants consideration. Many community services, particularly specialist services, operate in relative isolation of each other with limited focus on opportunities to share resources or reap possible economies of scale.

- Staff shortages and the recruitment of professional staff is a significant challenge in the provision of quality community services. Considerable gaps have been identified across areas such as Psychologists, Paramedics, Paediatricians, Home-helps, Social workers, Public Health Nurses, Area Medical Officers, Speech and Language Therapists, Ophthalmic Physicians, etc. The shortages being experienced mean that the maintenance of core services is becoming increasingly difficult to sustain. It should also be acknowledged that continuous efforts are being made to recruit internationally and to create additional college places where required.

- There is a lack of a concentrated programme of continuous training and development for community health care professionals. One area where progress has been made was the establishment of the Centre for Continuing Pharmaceutical Education in 1998, which brought about the development of a strategy for pharmaceutical care offered by community pharmacists.

- Community dental services is a further area where The Department of Health & Children has focused considerable resources and effort in recent years in order to address the key services deficiencies that existed throughout the greater part of the 1990s, particularly in terms of waiting lists. Other key issues that have been raised relate to:

  - Dental charges and the differences in charges between the Republic and Northern Ireland. This raises issues for those people who fall outside the Dental Benefit Scheme and the Dental Treatment Services Scheme.

  - Fluoridation. In response to this issue, The Department of Health & Children established a forum on Fluoridation in May 2000 to assess the impact of various levels of fluoride on areas such as public health, the environment and food safety.

  The overall objective of the Department is to improve the level of oral health in the population through the implementation of the Dental Health Action Plan. This is most evident through the level of additional funding that was allocated over the 1998 to 2000 timeframe to implement the plan i.e. £28m. The key areas to which funding was allocated were:

  - Oral health promotion and services to children

  - Adult dental services

  - Orthodontic services / other secondary care services

  - Continuing dental education

  - The restructuring of Health Board dental services

  - The extension of a pilot scheme for vocational training in dentistry

The key achievements to date are listed below:

1. As and from January 2000, dental treatments were extended to medical card-holders in 35 to 64 year old age group i.e. an additional 355,000 adults. In turn, a number of process improvements were introduced which allowed medical card holders direct access to routine treatment by a private dentist as opposed to having to go through the Health Boards. The number of forms that dentists were required to complete for each patient were reduced from four to one and an examining dental /general practitioner advisory committee was established to ensure the scheme was operated in an efficient and effective manner.
2. Eligibility for dental treatment was also extended to children who attended national school up to their 16th birthday. This was implemented in August 2000.
3. A key element of the plan is the development of consultant led orthodontic services in each Health Board. To date, we understand that all but one Health Board has implemented this objective.
4. Complimentary to the above, progress has also been made at Health Board level to establish an oral health database together with a framework for evaluating services which in turn will cover service quality issues, the development of information systems and dental epidemiological surveys. Indeed, in 1998, a representative group was established comprising Health Board management and consultant orthodontists to report on equity measures in service provision.
5. An extensive expenditure review of dentistry services has been completed as part of a public service wide initiative.
6. A national survey of adult dental health is due to be completed by the end of 2001. A Children's survey is planned for 2002.
7. Significant funding has been allocated to Health Boards for fluoridation schemes.
8. Training programmes to increase the number of specialists is also under review.

- In common with GP services, access to community services and professionals outside of normal working hours is limited and in need of improvement.
- A significant amount of community accommodation is located in older buildings that are sub-standard for their intended purpose and use. While efforts are on-going through the NDP programme to rectify this situation through upgrading and replacement, rising contractor and housing costs makes this task more difficult to achieve. The contribution made by the voluntary sector in the provision of housing and accommodation has been critical over the last decade and this is likely to remain so into the future. However, it has been argued that there is greater scope for the public sector to further support them in this role through financial or other aid.
- Responsibility for the provision of local transport services is another area that requires further clarification. As will be identified in the following section, the current provision is regarded as inadequate and the opportunities to make better use of other public transport vehicles does not appear to have been exploited.
- There are major gaps in information systems and data at community level, which adversely impacts on service integration, measuring performance and VFM. In general terms, information technology facilities, support and training are insufficient and require review and investment.

- The monitoring and evaluation of the performance of community and primary care service has for the most part been inadequate. Health Boards have adopted different approaches to the implementation of national strategies, which makes the process of comparison and benchmarking harder to achieve.
- Information on service availability and service entitlements has been somewhat fragmented and varied between Boards; this has been highlighted in the Ombudsman's report on the Nursing Home Subvention Scheme. As acknowledged in the same report, part of the problem is associated with the development of policy without the necessary funds to implement it.
- The provision of appropriate care to Asylum Seekers and the Travelling Community is a growing challenge that faces many Health Boards, in particular the sensitivities that are associated with providing housing to such groups in local communities.

  More importantly, given the high rate of mobility among these groups, Health Boards face the difficult task of ensuring that they all avail of the appropriate medical screening and other services. In this regard, there has been strong and proactive co-operation between different Health Boards in the sharing and transfer of medical and records.
- Other key priority areas for Health Boards concern the provision of appropriate services for children and the elderly. These are discussed in more depth in Section 10.

9.4 CONCLUSIONS

- Primary and community care have the potential to contribute to improved value for money by delivering effective but lower cost services, particularly for patients in need of preventive measures or continuing care. Currently, there are difficulties in achieving any such improvements across the Board when many GPs are not covered by public payments for the care they provide. The extension of GMS or similar schemes to full cover for chronic disease patients would facilitate an increase in the number of people registered with GPs. However, as referenced previously, the costs and benefits of such a strategy would have to be clearly established. Realistically, it is unlikely that there will be any significant changes in the GMS scheme and the organisation of GP services as they currently stand.

  However change will be necessary in the drive towards a more integrated and comprehensive health care service that upholds the principles of equity, equality and access.
- The implementation of a UPI system has the potential to significantly address current integration issues.
- If the self-employed model of general practice is to remain, then a variety of incentive schemes may need to be developed to achieve more consistent delivery of primary care. We do not envisage the ending of the current model and would therefore expect that Health Boards would develop financial investment strategies to accompany service strategies for primary care. An alternative, currently taking shape in the UK, is to give GPs much greater responsibility for community services and budgets, through Primary Care Trusts. This might be seen as a form of reverse integration, putting the self-employed in command of the publicly funded services. It is too early to draw any conclusions on the effectiveness of this policy.
- There is no evidence available to show that primary or community care is of poor quality or ineffective, but the absence of consistent evidence of any kind on the delivery of services is sufficient to demonstrate the current lack of integration of services. Overall, greater emphasis is required on a multi-disciplinary team-based approach to primary and community care where there is co-operation between specialists' teams and generalist teams.

- Further investment is required in infrastructure and staffing to bring community services up the required standards and to meet public demand. Some improvements have already been realised in recent years, and this effort will need to be sustained into the future. Among the biggest challenges facing Health Boards is the further development of multi-disciplinary teams and the upgrading and purchase of appropriate accommodation in light of rising costs.
- A key priority for community care in the future concerns the need to develop and implement robust information systems and establish performance management. These issues have already been discussed in Section 7.

SECTION 10: OTHER WELFARE AND CARE GROUP ISSUES

10.1 SECTION OVERVIEW

The purpose of this Section is to discuss the issues raised in previous sections in relation to specific care groups. It is not intended as a comprehensive analysis of all care groups.

In this section we set out the service issues in relation to:

- The Elderly
- Psychiatric Services
- Persons with an Intellectual Disability
- Childcare

For the first three areas listed, issues are categorised under four headings: general, acute services, primary care and community services. A more general overview of services is presented for childcare services.

10.2 THE ELDERLY

10.2.1 General Issues

Population Structure

The majority of the current service issues with respect to the elderly were raised in the "Years Ahead Report: A Review of the Implementation of its Recommendations". Central to these, and a fundamental challenge now facing The Department of Health & Children is the projected increase in the older population over the next 10 years. The 65 plus age group is expected to grow by in excess of 6,000 people per annum over the 1996 to 2011 time-frame which will see the population in this category increase from circa 414,000 to 504,000[1]. It is also expected that a higher proportion of this increase will occur in pockets of the population with high levels of need for health and social care. At the same time, the overall State population is expected to remain stable.

The changing demographic structure will create both a need and demand for health and social care services. This task is made more difficult by the historically low level of funding that has typically characterised the provision of services to the elderly during the 1980s and well into the 1990s. As such, The Department of Health & Children is starting from a relatively low investment base to ensure the adequate provision of services and the achievement of key policy aims as discussed in Section 4.

Co-ordination of Services

Another general issue is the lack of co-ordination of services throughout the system. This point was raised in the Years Ahead Report and also in the subsequent review of that report. Furthermore, services are not provided in a uniform fashion across all Health Board areas which creates inequalities.

[1] Source: Department of Health and Children

10.2.2 The Acute Sector

- Between 1988 and 1997, thirteen and a half new Consultant Geriatrician posts and ten new Departments of Medicine for the Elderly were created. Many of these were appointed on a part-time basis. It is widely regarded that as these are key services in the acute sector, all appointments in the larger urban hospitals should be on a full-time basis.

  Part-time appointments should only be made where the consultant is required to carry out other general medical activities because of resource constraints. With the projected growth in the older population, there will be an increasing requirement for all appointments to be made on a full-time basis in the future.

- There has in recent years been an increase in the number of psychiatric teams dealing with the elderly who suffer from psychiatric disorders. There is a national commitment to provide such services across all mental health services in the country.

  While progress has been made, the policy of re-designating elderly people from psychiatric services to more tailored, high quality services dealing with physical ailments has been less successful.

- From our own consultations with the acute hospital sector, it is widely held that intermediate/sub-acute facilities are inadequate which may result in the inappropriate discharging of elderly patients back into the community, or the blocking of hospital beds by the elderly to the detriment of other patients. The Eastern region has suffered from a lack of District Hospitals which provide some such facilities in other Board areas. There is also scope to reduce the number of hospital admissions by the elderly if appropriate primary and community care services were in place. These are currently inadequate in providing care for the elderly outside of the acute hospital setting.

- Related to the last point, liaison between the acute hospital sector and the primary care sector is inadequate. While the majority of hospitals employ personnel for this purpose, communication is generally indirect, for example, by means of a letter for patient discharges, rather than directly with the professionals concerned. In turn, the communication tends to be with the GP as opposed to the GP and the public health nurse. Scope exists to improve discharge procedures and follow-up within the community. Inadequate information and communication technology makes the objective of achieving better communication between acute and primary care providers, and within the primary care group, more difficult to achieve. There is a requirement to invest in the development of improved information systems in the community, suitably interfaced with those in the acute sector.

- There is an inadequate supply of assessment and rehabilitation beds in the acute hospitals. An analysis of the supply of beds across Health Boards in the Review of the Years Ahead Report identified that all Health Boards fell below the recommended norm of 2.5 beds per 1,000 old people for assessment beds. Only two Health Boards reached the recommended norm for rehabilitation beds i.e. 3 beds per 1,000 old people. The report also considered the development of day care facilities as slow and recommended that every hospital with a specialist geriatric department should provide a day hospital facility.

- Waiting lists for elective surgery are a further issue for the elderly, particularly those on the public waiting list.

10.2.3 Primary Care Level

The organisation of services at primary care level is generally regarded as being poor. The Years Ahead Report originally envisaged that GPs would be responsible for case findings and preventive care, while public health nurses would maintain "At Risk Registers". By and large this has not happened. It would also appear that there is considerable scope for improved co-operation between GPs and public health nurses.

The recent controversy over the Nursing Homes Subvention Scheme raised fundamental issues with respect to service eligibility and charging, among others. The Ombudsman's report which dealt with the payment by Health Boards of subsidies or subventions to patients in private nursing homes highlighted that every resident in the State is eligible to be provided with in-patient services, where necessary, by the relevant Health Board. The extent to which the State can now meet such a provision with the existing supply of beds in conjunction with an increase in demand is questionable. Service entitlement is also addressed by the National Council on Ageing and Older People under its proposed legislative framework.

A fundamental issue which needs to be resolved is the extent to which the State wishes to provide, or seek to provide, nursing home beds through nursing home subventions to the private sector, rather than through a policy of building State owned facilities. Certainly from a VFM perspective, the long-term costs arising from the continued subvention of beds from the private sector should be reviewed, especially in view of the growing elderly population and the issues raised in the Ombudsman's report. There are currently some 24,000 beds in the system, 12,500 of which are accounted for by the private sector. Of the total number of private beds, 7,000 are subvented by Health Boards. Issues arise with respect to the provision of additional public beds, the timeframe over which these can be provided and the associated cost vis-à-vis servicing long-term demand from the private sector.

10.2.4 Community Care Level

- The objective of the Years Ahead report to provide adequate paramedical services to support people in their homes has not been implemented to the scale or level defined. There is a real concern that many older people are in fact being denied these services.
- A considerable amount of work has been completed around the area of health promotion at a national level and a health promotion strategy for the elderly has been prepared. However, at community level it remains the responsibility of the public health nurses. The service is provided on an ad-hoc basis and is dependent on the individual coming in contact with the health service. There is a general lack of information and support to aid public health nurses in this role, which sees them relying very much upon their own practical experience. As we identified in Section 9, there is also a potentially wider role for the GP to play in the area of health promotion for the elderly and other groups.
- Investment is required in all community services for the elderly with a mental health disorder. Public nurses also require training to detect disorders, as is true of GPs.
- The number of home help assistants employed has shown some growth since 1988 and undoubtedly a significant amount of funding has been allocated to this area in recent years. However, it is still widely believed that the numbers are insufficient. In turn, there would appear to be some variation between Health Boards in the priority that they attach to this area.

- It is also proposed that the service needs to be further expanded and developed in terms of an emergency service, an out-of-hours service, a weekend service and as a relief service for carers. Fundamentally, the National Council on Ageing and Older People regard the home help service as the "most appropriate source of regular formal personal care at home for older people".
- The supply of carers is another area under threat. A further issue that faces the supply of home helps is the ageing of this group of individuals, with many over 45 years of age. An additional pressure is the number of women going back into full-time or part-time employment in the private sector where the pay is generally more lucrative. Finally many carers and home help assistants are concerned about the risks associated with taking on the responsibility for minding the elderly in the absence of an appropriate support infrastructure.
- Day care is widely considered the most neglected part of the community care sector. As with many other services, it is felt that day care centres are provided on an ad-hoc basis. As such, there would appear to be scope to increase the number of places available as well as the range of services provided. Transport to and from day centres is also poor and it does not appear to be entirely clear whether responsibility for this rests with the Department of Health & Children or with the Department of Transport. Opportunities to better utilise public vehicles used in other areas (a feature of other countries), do not appear to have been examined.
- One of the fundamental issues at community level is the provision of adequate and suitable housing for the elderly (both their own homes and public housing). The National Council on Ageing and Older People raised particular concerns about the current levels of diverse spending on public housing in addition to the lack of a standardised approach to ensuring that the homes of the elderly are in good repair and condition. This is considered particularly important in light of the high level of owner-occupied dwellings. In turn, there is a fear that the number of houses designated to the elderly by the voluntary sector will be scaled back as an increasing proportion are assigned to other groups. Finally, it would seem that there is a general lack of support and funding given to the voluntary sector in terms of home-care assistance provided through the Health Boards.
- Community social workers are seen as having a role in maintaining the elderly in a home environment in terms of protecting the rights of individuals against exploitation, providing support and advice to carers, and advising old people of their entitlements. This aspect of community care has not been developed to any great extent given the pressures placed on social workers for other areas.
- The geographic distribution of public health nurses remains un-even and needs to be standardised.
- The relationship between the voluntary sector and the statutory authorities requires improved co-ordination and definition, as highlighted in the case of housing. In turn, there needs to be greater assurance in areas where the voluntary sector is less prominent, that Health Boards will bridge the gaps.

10.2.5 Key Conclusions

- The growing numbers of people in the 65 plus age group represent an important challenge for all areas of the health sector in meeting and managing service requirements over the next five to ten years. The level of investment in facilities for the elderly is likely to be of a very significant magnitude to meet the requirements for medical assessment, rehabilitation, extended care, day services and nursing home units. The historically low investment and service base makes this challenge more difficult.

A noteworthy increase in capital and revenue spending particularly has occurred over the last two years. We understand further investment is planned over the next two to three years. It is not, however, clear as to the level of funding that will be available in two to three years time, which has an obvious impact on the strategic planning process. What is clear is that current spend levels will at a minimum need to be maintained into the foreseeable future if existing service shortcomings are to be properly addressed in the manner envisaged by the National Council on Ageing and Older People.

- The provision of quality community and step-down services are essential elements of future service provision. These are in terms of :
  - Paramedical services
  - The number and geographic distribution of public health nurses
  - Health promotion
  - The home-help service
  - Social workers
  - Day care facilities and ancillary support services such as transport
  - Housing
  - Specialist services to cater for patients with a mental illness or disorder.

- In addition to the above, improved co-operation and co-ordination between all areas of the health sector is key to providing a more integrated and efficient service.
- Both improvements in the community service and in co-operation across the sector are important factors in addressing the bed capacity difficulties faced by the acute sector. In tandem with this, there is a requirement for more dedicated rehabilitation and assessment beds in the acute sector in addition to the appointment of more Consultant Geriatricians.
- Finally, the issues raised by the Ombudsman report in relation to access and payment for nursing home services need to be assessed and defined in term of service delivery and service quality. As part of this process, available and future capacity requirements in public sector nursing homes will need to be weighed against the sustainability and effectiveness of subventing beds in private nursing homes.

10.3 PSYCHIATRIC SERVICES

10.3.1 General Issues

Human Resources

- There are ongoing difficulties in the recruitment and retention of suitably qualified staff to psychiatric services. In line with the policy to move from institutional based services to community services, a greater emphasis has been placed on providing a multi-team approach incorporating the skills of psychologists, social workers and occupational therapists. This compares to the traditional doctor / nurse led model of service delivery. However, the shortage of these key professionals, including nurses, creates a barrier in enhancing service quality. In his report, the Inspector of Mental Health Hospitals stressed that the model of psychiatric services envisioned by Government policy requires the

adequate resourcing (both physical and human) of programmes and services at both acute and community level.

It is accepted that there is a requirement to enhance awareness of career opportunities in the mental health services. Some progress has been made on this issue. During the first half of 2000, a concerted marketing campaign was undertaken by the Nursing Careers Centre and the schools of nursing around the country. This resulted in 242 training places in psychiatric nursing and 156 places in mental handicap nursing being filled.

- Psychiatric medical training is Ireland is co-ordinated by the Irish Postgraduate Training Committee, a sub-unit of the Postgraduate Medical and Dental Board. The latter administers a training course devised by the British Royal College of Psychiatrists. While the UK based course is accepted as being broadly comprehensive in terms of general medical training, it does not provide participants with an appropriate level of knowledge or understanding of Irish mental health services. There is also a view that there is an over-reliance on the UK model and that more value could be created by incorporating elements of other European and North American models.
- There is no statutory requirement for continuous professional training in the mental health services in Ireland. The Inspector of Mental Hospitals regards professional development and education as essential to achieving continuous quality improvements in service delivery.

Recognition of the Role of the Voluntary Sector

The voluntary sector plays a key role in psychiatric service provision. In an effort to further promote co-operation with the sector, funding has been provided in recent years to such organisations as the Mental Health Association of Ireland, Schizophrenia Ireland, G.R.O.W, Aware and Bodywhys to help develop their services and promote positive mental health. The funding has assisted the organisations develop their own medium and long term strategies.

Quality Procedures

A considerable amount has been achieved in relation to adherence to proper procedures and protocols facilitated by the Guidelines on Good Practice and Quality Assurance in Mental Health Services, 1998. However, the 1999 report of the Inspector of Mental Hospitals identified that more needed to be done and that a Code of Practice needed to be established and reviewed by the new Mental Health Commission to address the following:

- The documentation of procedures on patient care such as case note entries, recording reasons for seclusions, the reasons for extending temporary patient reception orders.
- The current poor levels of communications with patients' relatives.
- The absence of complaint procedures and mechanisms in some services.
- The absence of public displays of patients' rights set out in the Mental Treatments Act 1945.

In his 1999 report, the Inspector of Mental Hospitals also acknowledged that while many improvements had taken place in the prescribing of drugs, particularly to long-term patients, continuous attention should be paid to the writing and signing of medical prescriptions.

Measuring Service Quality and Costs

We found very little evidence to suggest that a *co-ordinated* approach to measuring service outcomes and costs has been made across the provision of psychiatric services. However, this is not to say that no effort has been made.

In 1995, for example, the Mid-Western Health Board undertook a study, the key objective of which was to examine patient outcomes and to evaluate the therapeutic effectiveness of the services offered. The Board also undertook a further study to review the cost-effectiveness of alternative acute care. One of the key points that emerged from that study was that there was no standard methodology for the codification of costing standards, nor were there any guidelines that would facilitate comparative analysis.

Management Information Systems

Information and data to support the development of psychiatric services is primarily collated through the annual report of the Inspector of Mental Hospitals, the end of year returns made by each hospital to The Department of Health & Children, and the National In-patient Reporting System (NPIRS). The NPIRS database collates data from Health Board hospitals, the psychiatric units of general hospitals, private hospitals and children's centres and is recognised as being both accurate and complete.

In overall terms, the availability of information on psychiatric services is regarded as being quite extensive. The area where significant gaps remain is in relation to attempted suicide and para suicide. However, steps have already being taken to address these deficiencies through the recommendations of the Report of the National Task Force on Suicide.

Specialised Services

The Inspector of Mental Health Hospitals proposed in his 1999 report that there was a requirement to enhance the level of specialist psychiatric services available particularly to young children and adolescents. This has been adopted as a key priority for The Department of Health & Children, and a sizeable amount of funding has been allocated to develop these services in recent years. Progress will be further enhanced by the recommendations of the "Report of the Working Group on Child and Adolescent Psychiatry", 2001.

A further priority of The Department of Health & Children is to provide appropriate facilities for the care of the mentally ill whose behaviour is a risk to themselves or to others. A Working Group was established to examine the needs of this group, following on from which a policy document was drafted and circulated to the Health Boards for comment.

The document was endorsed by the Boards and provision has been made as part of the NDP to develop intensive care units for the care of these patients.

Finally, efforts are being made to encourage treatment for alcoholism on a non-residential basis. To assist this process, funding has been provided to the Health Boards for the provision of trained personnel to work in the community services and in co-operation with GPs.

Psychiatric Services to the Criminal Justice System.

It is recognised that deficiencies exist in the provision of psychiatric services to forensic services. In particular, there is a requirement for the provision of professional services to courts and prison services in terms of psychiatrists, psychologists and psychiatric nursing. These weaknesses have been recognised by the Department, and in 1999 one new psychiatric

consultant was appointed in the Eastern Health Board Region. Further funding was allocated to the development of services in Dublin, Cork and Limerick.

The Department of Health & Children has also requested that Health Boards communicate directly with prison services regarding the arrangements required for health and social services for prisoners, including psychiatric services.

10.3.2 The Acute Sector

Transfer of Patients to General Hospitals

A key element of national policy is the transfer of patients from admission / acute units in psychiatric hospitals to dedicated units in general hospitals. In 1999, the proportion of patients admitted to acute psychiatric units in general hospitals continued to increase accounting for 35% of admissions, with a further 15% admitted to private hospitals[2]. The total number of acute psychiatric units in general hospitals now stands at 18. In conjunction with this, the number of in-patients resident in psychiatric hospitals and units fell from 4,820 in 1998 to 4,469 in 1999[3]. While progress has most certainly being made, it has been somewhat slower than anticipated owing to issues arising with building contractors and hospital management and unions.

In 1999, only one new unit opened in the general hospital sector – The Adelaide & Meath Hospital incorporating the National Children's Hospital at Tallaght replaced St Loman's Hospital in Palmerstown with some 50 beds. St Loman's has subsequently been converted to a rehabilitation unit.

Across the country, the planning and design of the designated acute units are at various stages of development. These include St Vincent's Hospital, Elm Park, Beaumont Hospital, James Connolly Memorial Hospital, Sligo General Hospital, Ennis General Hospital, Portiuncula Hospital, Portlaoise General Hospital, Castlebar General Hospital and Nenagh General Hospital. A further four acute psychiatric units at Dundalk, Wexford, Mallow and Mullingar General hospitals are under consideration as part of the National Development Plan.

It is anticipated that at the end of 2006, the programme of acute psychiatric units will be significantly advanced which will consequently reduce the number of admissions to psychiatric hospitals. The exceptions would be Wicklow Mental Health Service and St Vincent's Hospital Fairview. The report of the Inspector of Mental Health Hospitals also identified that the number of acute beds may in fact need to be revised upwards in some locations to cater for local catchment needs.

The Use of Acute Psychiatric Beds

A review undertaken by the former Eastern Health Board in 1999 on the decision-making mechanisms and processes that govern bed usage identified that:

- Circa 50% of acute psychiatric beds were not being used for acute purposes as a result of bed blocking.
- Bed blocking by non-acute patients resulted in a shortage of acute accommodation for patients requiring admission.
- There was a sufficient number of acute beds in the Eastern region if all designated beds were properly used.

[2] The Report of the Inspector of Mental Health Hospitals, 1999
[3] Irish Psychiatric Service, Activities 1999, The Health Research Board

The problems encountered above were also attributed to a deficit in community accommodation in addition to a shortage of non-residential services such as day hospitals, community mental health centres and multi-disciplinary community teams. As a result, the report recommended that 1.5 residential places per 1,000 of the population were required.

We cannot validate the extent to which the above findings and recommendations can be generalised throughout the country in the absence of comparable studies. However, as we will identify below there are regional differences in the level of community-based facilities and services provided which may result in the inappropriate use and blocking of beds in the acute sector.

Involuntary Admissions

In 1999, the number of involuntary admissions accounted for 11% of all admissions or 75.3 per 100,000 population. This is quite high relative to other countries such as England / Wales where the comparable figure is 49 per 100,000 population. In Italy the figure is just 26 per 100,000 population. The review of activities by the Health Research Board also highlighted that there was almost a "two-fold difference between the highest and lowest rates of non-voluntary admissions between Health Boards".

10.3.3 Primary Care Level

The Report of the Commission of Enquiry on Mental Illness 1996 and Planning for the Future 1994 both advocated the greater involvement of the primary care sector in delivering mental health services. There is a view that there is an over-reliance on outpatient clinics in managing clinical practice that was in fact more suited to primary care. It has also been suggested that psychiatric services should be more proactive in referring patients to GPs for continuing care. Against the background of these proposals, it is acknowledged that a major barrier to progress is the manner in which GPs are paid. A key priority for The Department of Health & Children is therefore to improve integration of mental health and primary health services.

10.3.4 Community Care Level

Residential Services

In 1999, there were 392 residences across the State providing 2,873 low, medium and high support places (this compares with 121 residences in 1984 providing 900 places). The highest number of places were available in high support residences (1,075), this was followed by 1,062 low support units and 738 medium support units.

Of note is the fact that the number of admissions to community residences decreased from 47.9 per 100,000 population in 1998 to 28.1 in 1999.

By all accounts, the extent of community-based accommodation varies between Health Board regions. Similar to the difficulties encountered by the intellectually disabled, progress has been hampered by escalating property prices and also by objections from local residents to the designation of accommodation in their areas. Matters can be further complicated and delayed by the requirement for in-depth discussions with unions to facilitate the transfer of patients from in-patient settings to community facilities. The level of activity by the voluntary sector in any given region also impacts on the number of residential places available.

Sub-standard accommodation across all types of residential services in terms of decor and furnishings was a further issue that was highlighted for attention in some regions by the Inspector of Mental Hospitals in his 1999 report. However, we understand that community residences are being revamped on an on-going basis and provision has been made under the NDP for the development of additional residences.

Non-Residential Services

The Report of the Inspector of Mental Hospitals (1999) highlighted that the development of non-residential services was unbalanced throughout the country, with significant progress being made in some regions and very little in others.

Specific reference was made to the variability in the extent to which multidisciplinary community mental health teams had been established in suitable premises providing day hospitals / other day accommodation, homecare work and assertive community treatment in regions. The report also highlighted that in a number of instances, premises were being utilised for only part of the day, and as such opportunities existed to make greater use of available resources. Although regional variations remain, progress has been made in establishing mental health centres day hospitals and other day facilities. In 1984, there were 32 day hospitals and centres. The comparable figure for 1999 was 176[4].

Rehabilitation Services

The Health Boards are in general placing greater emphasis on providing more extensive rehabilitation facilities. In the ERHA region, Gallon House was re-opened as a high support residence. In the North-East region, a new rehabilitation initiative for people suffering from severe and mental illness has reportedly shown considerable success in reducing the number of admissions to St Davnet's Psychiatric Hospital.

10.3.5 Key Conclusions

- National policy for psychiatric services and the associated allocation of funding will continue to centre on the provision of a community-oriented service for the foreseeable future. This includes the development and expansion of residential, non-residential services and rehabilitation services and the transfer of patients from admission / acute units in psychiatric hospitals to dedicated units in general hospitals, of which there are now 18, with plans for further development underway. Despite the progress made in this area there are concerns that in some instances development was slower than originally anticipated which resulted in the delayed transfer of patients.
- The expansion of specialist services is required particularly in terms of children and adolescent psychiatry, psychiatry of old age, forensic psychiatry, the disturbed mentally ill and rehabilitation psychiatry.
- Suicide prevention and care has been to the fore of policy development in the latter part of the 1990s and there will be a continued focus on implementing the recommendations of the National Task Force in Suicide, where significant progress has already been made.
- The issues surrounding staff recruitment and the provision of suitable training courses will need to be reviewed.
- A key priority for The Department of Health & Children will be the enactment and implementation of the Mental Health Bill, which seeks to further uphold and support the rights of psychiatric patients through the definition of protocols and procedures and the

[4] Source: The Department of Health & Children

setting up of the Mental Health Commission. In conjunction with the thrust of the Mental Health Bill, some efforts have been made in recent times to measure and track service outcomes and quality, although much greater effort is required to fulfil the recommendations made in "Planning for the Future", 1984.

- Funding to the sector has increased significantly. This will have a real impact on addressing the service gaps that have been outlined above. The planning and development of psychiatric services is also enhanced through the availability of data primarily through the NPIRS. Where information gaps exist, for example, in the area of attempted suicide and para suicide, efforts are being made to address these deficiencies.

10.4 THE INTELLECTUALLY DISABLED

10.4.1 General Issues

Management & Planning

- One of the most significant developments to aid the provision and funding of services for the intellectually disabled was the establishment of the National Intellectual Disability Database in 1995 in line with the targeted actions set out in "Shaping a Healthier Future" and the recommendations arising from the "Needs and Abilities" report 1990. The functions and role of the database were defined as follows:
  - To improve the accuracy of data available to Health Boards on the population of people with an intellectual disability.
  - To enable the current needs of people with an intellectual disability to be assessed more accurately.
  - To support planning for the future development of services for people with an intellectual disability.

  In the sections that follow we highlight a number of issues associated with service provision that exist today. However, it is important to recognise that the national database is widely credited with fulfilling its objectives and mandate, thus contributing to service improvements through the availability of more robust management information. The 1999 report not only sets out the level of services provided but also includes an assessment of future needs for the 2000 to 2004 time period which is cognisant of the progress made against the Assessment of Needs Report 1997 to 2001.

  While we have not tracked in detail the development of services to persons with a physical and sensory disability (although many of the issues discussed below are common across all forms of disability) it is worth noting that in 1998, a National Database Development Committee was established with the objective of developing a database for this group along the lines of that developed for persons with an Intellectual Disability. Pilots have been undertaken in four different Health Boards (The ERHA, the Western Health Board, the North Eastern Health Board and the South Eastern Health Board) to test content and the procedures for data collection and analysis. Following the pilots, a full set of recommendations with respect to the operations and management of such a database will be made.

  It is becoming increasingly recognised that the establishment of population databases such as those described above have a potentially pivotal role to play in the service planning and service evaluation processes. While it may be argued that the population of persons with a disability is relatively discrete and easy to track vis-à-vis other groups, this should not in any way deflect away from efforts to develop and implement similar initiatives for other groups.

- In addition to the setting up of the database, "Enhancing the Partnership" has led to steps being taken to clarify and enhance the relationship between The Department of Health & Children, the Health Boards and the voluntary sector in the provision and funding of services to the intellectually disabled. The establishment of The Mental Handicap Services Consultative Committee (MHSCC) and The Mental Handicap Services Development Committee (MHSDC) structures at a regional level appear to have enhanced the local and regional planning and co-ordination of services.

  This year will also see the first set of service agreements from the Health Boards to agencies for the provision of services as recommended by "Enhancing the Partnership". To assist this process, The Department of Health & Children designed a national template that was distributed to all Health Board Chief Executives to facilitate a standardised approach to data collection and presentation. It is against these service plans that funding will now be allocated.

  Finally, a National Monitoring Committee has been recently established that is representative of the four key partners in service planning and development i.e. the Department of Health & Children, the Health Boards, the voluntary sector and parents. The function of the Committee is to monitor developments against targeted objectives. It also provides parents with an improved insight into service development and the issues faced, and provides them with a mechanism to input into the process.

  Co-ordinating Committees for the Physically and Sensory Disabled were also established in each Health Board in 1998.

- As far back as 1990, the report of the Review Group on Mental Handicap Services recommended that systems should be developed to "measure the efficiency and effectiveness of different services and to measure the health and social gain for clients of the policy of care in the community and to measure customer satisfaction".

  Efforts are on-going to undertake research that will improve the services offered and in quantifying key issues. One such example is the Centre for the Study of Developmental Disabilities in UCD, which is reviewing residential services in terms of how they contribute to an improved quality of life and how this compares to institutional settings. Costings are also being assessed as part of this study.

  In a separate study, the Mid-Western Health Board is piloting early intervention services for children with a physical / sensory disability.

  We identified one voluntary agency involved in the provision of services to the intellectually disabled that is embarking on a programme to measure service outcomes for patients. We understand that a number of Boards and voluntary agencies have also implemented initiatives in this area. In recent years, a greater focus has been placed on service quality and personal outcomes.

- Finally, for those organisations working in this sector, forward planning with respect to the provision of new residential places is becoming increasingly fraught with difficulties. Planning permission is more difficult to acquire in residential areas and escalating property prices are also impacting on the availability of premises, especially in Dublin. Both of these factors have a spill over effect on staff planning and recruitment policies.

Related to the previous point, it is assumed for planning purposes at national level, that £35,000 is the average annual cost per client of a residential place and £10,000 for a day place. The latter is recognised as being too low and is being looked at. Up to the last year or two, capital costs of £40,000 per client were estimated for community-based housing, rising to £60,000 for residential places. However, in the context of the current property market, these have increased greatly over the last two years. The key difficulty that service providers have with these assumptions is that they are inflexible and they do not allow the linking of funds to the level of care required by a client. The study commissioned by The Department of Health & Children in UCD (as referenced above) is seen as a first step in addressing this issue.

Demographics

In 1999, there were a total number 27,149 people with an intellectual disability[5]. Of these:

- 41.5% had a mild disability
- 35.5% had a moderate disability
- 14.6% has a severe disability
- 4.1% has a profound disability
- 4.3% were not verified.

The key demographic and population changes taking place that impact on service provision are briefly described below:

- In recent years there has been a marked increase in the number of people with a severe disability and also the number of older people representative of this group. In 1981, older people accounted for 26% of the total population in the severe range; this increased to 38% in 1996 and to 42% in 1999. Research completed in this area has shown a strong correlation between age and service utilisation and also between the degree of disability and service utilisation. The changes in demographics therefore imply that there is an increase in the demand for higher support residential services in addition to a requirement to develop specific geriatric support services.

  It is of note that:

  - Of those availing of day services, 49% have a mild disability.
  - Of those in full-time residential services, 78% have a moderate, severe or profound intellectual disability.
  - The proportion of people living in a home setting is proportional to the level of disability. 75% of those with a mild intellectual disability live in a home setting. This compares to 52% of those with a moderate, severe or profound disability.

- The average maternal age has been increasing with associated risks of disabilities among new-borns. In turn, improvements in neonatal care have increased the survival rate of babies at risk from an intellectual disability. While there has been a general trend towards falling prevalence rates of intellectual disability in the younger age groups, it is argued that this will need to be monitored on an on-going basis over the coming years in light of the above trends.

[5] Annual Report of the National Intellectual Disability Database 1998/ 1999.

- The longevity of people with an intellectual disability has also shown an increase. In 1974, 29% of the population with a mild, severe or profound disability were 35 years or over. The respective figures for 1996 and 1999 were 38% and 42%.
- It is estimated that circa 80% of parents who have children with an intellectual disability are over 50 years of age. Issues arise as to whether many parents will be able to sustain the level of care they currently provide to their children in the medium to long term. Linked to this, there is a concern that as the number of elderly parents caring for adult children with an intellectual disability at home increases, the management of crisis cases will impact on planned admissions to residential care. While the Department of Health & Children has developed a strategy to manage emergency admissions by requesting that all Health Boards establish funds to meet such costs, it appears that there remains a clear need for the provision of a range of additional residential options and respite services.
- Autism is being increasingly recognised as an area that requires specialised services. Since 1990, efforts have been made to improve health-related support services and educational services to this group. However, issues still remain including the increasing numbers of children being diagnosed with autism[6], the increasing demand and recognition for autism specific services, particularly for growing numbers of younger people, and the requirement for residential training and day services, as children grow older. The Department of Health & Children and the Health Boards are working in tandem to develop more specific population data.
- In summary, the impact of these trends are as follows
  - Increased demand for residential services
  - Increased life expectancy means that fewer places are becoming available through death
  - Increased demand for specialist and geriatric services
  - The need for therapeutic support services for people who continue to live with their families
  - Increased demand for respite places and home help services

Access to Personal Data

The extension of The Freedom of Information Act to voluntary hospitals marked an important step forward for the intellectually disabled and disabled people in general. In essence, it entitles service users and their families to access information on their files.

Access to Services

In 1999, the National Intellectual Disability Database highlighted that 522 (2%) people with an intellectual disability who required a service were in fact without a service. This compares with 604 people i.e. 2.3% of the intellectually disabled population in 1996. In overall terms, there are an additional 1,291 people receiving a service in 1999 compared to 1996.

In the short to medium term it is expected that the numbers of people with an intellectual disability will in fact increase in accordance with a growing birth rate, migration and improvements in medical care (In 1996, there were 26,694 people with an intellectual disability compared to 27,149 in 1999).

[6] The increase in the number of children diagnosed with autism is a worldwide trend. It is thought that part of the increase is due to improved diagnosis techniques and the revision of criteria.

One of the challenges facing the Department of Health & Children in future service planning is to meet the population's requirements in terms of numbers of people requiring services, the distribution and types of services required, etc. A major difficulty arises in marrying together the range of factors that define service needs. In turn, the levels of capital funding available beyond 2003 has not yet been disseminated to Boards and agencies, which creates on-going planning and development difficulties.

Other issues associated with service access include:

- Ready access to information on service provision and entitlements.
- Disparities in eligibility criteria for services and benefits between and within Health Boards. It should, however, be acknowledged that a considerable amount of work has been completed in addressing this.
- Inadequate statutory financial support for individuals with a disability and anomalies in the funding structure.
- The uneven geographic distribution of services.

Despite the above difficulties, progress has been made through the establishment of regional and local co-ordinating structures, which are credited with improving the planned development and management of services in accordance with local needs. This has been greatly facilitated by the availability of information through the national database and the additional investment in recent years in these services.

Human Resources

Like many other areas in the health sector, the recruitment and retention of staff is proving increasingly challenging, and efforts have been made to recruit from overseas, including the UK and the Philippines. In turn, work is being completed with the HEA to create additional training places, particularly for psychologists.

10.4.2 Persons with an Intellectual Disability in Psychiatric Hospitals

The policy of The Department of Health & Children is that persons with an intellectual disability should not be admitted to psychiatric hospitals unless they have a psychiatric disorder which cannot be treated elsewhere. In 1996, 970 people with an intellectual disability were accommodated in psychiatric hospitals. Of these, 310 were classified as not appropriately placed. In 1999, 854 people with an intellectual disability resided in psychiatric hospitals. Efforts are ongoing by The Department of Health & Children to fully implement its policy and provide an appropriate care setting for all patients through the NDP programme.

10.4.3 Primary Care Level

There is an on-going requirement for better communication at primary level including public health nurses, GPs and staff in paediatric hospitals to ensure that lines of communication and information are kept open to assist and support parents and to keep them informed of the needs of their children.

10.4.4 Community Care Level

The issues relating to the provision of community care to persons with an Intellectual Disability as discussed below are also broadly applicable to persons with a sensory and physical disability.

Residential Services

There is a requirement to increase the number of new residential places in line with the growth and ageing of the intellectually disabled population. In 1997, the "Assessment of Needs" report quantified a requirement for 1,439 new residential places. The 1999 report of the National Intellectual Disability Database identified a requirement for 1,677 places over the 2000 to 2004 timeframe, the majority of which it estimated were required in 2000. The Government's three-year development plan and the additional funding allocation made for 2001 to provide 450 new places has made a significant impact on addressing this issue, but gaps obviously remain.

Day-Care Services

Day care services are regarded as having an essential role in the spectrum of community services available. Among the issues that have been raised with respect to day services are:

- A shortage of dedicated day places for people with disabilities
- Services not operating to capacity
- Uneven geographic distribution
- Transport shortages

In addressing the above difficulties, the Assessment of Needs Report 1997 to 2001 recommended the provision of an additional 1,063 day places nationally. The 1999 report of the National Intellectual Disability Database quantified a requirement for 912 places over the 2000 to 2004 timeframe, again the vast majority of which it recommended should be created in 2000.

Since 1997, a variety of different types of day places have been developed and there has been an associated increase in the numbers of people availing of education, employment and early intervention services[7]. It is planned that a further 600 places will be created in 2001.

We recognise while issues remain to be addressed in relation to this area progress has been made.

Respite Services

After residential care, the availability of respite facilities is probably the second biggest issue in the provision of services for the intellectually disabled. Respite services form a critical support provision for those caring for the intellectually disabled in a home setting. While improvements have been made to the services, considerable gaps remain. One of the biggest challenges facing service providers is the securing of capital aid to fund respite beds. Unlike residential facilities, funding is not available from the Department of the Environment because people availing of respite services are not classified as being homeless.

Owing to the gaps that exist between supply and demand, it has been claimed that the services are not actively promoted and as such many parents are in fact unaware that they exist. However, this is gradually changing. We previously identified that The Department of Health & Children has allocated additional funding this year for the creation of 110 new respite places. Its overall objective is to allow access to planned respite breaks to all those who require it.

[7] Report of the National Intellectual Disability Database, 1999

Support Services

- The main community therapy services such as occupational therapy, physiotherapy and speech and language remain significantly underdeveloped and inadequate for the disabled. While progress has been made in enhancing the level of such services, there remains a need to expand these services to meeting the growing demand from the population group.
- Further work is required in the provision of educational services to cater for the distinct needs of autistic children and those with an intellectual disability at large. The establishment of the National Educational Psychological Service will assist in meeting these requirements. Overall, it is acknowledged that while greater co-operation now exists between the Department of Education and Science, The Department of Health & Children and the Health Boards in this area, there remain some structural gaps, which must be addressed.
- The Home Support service, which was established in 1992, has been of tremendous benefit to families. In light of the demographic and population changes taking place, it is argued that on-going initiatives are required to improve home support services. There is a concern over the availability of people to provide these services. The 1999 annual report on the Intellectual Disability Database highlighted a 19% decrease in the number of home support services available since 1996.
- Access to a range of sheltered employment services, including supported and open employment and vocational training, is a key way of promoting social integration and independence for the intellectually disabled. It is argued that these services should be further developed and in particular more people with an intellectual disability should be given a greater choice of services. The clear demarcation of activities between The Department of Health & Children and FAS (with the Department now only responsible for all rehabilitation training for persons with moderate, severe and profound intellectual disability and FÁS responsible for all other training), will lend itself to improving the current service offering. Previously the range of training provision to all groups of persons with an intellectual disability was the responsibility of The Department of Health & Children, which resulted in a non-targeted service offering. A similar strategy has been adopted for persons with a physical and sensory disability.

10.4.5 Key Conclusions

- The provision of services to people with an intellectual disability is a relatively well-defined and concise area greatly aided by the setting of the National Intellectual Disability Database in 1995. This in turn has improved the overall efficiency and effectiveness of service planning and development. Other initiatives implemented under Enhancing the Partnership and Widening the Partnership have and can be expected to have a positive impact on improving structures to support service planning and the co-ordination of activities at Department, Health Board and community levels.
- Efforts are being made to measure service outcomes and focus on service quality. However, more work is required in the area of developing systems to provide information on the costs of providing services on a consistent basis across this element of the health service.
- The changing structure of the population is recognised as having a profound effect on the demand for existing and new services:

- Increased demand for residential services
- Increased life expectancy means that fewer places are becoming available through death
- Increased demand for specialist and geriatric services
- The need for therapeutic support services for people who continue to live with their families
- Increased demand for respite places and home help services

- The objective to move people with an intellectual disability from psychiatric hospitals to a more appropriate care setting is on-going and progress has been made.
- There is an on-going requirement for better communication at primary care level to assist and support parents who have children with an intellectual disability.
- The objective to concentrate services in a community environment has made significant progress in recent years, once again facilitated by the National Intellectual Disability Database and also by a significant increase in capital and revenue funding. Considerable progress has been made in providing additional residential, respite and day services. However, gaps do remain which must be addressed going forward.
- Initiatives are on-going in expanding and developing the range of support services available and this must continue into the future. In particular, we identified a decreasing number of home help assistants in recent years together with difficulties in attracting staff to therapy services because of competition from within and outside of the health sector.

10.5 CHILDCARE

The following service issues were identified during the course of our work.

- The social, economic and political environment has significantly changed children's lives. There is a significant challenge in refining childcare services to the changing environment. Demographic trends and the increasing diversity in family life are impacting on family lifestyles. Key indicators of change include:
  - The child dependency ratio, which has changed from one paid worker per child in the mid 1980s to a projected two paid workers per child by 2005.
  - The increased participation in the workforce by women.
  - Information and communication technologies, which are having a major impact on the lifestyle of children.
  - The significant proportion of children (estimated at 12% in 1998) who are living in households below the 60% relative income poverty line and who, as a consequence, experience basic deprivation.
- Historically, there has been a lack of consistency on how childcare issues are handled particularly in trying to keep up with the significant evolving body of legislation affecting children and child protection.

- Legislation has significantly impacted upon childcare services. There are serious concerns that for much of the 1990s the requirements of the Childcare Act 1991 were not adequately funded. There was also a concern that a significant part of total funding has been directed at investigative measures rather than developing family support services and other preventative areas. It is recognised that it was difficult to achieve a shift to preventative areas because of the increasing funding requirement to support statutory responsibilities.

- Major reform to the criminal justice system for juvenile justice and vulnerable children in need of care and protection was a key issue that was brought to the fore in the latter part of the 1990s. The Childcare Act 2000 has introduced a series of measures to address these areas.

- There is an ongoing effort to improve the identification, reporting, assessment, treatment and management of child abuse. "The Children First - National Guidelines for the Protection and Welfare of Children" represented a major development in strengthening arrangements for the protection of children. The Guidelines also help clarify the responsibilities of professionals and individuals within organisations and provide guidance to enhance communication and co-ordination of information between disciplines and organisations. The challenge is to ensure uniform implementation of the guidelines nationally. A structure has been established to obtain agreement from all Health Boards on service plan commitments each year to implement priority areas of child protection.

  Areas identified for further development include:
  - a costing framework to identify full implementation costs and assist in planning;
  - provision of accredited training courses for information and advice officers;
  - development of publications aimed at community and voluntary organisations offering guidance on promotion of child welfare and the development of safe practices;
  - monitoring of the legal network;
  - creation of information sharing techniques across Health Boards on different practice initiatives being adopted;
  - development of family support planning templates.

- The National Children's Strategy identifies the need for a cross-sectoral approach to the provision of services to children. It is recognised that both in the development of the strategy and in the manner in which the Department of Justice, Health & Children, and Education now interact, a more effective cross departmental focus has emerged.

- Information to support decision-making on childcare issues is poor. There is a need for significantly improved information systems and the development of a coherent set of performance indicators for childcare is required. A review of the management information requirements in childcare is currently being progressed, the focus of which is to:
  - review and report on current information systems in the context of existing policy legislation and relevant research;
  - advise on current international trends in childcare information;
  - identify and report on management information needs and the high level operational needs of stakeholders;
  - the information needs being examined include: basic statistical information, management information, performance indicators, information required to support planning and evaluation functions, information required to assess the quality of

service, costing of services, outcome measurement, service activity and service delivery

- Childcare imposes a significant burden of work on The Department of Health & Children and in common with other areas of the Department's activities needs to be adequately resourced to meet the challenges arising in respect of information, legislation, service development and service monitoring.
- There are significant recruitment issues regarding the staffing of childcare residential units principally relating to the lack of sufficient numbers of qualified staff and the highly pressurised environment in which personnel work in these units.
- Child homelessness is a particularly urgent problem in major urban areas.
- A systematic process review of the quality of childcare nationally is lacking both as regards management of childcare services and clinical practice review. It is expected that The Social Services Inspectorate will have an ongoing role in the review of quality in childcare services. There are concerns that significant variations exist in the quality of childcare services being provided by different Heath Boards.
- Historically, the Health Boards did not act collectively or share experiences in the complex area of childcare services. The establishment of HeBE should provide a basis for conjoint working in this and other related areas.
- Improved social worker facilities are required in the community. Provision is being made within the National Development Plan for such facilities.
- The organisation and staffing of the Adoption Board requires modernisation.

PART 6
CONCLUSIONS AND RECOMMENDATIONS

SECTION 11: CONCLUSIONS AND RECOMMENDATIONS

11.1 CONCLUSIONS

The 1990s will, in retrospect, be seen as a period of significant change in the Irish health-care system. At the start of the decade, the system was in the process of emerging from a period of significant funding constraints and capacity cut backs, a direct consequence of stringent controls over public expenditure in the latter part of the 1980s.

A number of important developments have occurred in the Irish health system over the past decade, and the system today contrasts starkly with the position ten ago. 1994 saw the introduction of "Shaping a Healthier Future", a major advance in the development of a coherent strategy for the health system. 1996 saw the introduction of the Health Amendment Act, which placed in law the accountability obligations of Boards, in terms of service planning and management of the services within a given level of funding. In 2000, the Eastern Regional Health Authority came into operation to address the strategic and operational requirements relating to the complex issues arising in providing health-care in the Eastern region of the country.

From a value for money perspective, the significant increase in annual public health expenditure in recent years represents a fundamental change in the resourcing of the system. It raises the very valid question as to whether in increasing public health expenditure from £2.9bn in 1997 to £5.4bn in 2001 (Estimate), the system is indeed delivering value for money.

We have found that there is a wide acceptance of the need for the health system to deliver value for money and a common interpretation of what this means. Value for money is generally seen as covering the economy, efficiency and effectiveness of the Irish health system. "Shaping a Healthier Future" clearly established these principles. The real issue, however, is that value for money is not an integral part of the systematic ongoing evaluation of the Irish health system. Throughout the 1990s, the health system has lacked clear and consistent performance objectives and was singularly deficient in the application of comprehensive measurement systems across the sector to enable an informed assessment of value for money to be undertaken, and to promote timely interventions to address difficulties arising.

The reality is, other that anecdotally, the Irish health-care system cannot on any evidence based approach demonstrate definitively that value for money is being achieved. Unquestionably, the system has suffered from a lack of funding. What can be said is that there are pointers to suggest good value for money in certain areas, principally in the acute hospital system. There, we can identify high utilisation of capacity and increased use of day surgery as measures of efficiency. The establishment of Casemix programme in the early part of the 1990s also seeks to promote value for money in the acute hospital system. The establishment of structures to improve economy in the sector, particularly in improving materials management and purchasing functions across the system has also contributed to value for money. Furthermore, at a high level, one can point to the comparatively low average spend per head on health-care in Ireland relative to other developed countries internationally. There is a general sense therefore, that at least in some aspects of the system, value for money is being delivered. In other sectors, for example community care, the lack of performance indicators and information makes it extremely difficult to evidentially assess whether or not good value for money is being achieved.

The increase in the absolute amount of funding being made available to the health services demands that structures and systems are implemented which will enable a systematic ongoing evaluation of value for money to be undertaken. The evaluation framework for value for money can properly be set under the established and well understood criteria of economy, efficiency and effectiveness.

This report identifies areas where there is scope to improve value for money; central to achieving this objective is the need to invest in enhanced management information systems which will provide a basis for a coherent and consistent appraisal of economy, efficiency and effectiveness. Performance measurement and management must become an integral part of management practices throughout the sector.

Arguably, the real challenge in establishing value for money is to develop a quality and effective system of care with processes to measure outcomes in a systematic way. Again, an evidence based approach is required. This will require specific evaluation studies to be carried out and significant improvements in information systems. Currently, there are major deficits in the information required to gain a complete picture of the health and illness of the population. Information collected at the present time is spread widely through different agencies and different data systems which inhibits the use of the information in any meaningful way to monitor population health, identify health needs and use and manage health and services appropriately. The reality is that population health indicators in Ireland compare poorly with those of our European neighbours. Without the investment to support the evidence based approach advocated here, it is difficult to see how the effectiveness of the Irish health system can be proven in value for money terms.

This report points out a range of organisational, funding, service and systems/information issues relevant to improving value for money in the Irish health system. The new health strategy, due for completion in mid 2001 provides a real basis for addressing key issues in this report. A major challenge will be to plan the economic, efficient and effective development of the Irish health system over the next ten years, with a level of certainty that the necessary funding to implement the strategy will be forthcoming. There has been no shortage of strategic policy development at all levels of the Irish health-care system; there has however, been an absence of a multi-annual planning framework, supported by a commitment to funding. Such an approach is essential to provide a basis for the implementation of policy on a planned basis over the medium term.

In recent years, a number of positive features have emerged in the context of improving value for money. There is a growing acceptance that deficiencies in capacity, both as regard bed numbers and medical manpower, need to be addressed. There is an improving service planning process at Board level, a mechanism which will assist in bringing value for money to centre stage throughout the system: indeed, service planning has been one of the major advances in the Irish health-care system during the decade. For the first time, the funding under the National Development Plan provides a multi annual focus to both service developments (capital and revenue) and a commitment to funding over the medium term. A suite of performance indicators has been developed. The National Health Information Strategy can play an important part in implementing the necessary change in relation to performance management and monitoring throughout the system.

The challenge, were this study to be commissioned in ten years time is to be able to demonstrate evidentially that value for money has significantly advanced over the period. Value for money in health is too important to leave to periodic review. The Irish health system requires the systematic ongoing audit of health programmes against value for money criteria to drive continuous improvement through the sector.

11.2 RECOMMENDATIONS

The key recommendations of this study which focus on VFM are set out below, and are split into three groups: matters for Government, those for the Department of Health & Children, and those for the Health Boards, other agencies and health service management.

I: Matters for Government:

(i) Establishment of a Health Information and Evaluation Agency to enhance Value For Money

The routine and systematic evaluation of value for money is not generally present in the Irish public system. It can be agreed this is the case in the health services. Value for money means here economy, efficiency and effectiveness.

The National Health Information Strategy, currently being prepared in the Department for completion in the Autumn, is, we understand, examining the possible establishment of an agency with responsibility for information gathering and analysis. We support the establishment of an agency with the following remit:

- The development of a strategic framework for information in health.
- The implementation of national health information strategies.
- The ongoing development of performance management structures in the system, including developing performance indicator templates for application across the sector.
- Leading the development of a national IT strategy in health.
- Ongoing assessment of value for money of the system in terms of economy, efficiency and effectiveness. This will include systematic and regular reviews of expenditure programmes, and the assessment of the effectiveness of national strategies.
- Ongoing monitoring and evaluation of performance in the sector against performance indicators, including benchmarking and identification and communication of best practice.
- Development of service planning and evaluation processes.
- Management and development of the Casemix programme.
- Audit, and quality initiatives .

This agency will need to be properly resourced in terms of numbers of staff and skill sets (e.g. health economics, analysts, finance, public health etc). It should be accountable to the Minister for Health & Children.

(ii) Financing Mechanism for the Irish Health Systems

The financing mechanism for the Irish health system, particularly whether a shift to an insurance based model is desirable, has been the subject of debate in recent times. It is beyond the remit of this study to recommend any particular financing model. Any consideration of changing the financing mechanism for the Irish health-care system should only be made after a detailed examination of the potential impact in terms of cost, access, control over expenditure, capacity and delivery of services. Changing the financing mechanism in itself does not guarantee improved health service delivery.

This report provides an overview of health systems in other developed countries. In one respect or another, all these systems experience difficulties and service pressures, including financial problems. The tax based centrally financed system in Ireland promotes better cost containment than insurance models, but access is poorer. Service planning and service integration are also likely to be stronger in the type of centrally funded system we apply.

(iii) Structure and Organisation of the Health System

(a) There needs to be detailed clarification of and separation of roles at Department, Regional Authority, Health Board, and agency level. The supporting resources need to be clearly defined and a change management plan put in place to allow appropriate devolution. This should clearly define the remit of the Department which is currently too broad, and remove it from operational involvement in the system.

(b) There is a requirement to carry out a detailed review of the organisation structures within the Department to ensure that it carries out its functional and care group responsibilities optimally, and is properly resourced to carry out its remit.

(c) Processes for multi-annual budgeting and planning need to be approved and implemented. These should cover a three-year timeframe. A commitment to funding the health services within a multi-annual plan and beyond the current one year window is essential.

(d) A review should be commissioned on the structure of the system and role of Health Boards. The terms of reference of this review should focus on:

- Organisation of services nationally, including role and structure of Health Boards. The current structure has existed since 1970 and merits review.
- Assessment of alternative organisation structures for service delivery.
- Appropriate size and modus operandi of the Boards of Health Boards.

II: Matters for the Department of Health & Children:

(i) Health-care Policy

It is important that the new health strategy identifies a full policy framework across all areas of the system. Gaps in policy (in particular a detailed policy for the acute hospital sector) should be filled.

All future policies should be more explicit in terms of targets set, performance indicators to be used for evaluation purposes, and have a clearly set out framework for implementation. A policy setting methodology using needs assessment and good option appraisal (including technology assessment) needs to be set in place as the norm coupled with a well defined monitoring and evaluation framework.

In addition to the above this report has also identified a number of themes, which we believe are central to future policy formulation:

- A focus on regionalisation of services. Regionalisation needs to be defined, and the Department needs to adopt a leadership role in effecting an appropriate regionalisation strategy with the Health Boards. Planning at a regional level will need to address national priorities and strategies, and should not be adversely impacted or distorted by local issues.
- An acceptance of the need for redefinition of roles amongst existing service providers in the context of improving patient care and regionalisation.

- A priority to be given to health promotion and preventative measures.
- A need to encourage best practice, with a priority to be given to standardised protocols for treatment across the system that are evidence based.
- A focus on service integration with the need to reward co-operation across service areas and health boards.
- A focus on the development of primary and community care services.
- An explicit funding commitment to support policy.

(ii) Resource Allocation

There needs to be a fundamental assessment of the appropriate level of resource allocation to each defined Health Board area. This should have regard to a range of indicators including demographic profile, morbidity, mortality, social deprivation, rurality, and take specific account of the impact of projected cross boundary flows of patients between Board areas. This needs to be considered from a zero-base taking into account requirements resulting from a clearly defined national value system for health-care. This is necessary because the current funding arrangements are the product of a system of incremental financing arrangements over the long term, and core resource allocations should be subject to detailed scrutiny within the proposed fundamental assessment.

(iii) Structure and Organisation of the Health System

(a) There is a need to develop a consistent definition and understanding of governance in health-care in Ireland, particularly emphasising the duty of care which Boards and management carry for the development of appropriate organisation structures and systems for clinical activity.

(b) Detailed manpower planning for the health sector in conjunction with the educational sector should be undertaken.

(c) The Department should promote robust processes for strategic planning, and enhanced service planning at Board level.

(d) The Department must play a leadership role in developing a performance measurement culture within the health systems to encompass:

- Individual performance appraisal.
- Development of a prescriptive approach to VFM, with the establishment of the appropriate processes for monitoring and evaluation. This should entail setting challenging cost reduction targets on an ongoing basis in a context of greater co-operation between health boards and significantly enhanced investment in management information systems.
- Service delivery performance measurement and evaluation.
- Internal Audit, a function that has been underdeveloped in the health system but has been subject to recent reports C&AG and health boards.
- Internal Audit of management practices and systems.
- Introduction of system wide clinical audit & governance.
- Processes and systems for measurement and evaluation of health outcomes.

(e) A review of the current Consultants' Contract is required with regard to the requirement to implement effective and consistent structures to involve Clinicians in Management, to improve rostering and management of time inputs, and to advance clinical governance and clinical audit.

(f) A national HR strategy focussing on human resource management should be developed.

(g) There is considerable scope for the Department to proactively manage its interaction with the media, which should facilitate a broader analysis of health issues in the media.

(iv) Performance Measurement and Information Systems

(a) The National Health Information Strategy should set out explicitly all dimensions of the information needs of the health system (i.e. health gain information, management information, performance indicators).

(b) An IT strategy to deliver the information requirements identified in the NHIS should be developed at a national level. This could be carried out under the direction of the proposed Health Information and Evaluation Agency referred to above.

(c) By building on the work already carried out on performance indicators, a framework involving a hierarchy of performance indicators should be agreed and implemented consistently across the sector.

(d) The concept of shared services should be pursued, either through HeBE, the ERHA shared services platform or an alternative which would concentrate on providing at a minimum the following services:

- ISIT provision
- Financial transaction processing
- Purchasing and Materials Management

The implementation of the above recommendations will require a commitment to major investment in IT over the medium term. The level of funding proposed in the National Development Plan for IT at £20m per annum will not meet the requirement; indeed it is likely that the investment level required is a multiple of this.

III: Matters for Health Boards, other Agencies, and health service management:

Structure and Organisation of the Health System

(a) Commitment by Boards to increased conjoint working and collaboration through HeBE and otherwise, including in the area of information systems specification, selection and implementation.

(b) Commitment by Boards to working with the Department on the development of a regionalisation strategy for services, and to give primacy to promoting national strategies and policies. The national agenda must take precedence over more local, parochial issues- this will require an acceptance of change, including in the redefinition of the roles of certain hospitals in the system.

(c) Commitment to organisational development, including an assessment of whether organisation structures between Boards should be streamlined, including in the area of care group structures, and to identify best practice.

(d) Development of properly resourced management structures in larger service units (e.g. larger acute hospitals) – resources will need to be provided to Boards to implement such structures.

(e) Commitment by Boards to improved standards of corporate and clinical governance, including ensuring Boards are fully conversant with their responsibilities in these areas, and that appropriate organisation structures and systems are in place to discharge clinical governance responsibilities.

(f) Commitment to implementation of meaningful structures to involve clinicians in management.

(g) With clinicians, to promote and develop comprehensive systems of clinical audit.

(h) Strong commitment by CEOs to supporting the Health Materials Management Board, including promoting cost reduction targets.