

# Value for Money Audit of the Irish Health System Executive Summary



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**IN CONJUNCTION WITH**  
**THE YORK HEALTH ECONOMICS CONSORTIUM**

**VALUE FOR MONEY AUDIT**  
**OF THE IRISH HEALTH SYSTEM**

**VOLUME 1: EXECUTIVE SUMMARY**

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**THE DEPARTMENT OF HEALTH & CHILDREN**

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& Touche**

## **PREFACE**

*This Volume of the report presents an Overview and Executive Summary of the Value For Money Audit of the Irish Health System undertaken by Deloitte & Touche and the York Health Economics Consortium.*

*The main body of the report is presented in Volume II. Volume III contains the Appendices to the main report. Set out overleaf is the full Table of Contents for Volumes I, II and III.*

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**OVERVIEW**

## **THE DEMAND FOR HEALTH SERVICES**

The fundamental problem facing the health services in Ireland and elsewhere is the growth in demand and Health Care costs. This demand is driven by a range of factors including public expectations, demographics, the availability of new diagnostic and therapeutic approaches to care, and significant technological developments in medicine, including drugs. From the point of view of government, in a system where c.80% of the total cost of health is borne by the taxpayer, this places enormous demand on available resources. In Ireland, the position is further exacerbated by a significant level of under-funding of services in the 1980s. The health services throughout the 1990s have therefore been grappling with two fundamental problems in meeting the public's expectation; one is the need to make up the investment deficit of the 1980s, the second is the cost of those higher service levels and new procedures. No assessment of the Irish health system can overlook the serious capacity limitations in bed numbers and medical manpower, which limit the attainment of value for money from a patient perspective and which lie behind many of the pressure points in the system. The position is made more difficult by the requirement to meet the significantly higher income expectation of people working in the health sector, to address staff morale issues, and to meet the need to attract more and very highly skilled professionals into the service.

## **THE CURRENT EXPENDITURE**

Expenditure on the health services has grown from £1.5bn in 1990 to £3.8bn in 1999 (and to £5.4bn in 2001). This is a significant increase based on any measure, yet the perception is that it has, at best, only resulted in a modest improvement in services. As this report highlights, many gaps in services remain; there is also a lack of integration of services between secondary and primary care. Particularly in recent years, it is important to recognise that a significant part of the increase is due to factors driving up the costs of Health Care without necessarily increasing the levels of service provision. Much of the additional spend is in fact being absorbed in pay and non-pay inflation and in the increased cost of demand led schemes.

In absolute monetary terms, capital expenditure remained relatively static for the first half of the 1990s, increasing annually from 1996. By 2001, capital expenditure had reached £270m (including expenditure on IT). This is still an extremely low level of investment in the context of maintaining/replacing the current level of capital infrastructure (estimated at up to £5.0bn) without taking account of the investment requirements for new technologies and procedures. In addition, the lack of adequate investment in re-equipping existing facilities diminishes value for money. Furthermore, it is hard to conceive of an operation of such complexity as health, involving a commitment to expend £5bn per annum, being managed effectively with the current minimal level of funding of information systems.

## **POLICY AND STRATEGY**

There have been considerable developments in health policy and strategy throughout the 1990s. Much progress has been made in defining health needs and formulating the relevant strategies and actions necessary to meet those needs. Much of the improvements that have been achieved in the service derive from, in particular, the thinking behind "Shaping a Healthier Future", published in 1994.

Health is a sector frequently subject to criticism, but some successes are in evidence. Despite capacity limitations, the numbers treated in the acute hospital sector increased from 640,000 cases in 1990 to 830,000 in 1999. Significant increases in day case activity occurred over the decade, rising from 20% of total activity in 1990 to 36% in 1999.

Significant additional investment has been made in recent years in services for the elderly, in childcare and the intellectually disabled, among others. Intellectual disability is a good example of the use of needs assessment to inform policy, and the use of well defined databases to facilitate review, evaluation and better targeting of services. Policy development has been strong, with well developed strategies in areas such as cancer, cardiac and children. The introduction of service planning in the health sector is also a positive development.

A well thought out strategy for Health Care inevitably involves innovation and change that can only be achieved over time. It also requires explicitly committed funding provided through a multi-annual budgeting process to support not only implementation but also subsequent evaluation and monitoring.

Such a commitment runs contrary to traditional public sector financing (the National Development Plan being a notable exception), the more so in a sector where the potential rate of cost escalation creates cautiousness to medium term commitments. However, we are firmly of the view that such a multi-annual commitment to funding (and we mean by this essentially a three year cycle) is an essential prerequisite to effective implementation of policy and strategic objectives.

To advance policy, significantly improved mechanisms are required to support implementation and to systematically measure performance against explicit targets. This should include mechanisms whereby effective VFM measures are established, monitored and reported.

## **FUNDING**

The health service currently has some 87,000 approved posts and the current budget is £5.4bn. Apart from the private insurers who account for c.11% of funding and other private and household expenditure, in any reasonable timescale the funding of the service can only continue to come from the taxpayer. The current approach to funding can be best described as incremental, i.e. the previous year plus a percentage increase, plus some additional funding for new initiatives. The problem with this approach is that it militates against medium to long term planning in terms of infrastructure and service development, reinforces the status quo, and potentially causes management to focus on those projects for which funding is available and can be completed within a financial period, rather than those which could generate more long term benefits. It can also lead to an inefficient and inequitable allocation of resources as between competing Boards, as well as an inappropriate development of facilities and services either within or between Boards.

## **ORGANISATION AND STRUCTURE**

The current structure of the health service in Ireland dates back to the Health Act of 1970. More recent legislative changes in 1996 and 1999 sought to improve accountability, service planning and delivery. Part of the objective of these and other changes was to free up the Department from operational issues to concentrate more on policy and strategy. This has not yet been fully achieved and Health Boards need to be prepared to take on these operational responsibilities. This will also enable the Department to take on a more regulatory role. However, this is not the core issue.

It is difficult to imagine any demand led service organisation, which has grown at the rate of the Irish health service, which is still operating within a structure devised over thirty years ago. The optimum shape of the system including the role and structure of health boards urgently needs to be re-evaluated, to support regional self-sufficiency and improved equity of access. This will bring resourcing challenges, and the need to convince patients of consistent standards of care nationwide.

Within this structure, dedicated people are operating in an environment where the focus has been on administration rather than management of service delivery in what has been an incremental, resource constrained environment. The culture of financial restraint which has been instilled in a generation of health service personnel is not well suited to longer term strategic planning of investment. Enhancing skills throughout the system will be required to meet the challenges of the new era. A strategic approach to human resource management is required.

The lack of conjoint working between Boards has also been a limiting factor; in fact too often they have been competing not just for funding but also for people and infrastructure. A lack of a cohesive and consistent approach from the centre on many issues has resulted in an uneven pace of development of services.

The current structure provides a strong element of local democracy in the health service. There is however the counter argument, namely that the political nature of Health Boards constrains the delivery of the best VFM health services and can adversely affect decision making within the regions.

### **PUBLIC/PRIVATE MIX**

45% of the Irish population hold private medical insurance. About 20% of the beds and 23% approximately of admissions in public hospitals are designated as private. The number of insured persons has been rising, principally, it seems, because of the speed and certainty of access to care which the holding of insurance more easily provides. Tax relief on premia also promotes the holding of medical insurance.

There is a need to clarify the policy objectives on private medical insurance in the Irish health system, and define the role, costs and benefits of private practice in the public system. Care is however required to ensure an objective assessment of these issues is made, particularly to avoid using the public/private mix issue to mask fundamental capacity limitations in the public health system which are central to many of the current difficulties.

### **VALUE FOR MONEY**

The current level of expenditure and projected growth in the health service requires the development of a consistent approach to VFM across the service. The reality is that, other than anecdotal, the Irish Health Care system cannot on any evidence based approach demonstrate definitively that VFM is being achieved. The Irish system currently lacks any formal, broadly based VFM framework supported by management processes, consistently applied. The absence of adequate, comparable information systems also militates against ongoing monitoring and assessment of efficiency and effectiveness of how services are provided.

The inability of the health service to move rapidly in developing an effective VFM process reflects the multiplicity of organisations within the service, the different pace of development, the lack of consistency in management information systems and the absence of reliable databases. To address these issues requires a commitment to structural reform within the system, which is aimed at streamlining its organisation, promoting a management rather than an administration approach and ensuring the development of a consistent approach across the sector in the development of management information systems. A cohesive management structure, in which clinicians are integrally involved in management, and where audit and accreditation play a central role, must be developed.

The issue for government is that a demand led health service with a growing public expectation as to standards of service and care is capable of absorbing a more or less unlimited amount of funding. This report points to deficits and limitations across the system; in primary and community care, the mental health services, services for the elderly, childcare, and the acute hospital sector. By any analysis, the level of incremental funding required to address the service gaps and the other investment requirements outlined in this report, is very significant. We come from a position where the per capita spending on health in Ireland has been low by international standards. As a nation, we need to decide what type of health service we require. If a superior system is demanded by the public (and there is much evidence to believe this to be the case), then, as taxpayers, the financial implications of addressing the current health service deficits need to be accepted. In the medium term, the impact of an ageing population and the ever-increasing patient demands will place increased demands on resources. However, it should also be noted that Ireland has the youngest population of any EU state and this has, and will for a period of time, be of benefit in restraining growth in spending on health services whether by the Exchequer or by the private sector.

The OECD analysis of the 1998 position indicates that percapita spending in Ireland is low in comparative terms with other OECD countries. The more recent and significant increases approved by Government could have an impact on the relative placement of Ireland in 2001. Given that approved health spending has doubled over the last 5 years, it is difficult to believe that the 2001 comparative information (when it is available), will not show some improvement in our position in the league table. It is vital to note that the three years 1999-2001 have experienced 55% growth on the current revenue spending and 68% on capital spending. None of these increases are reflected in the most current OECD data.

From the perspective of the health service, the challenge is to undertake that fundamental organisational and management change necessary to deliver on the current strategy in a context where it can clearly demonstrate that for the additional funding becoming available, the service delivery not only meets the public expectation but represents value for money to the taxpayer in terms of cost efficiency, and more fundamentally in demonstrably improved population health status.

## **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 that this is also the case in the health services. Value for money relates to the issues of 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.

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- (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.

**EXECUTIVE SUMMARY**

## 1. INTRODUCTION

Value for Money (VFM) is an essential part of public reporting and accountability. In the health system, value for money focuses not just on the economy of expenditure and the efficiency of activities but also on more fundamental issues relating to the extent to which improvements in the health status of the population are being achieved.

This report considers Value for Money in the provision of Irish health services in the 1990s. During this time, public health expenditure grew from £1.5bn (1990) to £3.8bn (1999) and subsequently increased substantially to £5.4bn by 2001. The growth in public health funding in the latter part of the decade contrasts sharply with the circumstances in which the Irish health sector found itself in 1990. Then it was absorbing the aftershocks of the stringent cutbacks in public spending of late 1980s, a period which saw significant rationalisation in system capacity, the effects of which continue to affect the Irish health sector today.

This summary reflects the structure of the main report with which it should be read for a complete understanding of the issues raised. The key issues and comments from the various sections of the report are summarised under the following headings:

- Financing health systems
- Health Care Policy
- Data Analysis
- Structure and Organisational issues
- Health Management Information and Performance Management
- Service Issues
- Conclusions and Recommendations

## 2. FINANCING HEALTH SYSTEMS

The manner in which health systems are financed impacts variously on VFM. In most developed countries governments have significant involvement in both the financing and delivery of Health Care. A market mechanism based on ability to pay is not considered appropriate for Health Care, as a result of which governments typically intervene in the system to ensure Health Care is available for all.

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 particularly for more complex problems.
- 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. As a result, 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 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;

The financing of Health Care systems is typically achieved through general taxation, social insurance, private insurance and consumer out of pocket expenditure. Health Care is paid for under a range of models, with most provision not being paid for directly by the consumer. Providers may be paid by fees per patient or activity, by capitation funding, by block grants and contracts, which may not be sensitive to the volume of services. An international comparison is shown below:

<b>FINANCING MECHANISM</b>	<b>MAIN REVENUE RAISING MECHANISM</b>	<b>SUPPLEMENTARY REVENUE RAISING MECHANISM</b>
<b>Tax based financing</b>	Ireland UK Canada Australia Sweden New Zealand	The United States (elderly/children) Belgium Germany France
<b>Social insurance based mechanisms.</b>	Belgium Germany France The Netherlands	-
<b>Controlled market insurance</b>	Switzerland (previously risk related private insurance now community rated)	Ireland (VHI) Australia The Netherlands (wealthier citizens are not covered by social insurance)
<b>Private insurance Free Market</b>	The United States	UK New Zealand Canada (Mainly Pharmaceuticals)
<b>Out of pocket payments</b>	-	All

The issue of fairness to the sick and poor varies according to the finance raising method used.

<b>REVENUE RAISING MECHANISM</b>	<b>FAIRNESS TO SICK</b>	<b>FAIRNESS TO POOR</b>
Tax	High	High
Social Insurance	High	Medium/Low
Private Insurance	Low	Low
Out-of-pocket	Low	Low

The Irish Health services are funded primarily from general taxation and the entire population is entitled to a core publicly funded service, including hospital in-patient services. There is, however, a mix of public and private care in the system, which is reflected in the fact that voluntary private insurance is an established part of arrangements used to meet the cost of hospital services.

Whilst c.45% of the population is covered by private health insurance plans, the total annual expenditure under such plans is small relative to public spending on health services.

The key issues associated with different methods of financing Health Care relate to:

**Control over health service capacity** – Control over capacity is greater under a centrally funded system. Control over capacity is weaker in insurance systems where payments are made by multiple agencies. 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** – Control over expenditure is likely to be stronger in a centrally controlled system than in an insurance based one. Demand management is not feasible or well conducted in centrally funded health systems and rationing may be an inevitable result, in the absence of tightly defined care pathways. In insurance based systems, it is similarly difficult to control demand growth as again clinical pathways may not be specified.

**Ability to implement coherent planning and national strategies** – Strategic and service planning, particularly in relation to service integration is likely to be more robust in a centrally funded system. Provider independence (GPs/Consultants) is historically strong in western developed countries, which presents a barrier to integrated planning under any system, because there are limited corporate mechanisms to achieve this objective. In addition the absence of registration of a population with a GP practice undermines coherent and integrated approaches to record keeping or planning services for health gain. Whilst the central payments systems provided by insurers can provide a comprehensive record of a patient's care there is no evidence to suggest that such systems are used for planning health service delivery.

**The extent to which Government is the effective guarantor of Health Care funding** – In almost all developed countries, the government effectively stands as the final supporter of Health Care funding, including within an insurance based model. This is because many of the sickest people will be elderly or unable to work and thus unable to support insurance schemes based on voluntary contributions. Governments therefore have to provide a safety net for such groups. In addition in some countries the provision of emergency care in terms of ambulance services or Accident & Emergency units may fall outside the remit of insurance and thus the government is left guaranteeing Health Care for such emergency care. Insurance premiums are also politically sensitive in countries where insurance is compulsory or where voluntary insurance covers a large part of the population. Not every government has had to intervene to prop up insurers and some systems with well established insurance agencies may not require such support currently. Increases in unemployment levels in times of recession can adversely affect social insurance systems. Unless governments are prepared to accept denial of services or medically induced bankruptcy, it is difficult to see how they can not stand ready to support health insurance funds in the event of financial difficulty.

**The merits of fee-for-service and capitation** – Capitation and fee-for-service can exist in both centrally funded and insurance based systems. Fee-for-service systems encourage intervention and the provision of services, even when these are of limited therapeutic value. Capitation provides no incentive to intervene and may encourage under provision of care or monitoring of care. The introduction of fee for service arrangements into an existing capitation system is likely to increase costs. In our view the health benefits of higher rates of consultation are not clear-cut. Fee-for-service would increase convenience of access to more responsive providers, but without evidence of improvement in health, a general move to fee-for-service is not recommended.

**Accountability to the public** – Direct accountability to the public is limited in all developed countries' Health Care systems irrespective of financing mechanism.

**Risks of adverse selection and discrimination against the sick** – Adverse selection and risk discrimination against the poor are inevitable features of insurance. The focus of insurance is to discriminate against bad risks and to limit their ability to insure. However, in Health Care there are widespread concerns that those facing high risks (for example the elderly) through no fault of their own, should not be excluded from social protection. This can also cause technical difficulties in terms of the implementation of risk equalisation processes. These issues are not present in centrally funded systems.

**Universal access** – The issue of access is frequently seen as a 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 poorer 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 gain access after a longer wait. For the middle income worker and above, access under public finance may be poorer in that services are more limited than they could obtain under an insurance model of funding. 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, 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 & delivery of Health Care** – If an acceptable level of equity is to be achieved in a health system then healthy people in a society must pay the majority of the cost of Health Care for those who are relatively sick. Every developed country subscribes to this principle though some take it further and seek greater support for the old and the sick. Whatever the funding mechanism (and the precise mechanisms may not matter appreciably) the cost of services for the old and sick are a cost to the younger and the healthier. If, however, the access for the old and sick is based on fee for service systems, there is clearly scope for the cost of care to be higher. On the other hand, in cost contained centrally funded public systems the level of service provided may be limited.

Our studies have shown that there are prima facie difficulties inherent in all the major types of funding. Whilst insurance based systems may provide better levels of access there is a considerable trade-off in terms of equity and value for money with tax based systems. In a tax based system, equity and fairness are high. Other systems are less equitable though social insurance can be fair on the poor if they are enrolled at public expense into sick funds. Tax based systems also offer better control over costs. Overall the choice remains between cost and access, though complex mechanisms can be developed to balance these effects.

## Trade-off between Health Funding Systems

INSURANCE	TAXES
<ul style="list-style-type: none"> <li>• Better access likely</li> <li>• Worse cost containment likely</li> <li>• Higher input prices and clinical staff wages/fees</li> </ul>	<ul style="list-style-type: none"> <li>• Worse access likely</li> <li>• Better cost containment likely</li> <li>• Lower input prices and clinical staff wages</li> </ul>

Changing a nation's system of health funding is one that needs serious consideration and is beyond the remit of this study. There are no easy solutions, no panaceas. A new financing mechanism may address certain deficiencies in the existing system, but create others. Changing the financing system does not necessarily improve health service delivery. Change should only be undertaken following a detailed examination of the complex interrelationships between financing, cost, access and delivery of services. Furthermore, the effort required to change the system of funding is significant. If a fraction of such an effort was put into improving and managing the existing system the perceptions that are behind the suggested need to change may well disappear.

### 3. HEALTH CARE POLICY

#### 3.1 POLICY OVERVIEW

There have been considerable developments in health policy through out the 1990s. This highlights the effort and progress that has been made by The Department of Health & Children and others in defining health needs and formulating key strategies and actions to achieve these. Overall there has been no lack of strategic thinking or policy implementation in the Irish Health Care system.

The most fundamental policy document of the decade was "Shaping a Healthier Future" issued in 1994. This strove to develop an overall strategic planning process for the Irish Health Care system through the integration of key policy objectives and principles into a single framework that would serve to underpin the provision of all future health services. This was a well-considered and rounded strategy, which created a coherent framework within which health policy could be developed. However the major criticism of this strategy is the lack of a framework for both its implementation and subsequent monitoring and evaluation. Furthermore, the lack of explicit funding for the strategy over a period of years has rendered aspects of what is a well-considered strategy somewhat aspirational.

The other notable policy developments during the 1990s were the implementation of specific strategies for cancer and cardiovascular services in an effort to streamline and co-ordinate services where significant health issues exist. It is too early in their implementation to assess whether these policies are being implemented in a manner that can show demonstrable health gain.

There are also some gaps in terms of policy development and, for example, the acute hospital service (a major gap) physically handicapped, ophthalmology, Accident & Emergency services which need to be addressed by the new health strategy.

In general, future policies need to be more explicit on targets set, have an associated set of performance indicators, which are routinely measured within a given timetable, and should be subject to periodic audit to evaluate their effectiveness. The level of monitoring and evaluation carried out by the Department in the past has been limited. The health system at present also lacks a comprehensive process for policy audit and evaluation.

### 3.2 SUMMARY OF VFM ISSUES: POLICY

CONTRIBUTING TO VFM	LIMITING VFM
<ul style="list-style-type: none"> <li>• Wide range of policy development.</li> <li>• “Shaping a Healthier Future” strong overarching strategic framework.</li> <li>• Well-developed strategies emerging in specific areas for example cancer, cardiac, children.</li> </ul>	<ul style="list-style-type: none"> <li>• Policy development not explicitly linked to long term funding. A multi-annual approach is required to funding.</li> <li>• Policy gaps in significant areas of Acute Hospitals, Accident &amp; Emergency. The complete absence of a current acute sector policy is a major gap.</li> <li>• Strategies frequently lack explicit targets, performance indicators and routine audit.</li> </ul>

## 4. DATA ANALYSIS

An examination of trends in the Irish health sector over the period 1990 to 1999 reveals the following:

### (i) Population

Estimated population growth in the decade was 7%. A feature of the period is the 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 has marginally fallen in numbers, 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.

The growth of the Irish population in the 1990s was therefore 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.

### (ii) Health Expenditure

A fundamental question to be answered relates to why, given the significantly increased spend in health services from £1.5bn in 1990 to £3.8bn in 1999 (and to £5.4bn in 2001), there is a perception that there is only a modest discernible increase in services. It is important to recognise that a significant part of the increase is due to factors driving up the costs of Health Care without increasing the levels of service provision. For example, in the period 1997 to 2001, an increase in non-capital public expenditure of £2.8bn has arisen.

Of this no more than 40% can be attributed to service developments, the balance being absorbed in pay and non-pay inflation and in the increased costs of demand led schemes. Of the c.£1bn increase in funding of services in the 1997 to 2001 period, half has gone into continuing care, with some £250m in aggregate being put into acute services development. The rate of increase in the allocations is largely arising as a result of factors outside of management’s control (pay awards, specific programmes, legislation). Work carried out by the Dublin’s Academic Teaching Hospitals indicates that the financing of core activities in the hospitals (i.e. excluding funding associated with service developments), has in fact been decreasing.

In the period from 1994 to 1999 the general level of inflation was of the order of 2% per annum. Medical inflation however in that period on a global basis significantly outstripped general inflation. A number of factors are causing Health Care costs to rise significantly in excess of general inflation:

**Price inflation in medical equipment** - Price inflation on medical equipment has run at a level of c.3% per annum over and above the general reported level of inflation in the economy through out the 1990s.

**Technology** - Health Care has been impacted by significant increases in technology, (including drug technology), which brings with it increases in the cost of equipment and increases in treatment costs for patients.

**Demographics** - Changing demographics represent a significant influence on the demand for Health Care. People are living longer, and the increasing number of elderly in the population as a whole places increased demands on the Health Care systems. In addition the population has increased by c.7% in this decade.

**Patient expectations** - Patients increasingly demand the highest possible standards of care from health service providers. This influences costs in terms of demands for the most technologically advanced methods of treatment, and also in terms of the quality of the physical care environment.

**Legislative change** - Health services are affected by the increased costs of meeting new legislative requirements such as those in relation to Health & Safety, the minimum wage, and the directive on working hours.

**Improvements in pay and conditions** - There have been a number of pay awards to medical nursing and other staff within the health system during the period in excess of general inflation.

Over the period from 1990 to 1999, net non-capital health expenditure by government rose by 147%. Relative to general inflation, this is equivalent to a growth in real terms of c.125%.

In absolute monetary terms, capital expenditure remained relatively static for the first half of the decade, increasing annually from 1996. By 1999 capital expenditure had reached £181m (including expenditure on IT), reflecting a significant uplift on the level in 1990, but nevertheless an extremely low level of capital investment in the context of maintaining the current capital infrastructure.

During the 1990s Voluntary Health Insurance expenditure consistently represented between 11% and 12% of public net non-capital expenditure, highlighting the dominant role of public health provision in the Irish Health System.

Total public non-capital health expenditure per capita increased from £442 in 1990 to c.£1,000 in 1999 and an estimated £1,400 in 2001.

### **(iii) Personnel and Pay**

The numbers of people working in the health system increased by 13,000 to 77,000 or 22% over the 10-year period, 1990-1999, indicating a significant commitment of additional resources to the public health system during the decade. By 2001 there were some 87,000 approved posts in the sector.

Approximately one in two of these additional resources went in to clinical or paramedical areas, representing an overall increase of c.19% in these areas over the 10 years. This increase includes the growth in numbers of social workers.

Overall pay costs in the Health Boards increased from £589m in 1990 to £1.42bn in 1999 an increase of 140%. A significant growth area was community care, where pay costs grew fourfold reflecting the increased numbers devoted to this area over the decade.

Based on health Board pay costs, which reflect c.65% of the total pay costs in the health system, significant real increases in average pay costs arose in all categories of staff during the decade.

#### **(iv) Non Pay Expenditure**

Non Pay expenditure in Health Boards increased from £400m to £1.1bn over the ten years to 1999, an increase of 175%. Significant cost increases arose in the areas of drugs and medicines, medical and surgical supplies, grants to agencies and capitation payments. Expenditure on the Community Drugs Scheme also rose sharply towards the end of the decade.

Maintenance costs (excluding minor capital schemes) amounted in aggregate to a mere £27m across all Boards in 1999, by any standards extremely low having regard to the physical infrastructure and equipment in the public health system. Once-off capital funding of £90m was provided in 2000 for re-equipment. It is difficult to see how this level of maintenance expenditure comes anything near the level required to maintain the considerable asset base of the health system. This must adversely impact on the achievement of a value for money service.

#### **(v) Acute Hospitals**

The Value for Money achieved by the acute hospital system can be measured by activities or by outcomes. Relative to other countries, the Irish hospital system has relatively lower costs and fewer clinical staff. It also has relatively fewer acute hospital beds than many countries. 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. As in most health systems internationally, there is no systematic assessment of outcomes and so the extent to which the hospital system is improving health cannot be routinely be demonstrated.

During the 1990s:

- Total cases treated in acute hospitals (inpatient and day combined) increased from 640,000 in 1990 to 830,000 in 1999, and to 868,000 in 2000.
- In-patient admissions remained relatively static throughout the period, not surprising given the relatively unchanged number of acute inpatient beds available in the period.
- Throughout the period, the average occupancy rate in the acute hospitals sector remained extremely high at c.82%-85%. In some cases, occupancy rates frequently exceed 100%, which compromises service quality. This level of occupancy is high by international standards and reflects high utilisation of available capacity in the hospital system.

The persistency of the occupancy rate at this high level throughout the period points to an efficient hospital system in terms of the utilisation of capacity; it also raises an important question as to the adequacy of the inpatient bed capacity particularly when considered in conjunction with the continuing presence of waiting lists for inpatients throughout the period.

- Average length of stay in hospital has fallen from 6.9 to 6.7 days. The increasing proportion of the elderly will put upward pressure on length of stay in the absence of suitable intermediate facilities.
- The number of day beds available increased from 284 in 1990 to 704 in 1999. During the same period there was an increase in day cases of 140%. Day cases as a percentage of total admissions increased from 20% in 1990 to 36% in 1999. In every year during the decade a progressive increase in day cases occurred. This also is a significant measure of increased efficiency in the acute hospital system during the decade. Based on data from the Casemix Programme, day cases typically cost c.20% of the average in patient cost highlighting the importance of optimising day case treatment in the system. Extending day case activity will require investment in appropriate infrastructure.

#### **(vi) Special Hospitals**

Total net expenditure in the Special Hospital Programme nationally during the decade 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, a measure which suggests improved value for money in the effectiveness of care. 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.

Progress has been made in developing community services, through the opening of new health centres, day hospitals and other facilities.

#### **(vii) GMS-Primary Care**

Based on GMS data, the payment per head of eligible population has grown from £30.83 to £51.09 over the period from 1990 to 1999, which in real terms reflects a growth of c.40%. To provide 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.

Over the 1990s expenditure per head on out-of-hours services has grown from £1.07 to £9.68. This is not directly constrained by the GP funding system, and reflects changes in the hours eligible for claim, and the need for more out-of-hours services for working parents.

Expenditure on pharmaceuticals rose from £107m in 1990 to £222m in 1999. However, after adjustment for general inflation, the rate of increase in costs of prescribed drugs is smaller than might have been anticipated. Ireland has established price agreements, which amongst other things allows it to buy pharmaceuticals for its health services at a price that reflects prices in Europe and the UK NHS. These price agreements potentially offer considerable value for money. However, there is evidence to suggest that management of GP's prescription patterns could achieve further improved value for money.

The trends in expenditure and the absence of any direct management of the level of prescribing by GPs suggests that the current GMS system lacks the tools and processes to shift prescribing towards improved value for money.

In addition to payments for the prescriptions of GMS card holders, during the decade the GMS system made payments under two other schemes for prescribed drugs, namely the Drug Cost Subsidisation Scheme (superceded by the Drugs Payment Scheme), and the Long Term Illness Scheme. The existence of the two schemes raises questions about the benefits and costs of having two such schemes rather than one. As they stand both schemes are likely to face difficulties in controlling total spending. More generally it is not obvious what policy objective is being served by operating the two similar schemes.

On a similar note, there are two different systems for providing dental treatment to 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 needs. It is also possible that some double claims are made, for patients who are covered by both schemes.

The GMS system provides a rich source of data on medical card holders; however in practice limited evaluation of the expenditure is undertaken by the GMS Board, who concentrate on their role as a payments agency. Improved value for money is possible through regular analysis and evaluation of GMS data.

## **5. STRUCTURE AND ORGANISATIONAL ISSUES**

### **5.1 OVERALL STRUCTURE**

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. It is timely to review the appropriateness of current structures, particularly in the context of implementing the new health strategy in the most effective way, any increase in system capacity, and increasing regionalisation of services.

A number of major changes to the structure of the system have been introduced in recent years as a consequence of the Health Amendment (No 3) Act 1996, and the Eastern Regional Health Authority Act of 1999, which have focused on ways to improve accountability, service planning and delivery.

#### ***5.1.1 Department of Health and Children***

The role of the Department is to develop policy and manage overall control of expenditure. Its role is not to engage in the detailed operational management of health services. The Irish health system is lacking in explicit arrangements and structures to monitor value for money in the Irish health system. The intention with the introduction of service planning and the accountability legislation was to emphasise this issue and free up the Department to focus more on policy and strategy. In reality, the Department continues to have a significant level of operational involvement in the health system. This needs to change. The Department needs to devolve more of its operational activity to the Health Boards and Health Boards need to be prepared to take on these responsibilities. This will also assist in emphasising its regulatory role in the system.

We are concerned that the remit of the Department is too broad, spanning a range of health and social service issues. The Department has been continually asked to do more; this arises in an environment where 20% of the positions within the Department are currently 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 or has no resource at all, for example financial, statistical, social analysts, strategic planning, QS, health economics, personnel with direct experience of working in the health services.

There is a mismatch between structures within the Department and the various Health Authority/Boards (which are increasingly moving to a care group focus). The structure and modus operandi of the Department needs to be responsive to this, not only to discharge its functional responsibilities but also to provide a cross programme and care group focus to its work in a seamless fashion.

### **5.1.2 Health Boards**

A formal VFM framework is not ingrained in the organisation structures of Health Boards. For the most part, VFM at Board level is concerned with achieving improved economy measures through the Materials Management function, which have had mixed success. Boards do not have people within their organisation structure whose sole responsibility is dedicated to delivering VFM in terms of efficiency and effectiveness.

The absence of a formal, broadly based VFM framework supported by management processes and adequate information systems militates against, ongoing monitoring or assessment of efficiency and effectiveness of how services are provided. It also hinders any possibility of developing consistent measures of VFM across the wider health system.

The current structure provides a strong element of local democracy in the health service. There is, however, a counter argument to this level of local democracy, namely that the political nature of Health Boards constrains the delivery of best VFM health services and can adversely affect decision-making within the regions. Boards have a responsibility to follow national priorities. This will become more important if, as we advocate, a strategy of regionalisation of services is developed.

We would suggest that at Board level, there is a requirement for smaller tighter Boards. In addition there is a need to ensure the focus of local political input is on a representation basis i.e. representing the local population, and not on a decision-making basis. 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 within the context of a national and regional strategy.

Governance is an increasingly important issue for Boards and voluntary agencies funded by public monies. It is essential that Boards have a full appreciation of their corporate and clinical governance responsibilities. There is merit in codifying and clarifying precisely what is meant by governance in today's Health Care environment for what generally are volunteer Boards to ensure there are no misunderstandings of their responsibilities in this regard. Specifically, it is increasingly important for Boards, their management and other voluntary providers to ensure that appropriate organisational structures and systems are in place to enable them discharge their duty of care in relation to clinical activity in their organisations.

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.

The common recruitment pool is also a constraint in attracting the appropriate skill set to specific jobs in the sector. The capability of managers to change from what, in financial terms, has until recent years been a highly resource constrained environment to one where considerable increases in funding have been made available for service enhancement has proven to be a major challenge to the culture ingrained in the Irish health system.

The Boards also suffer from a lack of resources in areas such as strategic planning, health economics, monitoring and evaluation, and aspects of Information Technology, HR and finance.

A further cultural issue pertaining to the Health Boards relates to the nature of interactions between themselves. During the 1990s, the culture between Health Boards was one of competition rather than co-operation, sharing and learning. This inhibits value for money. This competition goes beyond competing for the limited funding in the system, there is ongoing competition for human resources and perhaps most significant a lack of willingness to share knowledge and experiences. The extent of conjoint working is increasing. The establishment of the Health Boards Executive (HeBE) should provide a mechanism to improve co-operation and conjoint working of Boards, including the development of shared services models.

The key challenges for VFM arising from the current structure are set out below:

**Governance & Accountability** – Decision-making at Health Board level needs to be based on agreed national and regional strategies and not distorted by local issues.

**Strategy & Service Planning** – At health Board/ hospital level comprehensive strategic planning is still in its infancy. The role of service planning at unit, regional and national level is still in its early stages of development.

Planning must be supported by comprehensive needs assessment, otherwise there is a danger of not achieving best value for money for the expenditure. Clinicians need to be engaged to a much greater extent in the service/strategic planning process throughout the system.

A fundamental part of developing improved longer term strategic planning is the requirement to have multi-annual budgeting as an integral part of the planning process. Without this, the capability to implement well formulated policy is impaired.

If we are serious about the coherent development and implementation of health policy, a commitment to multi-annual funding is required. This is particularly the case where significant investment is required in the health system, as is the case in Ireland. The medium term funding plan associated with the National Development Plan in health is the direction required for the broader health service.

**Service Delivery** - Considerable work is required to integrate services within Health Boards, particularly integration with the 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.

## 5.2 STRUCTURE AND ORGANISATIONAL ISSUES

### Organisation

There are a number of salient points in relation to the current organisation structure and level of resources:

- The system is not organised in the same way in all Health Boards across the country.

- There are variations in the level of decentralisation/devolution of functions from health Board to agency level. In our view, the larger units in the system e.g. major acute hospitals should have properly resourced management structures autonomous of Health Boards, but accountable to them to bring decision-making closer to the point of service delivery. The larger voluntary hospitals are more advanced in having such structures in place.
- The competitive relationship between Health Boards serves no purpose. The establishment of HeBE should help address this as an issue.
- The Health Materials Management Board should have a stronger role in VFM , working closely with and co-ordinating Boards in their purchasing. More realistic cost reduction targets should be set, and savings achieved ought to be shared with agencies that achieve them for service development purposes.
- Appropriate structures to consult the public are lacking; this should be differentiated from the issues associated with the memberships of Boards. A more fully developed Patients Charter is part of the response to this issue. In addition there is a requirement to further develop the evolving customer focus of organisations, which will impact on the organisation structures
- The underlying emphasis within the system, from a non-clinical perspective, is one of administration and not management.
- There is absence of structure around management of primary care, which is not assisted by the self employed, professionally independent nature of GPs.
- The Consultants Common Contract needs to be reviewed and where necessary changed, to ensure a real and engaging commitment of clinicians to involvement in management and in clinical governance/audit.
- There are significant resourcing issues in terms of recruitment and retention in conjunction with significant staff and skill shortages.
- Particularly in the context of the increase in funding of the system in recent years, we have concerns that there are insufficient people in the system with the necessary skills to manage and implement change within the system

**Performance Measurement** - The health system does not operate within a performance culture, and, in common with the public sector more generally, there is scope to enhance performance measurement within the system. The introduction of clinical audit has been unacceptably slow. On the non-clinical side there is a lack of comparable audit based assessment of management actions. The introduction of accruals based accounting and service planning have been positive developments in the health sector under this heading.

**Resource Allocation-** The resource allocation to Boards and other providers in the Irish system is the product substantially of an incremental system of funding, one year with the next. This does not guarantee equity in funding between regions. Furthermore, such a funding system is unlikely to best match the needs of the population nationally. In the context of the new health strategy, the prospect of increasing regionalisation of services, and further capacity being injected into the system, it is important that resource allocation to regions is fundamentally reviewed to more explicitly reflect, inter alia, population profile, morbidity, social deprivation, rurality etc.

### 5.3 SUMMARY OF VFM ISSUES: STRUCTURE AND ORGANISATIONAL

CONTRIBUTING TO VFM	LIMITING VFM
<ul style="list-style-type: none"> <li>• The establishment of service planning and progressive improvement in quality of service plans.</li> <li>• The introduction of Accountability legislation.</li> <li>• The potential within HeBE to foster greater conjoint working between Boards.</li> <li>• The emergence of a care group focus in Boards.</li> <li>• Development of new functions in Boards for example Public Health, GP Units.</li> <li>• Some achievements in explicit VFM for example economy measures promoted by materials management function.</li> <li>• Recent development of performance indicators.</li> </ul>	<ul style="list-style-type: none"> <li>• Structure, size and composition of Boards potentially limiting VFM.</li> <li>• Department of Health is still too operationally focussed, under resourced, and with too broad a remit.</li> <li>• Lack of explicit resource allocation system to Boards linked to planning and activities – current system is largely incremental.</li> <li>• Historically, co-operation between Boards has been limited, for example, lack of shared services.</li> <li>• Ineffective implementation of structures to introduce clinicians in management.</li> <li>• Clinical governance/clinical audit – inadequate and inconsistent across system.</li> <li>• Lack of explicit approach to VFM in system, no routine measure of efficiency and effectiveness.</li> <li>• Lack of routine performance management culture – too often focused on administration not management.</li> </ul>

## 6. MIS AND PERFORMANCE MANAGEMENT

### 6.1 PRINCIPAL DATA SOURCES

The principal sources of data in the Irish Health Care system are:

#### **Hospital Inpatient Enquiry System (HIPE)**

HIPE delivers a set of codified medical records by case, the principal aim of which is to report clinical activity. 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.

#### **Casemix**

The Casemix Measurement System is, in essence, a system to measure the relative cost efficiency of certain acute hospitals in the Irish system. The current Casemix system in operation in Ireland has to be seen as still in its development phase. The system needs to build on the lessons learned and extend its coverage to a wider number of hospitals in the system, an extended range of specialities, and be subject to ongoing extensive audit of specialty costing and coding procedures at hospital level .

#### **Integrated Management Returns (IMRs)**

IMRs deliver financial, personnel and activity data for the Health Boards and acute hospital sector from agencies to the Department of Health & Children. Returns submitted are not always complete, and data is not always submitted in a timely manner. Different data definitions and standards are also applied by Health Boards, particularly in relation to personnel data.

## **Public Health Information System (PHIS)**

The principal function of PHIS is to report on the health status of the population on an annual basis.

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.

## **Service Plans**

The Health (Amendment) Act 1996 set out the requirement for Health Boards to submit a service plan to The Department of Health & Children on an annual basis.

- Service planning process is better developed in some Health Boards than others.
- A coherent approach to service planning has not been adopted across all Health Boards despite the establishment of templates by the Department. 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.
- The monitoring of performance against the service plan needs to be more explicitly developed, both at health Board and Department level.
- There is a clear need for a coherent set of performance indicators for the Irish health system, and that these are consistently applied in service planning and evaluation. An amount of valuable work has already been done in this area.

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 statutory accountability.

## **6.2 MAJOR ISSUES**

The major issues in relation to the development of management information in the health system have been:

- There has been a general lack of resources made available to the health services for management information systems. The investment in IT for the entire sector on an annual basis 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, however a significant proportion of additional funding related to Y2K specific projects. 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 mitigates 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 absence of a Unique Patient Identifier in the 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.
- 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.
- There is also evidence of system capabilities being under-utilised or indeed inadequately understood in the sector. There is also a lack of a clear definition of data requirements to support strategic priorities.
- We have concerns that there is a lack of appropriate skills at all levels to analyse and interpret the data. Questions also arise as to whether adequate training has been provided to staff in the system.
- There is concern that systems are being implemented in the absence of clear national strategy, objectives and business case. Furthermore, systems development and implementation does not always involve service managers (i.e. end users) and implications for existing process and procedures are not necessarily fully considered.
- Following from the above, there is also 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 following gaps are widely accepted as arising in current health information systems:

- Health inequalities
- Morbidity
- Health status of the population
- Waiting list – (under utilised)
- Accident & Emergency
- Primary and community care
- Health services research database
- Lack of data and systems at community level.
- Asset management / utilisation
- Vaccinations / childcare health
- Strategy related systems
- Screening
- Theatre management

While there are major gaps and issues to be addressed, there is evidence of a growing recognition of the requirement to define consistent and comparable sets of performance indicators. There is in turn, a recognition of the need to standardise the collection, monitoring and evaluation of data and the provision of reliable, timely and relevant management information at Department, Board and agency levels.

### **6.3 FUTURE REQUIREMENTS**

The principal areas and issues which need to be addressed going forward are:

- Instigating a co-ordinated and structured approach to systems development and performance management across all levels of the health system within a strategic framework.
- Development of Unique Patient Identifier within the system.
- The development of electronic records at GP level to enhance service integration.
- Investment in IT systems and capabilities at community level.
- The definition of clear data and performance requirements to support strategic priorities.
- The development of a balanced set of performance measures that includes financial measures but which also ensures that increased attention is given to other areas such as outcome measures, organisational measures, etc. A clear focus on information to establish needs (population registers, health status indicators, health risk indicators etc) will be essential.
- The standardisation of data and data definitions at national, regional and local levels.
- Enhancing managerial and staff capabilities to manage performance and undertake data analysis. In particular there are skill gaps at Departmental level that must be addressed if it is to fulfil its role in policy development and monitoring and evaluation.
- Developing a culture that supports performance management, the utilisation of data in policy making and evaluation and VFM.
- Providing greater clarity around the definition of roles and performance expectations, and in implementing clinical audit and clinical/corporate governance.
- Developing management reporting in key areas of activity.
- Addressing the deficiencies that exist with regard to the costing of activities at all levels in the system.
- Priority in the short term should be given to developing coherent national systems to establish information in key areas such as waiting lists, activity in Accident & Emergency, and public/private mix.

In conclusion, the Irish Health Care sector has suffered from a general lack of investment and attention to IT systems and performance management during the 1980s and 1990s. Some progress has been made over the last two years as more funds have come on stream. Although, further funding has been earmarked under the NDP programme, it will not be in anyway sufficient to address the gaps that exist. Very significant investment is required if the system is to perform in the way it is now expected and if there is to be a recognisable improvement in managing VFM.

Equally important, a co-ordinated and structured approach must be adopted that provides for the sharing of data, the integration of systems and the ownership of performance.

## 6.4 SUMMARY OF VFM ISSUES: MIS AND PERFORMANCE MANAGEMENT

CONTRIBUTING TO VFM	LIMITING VFM
<ul style="list-style-type: none"> <li>• The implementation of the service planning process.</li> <li>• The development of population specific databases to quantify health needs and service requirements. Examples include the National Intellectual Disability Database and the National Cancer Register.</li> <li>• The development of key systems such as Casemix, HIPE and PHIS.</li> <li>• The National Health Information Strategy including proposals to develop a Unique Patient Identifier System (UPI).</li> <li>• The agreement of an initial set of joint performance indicators between the Joint Department / Health Board Service Planning Group.</li> <li>• Integrated Management Returns.</li> <li>• Steps to introduce a more efficient approach to public procurement in the health sector including linking into the Government's e-procurement initiative.</li> </ul>	<ul style="list-style-type: none"> <li>• An inadequate level of investment in IT infrastructure and training.</li> <li>• The lack of a co-ordinated and structured approach to systems development and performance management across the sector.</li> <li>• A reluctance and inability (due to resource and skill constraints) to use and analyse available data to inform decision-making and the performance management process.</li> <li>• The lack of electronic records at GP level. The lack of systems and capabilities at community level.</li> <li>• The lack of clear data and performance requirements to support the strategic planning process.</li> <li>• The lack of a standardised set of data definitions at national, regional and local levels.</li> <li>• A general lack of understanding of the role of MIS or performance management in the strategic planning process.</li> <li>• Lack of clarity around the definition of roles and performance expectations</li> <li>• Slow progress in the widespread implementation of Corporate/ Clinical Governance, clinical and internal audit.</li> <li>• Deficiencies in management reporting and activity based costing.</li> </ul>

## 7. SERVICE ISSUES- ACUTE HOSPITALS

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% of Health Care expenditure by government

### 7.1 KEY ISSUES:

#### *Lack of Acute Sector Policy*

The absence of an acute sector policy is a major gap; such a policy is badly needed to avoid non-objective decision-making in the sector.

### ***Lack of VFM strategy***

There is no systematic approach to the explicit achievement of value for money in all hospitals. For example, there is no widespread culture of routinely evaluating economy, efficiency and effectiveness, in producing appraisals of significant spending decisions, in which alternatives are explicitly assessed on cost/benefit basis.

### ***Lack of VFM Audit***

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, and/or within a separate agency responsible for a range of performance monitoring, evaluation and audit.

### ***Capacity***

The fundamental problem in the acute hospital sector is lack of capacity. Waiting lists, cancellations and difficulties in A&E Departments are symptoms of the lack of capacity. There is a shortage of bed capacity in the public system. Increased bed capacity will need to be planned in the system over a period of years, having regard to the new health strategy and the requirement to increasingly regionalise services, to develop centres of excellence in acute care in a number of locations throughout the country. Such an approach should promote greater equity and access in the acute system.

Increased bed capacity is required, inter alia, in areas such as general medicine, high dependency care, beds for the young chronic sick, stroke victims, intensive care, and geriatric assessment.

Capacity constraints also exist within medical and clinical resources in the acute system. The number of consultants employed is low by international standards.

### ***Regionalisation and Roles of Hospitals***

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 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.

There are many smaller hospitals in the Irish system, which inevitably raises questions of quality of care and value for money.

Particularly in the context of a strategy of increased regionalisation of services, the roles of hospitals in the system will need to be defined, and in certain cases redefined.

### ***Poor Service Integration***

There is a lack of integration between secondary and primary care in the Irish system. Currently, integration of community nursing with hospital activities is limited. The staff report to different management structures and may visit the hospital relatively rarely.

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.

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, potentially through electronic records in the future, will be an important element in the development of integrated services that cut across traditional institution boundaries.

### ***Lack of Clinical Audit***

The Irish hospital system currently has a serious lack of well-developed and widely shared clinical audit. This may reflect:

- Availability of resources for audit activities;
- Willingness 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

### ***Lack of Hospital Accreditation***

There is also a lack of a comprehensive system of hospital accreditation in Ireland.

### ***Ambulance Services***

There are still issues in relation to provision of ambulance services for example the use of nurses to crew ambulances and potential conflicts between ambulance staff and nurses. 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.

Overall, the impression gained from the current study of value for money is that many of the issues identified by the C&AG in 1997 as potentially improving services and contributing to greater value for money have not been addressed.

### ***Accident & Emergency***

A fundamental issue with particular relevance to Ireland is the size of Accident & Emergency 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.

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 are concerned that they currently operate several Accident & Emergency Departments, which would ideally be rationalised and restructured;
- Board staff made frequent reference to local political factors, including the views of local clinicians, that militated against change;
- The lack of a national strategy for Accident & Emergency is a barrier to change locally.
- The lack of application of effective systems supported by the 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 lack of widespread introduction of Medical Admissions Units.
- The level of inappropriate attendance at Accident & Emergency. The reasons include:
  - a belief that it is a more appropriate place to attend than a GP surgery;
  - because of the nature of the medical condition;
  - the absence of an adequate out-of-hours GP service;
  - the cost (or perceived cost) of attending Accident & Emergency is perceived as less than the cost of seeing a GP for non-GMS cardholders.

### ***Waiting Lists***

The existence of waiting lists is not peculiar to the Irish Health System. They exist for numerous reasons including acute system capacity, structural capacity limitations 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.

The critical issue is how long people wait for treatment as opposed to the numbers that are actually on waiting lists. In addition the numbers on waiting lists represent a small percentage of the overall numbers treated in the system.

Within the Irish system, the utilisation of the bed capacity is running at an average of 85% (in certain units it exceeds 100%). In our view, capacity constraints are the fundamental reason why waiting lists are prevalent. The current infrastructure is at the limits of its 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.

There is scope to improve information systems on waiting list/times to provide more timely and accurate information. Consideration should be given to systematic management of waiting lists on a national basis, which ought to provide for a redistribution of cases between hospitals and consultants, which are beyond agreed waiting time criteria. In 1989, the Commission for Health Funding recommended common waiting lists to address the inequities between the public and private systems.

There are a number of questions on the common waiting list concept. Would it be difficult to implement and monitor? Would it adversely affect the private insurance market, and the attractiveness of the public health system to consultants because of the impact on their private practice?

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. 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 protocols/criteria 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.

The Report of the Review Group on the Waiting list Initiative made a number of valuable short medium and long-term recommendations. 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 list levels and their management.

## 7.2 SUMMARY OF VFM ISSUES: ACUTE HOSPITAL SERVICES

CONTRIBUTING TO VFM	LIMITING VFM
<ul style="list-style-type: none"> <li>• High utilisation of existing capacity, and increased activity.</li> <li>• Significant growth in day case services during 1990s.</li> <li>• Evidence of innovative approaches to aspects of acute care throughout the system.</li> <li>• Improved management of waiting lists, and dedicated investment to reduce numbers on list.</li> <li>• Increased medical and clinical manpower throughout system.</li> </ul>	<ul style="list-style-type: none"> <li>• Significant capacity limitations               <ul style="list-style-type: none"> <li>– Beds</li> <li>– Medical manpower</li> <li>– Diagnostic equipment</li> </ul> </li> <li>• Lack of coherent integration of hospital and community services.</li> <li>• Significant lack of capital investment and maintenance expenditure resulting in outdated facilities and equipment.</li> <li>• Lack of intermediate, rehabilitation and chronic sick and other specialised bed capacity.</li> <li>• Lack of acute hospital strategy, militating against development of regionalisation strategy, and lack of definition of appropriate number and roles of hospitals.</li> <li>• Large number of smaller hospitals in system, imposing service and staffing limitations.</li> <li>• Urgent care strategy lacking, covering Accident &amp; Emergency and ambulance services. Scope to develop integrated network of Accident &amp; Emergency, trauma units, medical assessment units, etc.</li> <li>• Lack of full implementation of C&amp;AG report on ambulance services.</li> <li>• Lack of systematic hospital accreditation.</li> <li>• Lack of involvement of clinicians in management.</li> <li>• Lack of clinical audit.</li> <li>• Lack of technology assessment and services frameworks and protocols.</li> </ul>

## **8. PUBLIC PRIVATE MIX**

### **8.1 PRIVATE HEALTH INSURANCE**

The public-private mix of funding and services in Ireland is a long established way of delivering Health Care.

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 perception that a two tier system now exists, for access to care. In the absence of shared data between public and private sectors, it is difficult to demonstrate the differences between the two services.

Private health insurance may be vulnerable to future economic downturns, which may change the age composition of membership. This would push up the premiums of those staying insured.

Private health insurance has existed in Ireland for some time. Some 45% of the population hold such insurance, which is supported by tax reliefs on premia. Policy on private medical insurance needs to be clearly articulated, as does the role, cost and benefit of private practice in public hospitals.

#### ***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 its 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.

Private health insurance makes only a limited contribution to the cost of public Health Care. During the 1990s Voluntary Health Insurance expenditure consistently represented between 11% and 12% of public net non-capital expenditure. 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 less intensive rather than higher users of Health Care and they do not use it for all procedures and treatments, for example major trauma. However, as noted in the 1999 White Paper, it is likely to prove difficult to move away from the current system.

#### ***Private Health Care and Public Health Care – The Consultants***

There is 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.

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 hinders a conclusive assessment of this issue.

Currently, there is no systematic and shared record keeping between private and public systems. Both sides, and consultants too, could benefit from an open and transparent system of sharing data, which dispelled the current climate of suspicion, in which consultants are widely perceived 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.

Private Health Care is a substantial source of income for consultants who wish to take up the opportunity to treat private patients. 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.

#### ***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 Department has indicated that over time, full economic pricing of private beds in public hospitals would be introduced.

## **8.2 CONCLUSION**

The policy objectives on private medical insurance need to be clarified, and the role, costs and benefits of private practice in public hospitals defined. Care is required to avoid using the public/private issue to mask fundamental capacity limitations in the system which are central to many of the current difficulties.

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. An assessment is required of whether the activity generated by the insured population justifies the current allocation of private beds in public hospitals (currently 20%) having regard to the age profile, income and health of those with private insurance. 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 hospital 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.

## 9. SERVICE ISSUES - PRIMARY CARE

### 9.1 GP SERVICES

GPs are frequently the first contact of patients with the Health Care system and play a pivotal 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. There are, however, a number of key issues that warrant attention:

#### *Key Issues*

- It is estimated that of the c 2,250 GPs in Ireland in active practice, almost half are single handed practitioners. This militates against service integration.
- Practice nursing within GP practices is significantly underdeveloped.
- Out-of-hours GP cover nationally is at best variable and in some areas poor, pointing firmly to the need to encourage the development of GP Co-operatives. This impacts on inappropriate admissions to Accident & Emergency departments and contributes to a significant rise in out-of-hours claims by GPs.
- Monitoring and evaluation systems at General Practice level are not well developed and lack integration into secondary care and other health systems. The use of information technology at GP level needs to be enhanced, which will require investment in systems and training.
- Preventative services at GP level need to be further developed as part of a broader community based health promotion/prevention strategy.
- Significant scope exists to improve information management and evaluation within General Practice.
- GP Practice requires a formal process of audit and peer review to optimise standards of care.
- Medical Centres in which a basket of primary care services (physiotherapy, counselling, dietary advice) are provided in addition to general practice need to be incentivised. This could be through taxation incentives for investment in such facilities, or State provision of facilities on a selective basis to GPs entering into co-operative arrangements in such centres.
- Scope exists to selectively extend eligibility to a wider range of free GP services, for example to promote health preventative measures, and for the elderly (to reduce inappropriate acute hospital admissions). We do not however advocate a full free GP service. To achieve this would in any event be complex given the self employed nature of general practitioners and the private patient income they currently enjoy.
- Integration between GPs and acute hospitals and with other community care providers (e.g. Public health nurses) is significantly underdeveloped.

A key change which has 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 including:

- Incentives for improved organisation of general practice
- Assistance to group practices who develop a wider range of services

- The establishment of group practice pilots, offering a more comprehensive range of services and with a focus on developing closer links with local hospital services
- 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.
- 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 COMMUNITY SERVICES

### *Key Issues*

- There is a lack of a clear strategy for public health, nursing and there is greater scope to improve the level of integration with GP services.
- Integration between community services is for the most part quite poor.
- Staff shortages represent a significant challenge in the provision of a multi-disciplinary and team approach to community services.
- Access to services outside of the core nine to five working day is limited.
- Responsibility for local transport services have not been clearly defined.
- Information systems are quite poor and lack integration with other levels of the Health Care sector.
- Information availability on service access and entitlements is fragmented across health Boards.

## 9.3 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. It may be difficult to change 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, between generalists teams and between specialist teams.
- Further investment is required in infrastructure and staffing to bring community services up the required standards and to meet public demand. Improvements have certainly already been realised in recent years and this effort will be sustained and 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 the light of rising costs.

#### 9.4 SUMMARY OF VFM ISSUES: PRIMARY AND COMMUNITY CARE

<b>CONTRIBUTING TO VFM</b>	<b>LIMITING VFM</b>
<ul style="list-style-type: none"> <li>• Capitation funding of GPs under GMS.</li> <li>• National controls on pharmaceutical prices.</li> <li>• Introduction of GP Units at Board level.</li> <li>• Emergence of GP co-operatives.</li> <li>• Emergence of Practice Nursing role.</li> <li>• Since 1993, specific investment provided under GP Development /Capital funds.</li> <li>• Introduction of Indicative Drug Scheme, increasing management of drugs spend.</li> <li>• Investment provided for development of GP practices.</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of integration of GPs with hospitals and Public Health nurses.</li> <li>• Lack of consistent registration of patients, weakening framework for screening and immunisation.</li> <li>• Lack of out-of-hours cover in certain parts of the country.</li> <li>• Significant growth in out-of-hours GP spending may not necessarily be contributing to VFM.</li> <li>• Extent of single-handed GP practice.</li> <li>• Lack of consistent prescribing, linked to lack of technology appraisal and lack of protocols and national service frameworks.</li> <li>• Failure to follow up and implement C&amp;AG reports, for example prescribing patterns, dentistry.</li> <li>• Public dental schemes have overlapping eligibility.</li> <li>• Poor use of IT at general practice level.</li> </ul>

## 10. SERVICE ISSUES - OTHER WELFARE AND CARE GROUPS

A summary of key issues among other welfare and care groups and how they impact VFM are described below:

### 10.1 SUMMARY OF VFM ISSUES: THE ELDERLY

CONTRIBUTING TO VFM	LIMITING VFM
<ul style="list-style-type: none"> <li>• The establishment and funding of an advisory body to the Minister, namely the National Council on Ageing and Older People with responsibility for policy development.</li> <li>• An increase in the number of psychiatric teams dealing with the elderly.</li> <li>• The introduction of the home-help service but with concerns over the future availability of staff.</li> <li>• The development of a health promotion strategy for the elderly.</li> </ul>	<ul style="list-style-type: none"> <li>• A low level of investment in infrastructure or services for the greater part of the 1990s.</li> <li>• A lack of co-ordination to service provision across the system.</li> <li>• Slow progress in re-designating elderly people from psychiatric services to more suitable surroundings.</li> <li>• Inadequate intermediate / sub-acute facilities.</li> <li>• A lack of integration and communication between the acute sector and primary / community services.</li> <li>• The inadequate supply of assessment and rehabilitation beds in the acute sector.</li> <li>• Poor co-ordination between primary care and community services including the lack of ownership of “At Risk Registers” and preventive care.</li> <li>• The lack of a shared understanding and approach to the implementation of the Nursing Home Initiative across Health Boards.</li> <li>• Lack of paramedical support.</li> <li>• The ad-hoc provision of day care services.</li> <li>• Definition of roles and responsibilities for the provision and maintenance of public housing including the role of the voluntary sector.</li> <li>• An uneven geographic spread of public nurses.</li> <li>• The lack of a co-ordinated approach to performance measurement.</li> </ul>

## 10.2 SUMMARY OF VFM ISSUES: PSYCHIATRIC SERVICES

CONTRIBUTING TO VFM	LIMITING VFM
<ul style="list-style-type: none"> <li>• The development and updating of policy on a regular basis.</li> <li>• Establishment of service agreements with the voluntary sector.</li> <li>• The development of Guidelines on Good Practice and Quality Assurance in Mental Health Services and the development of the Mental Health Bill.</li> <li>• Regular and timely data provision through the Report of the Inspector of Mental Health Hospitals and the National In-patient Reporting System.</li> <li>• The transfer of patients from psychiatric units to dedicated units in general hospitals – although progress has been slower in some regions than originally anticipated.</li> </ul>	<ul style="list-style-type: none"> <li>• Low levels of funding during much of the 1990s but significant increases in provision have been made in recent years.</li> <li>• Difficulties in recruiting suitably qualified staff.</li> <li>• The lack of a requirement for continuous statutory training.</li> <li>• The lack of a co-ordinated approach to measuring service outcomes and costs which is partly attributable to the lack of a standard methodology for the codification of costs.</li> <li>• Limited data on attempted suicide and para suicide.</li> <li>• Limited facilities and infrastructure for specialised services. However, deficiencies have been defined and initiatives are being implemented.</li> <li>• The inadequate provision of psychiatric services to the criminal justice system (although improvements are planned and are on-going).</li> <li>• A deficit in community residential accommodation resulting in the inappropriate use of acute psychiatric beds.</li> <li>• Regional variations in non-residential services and the provision of rehabilitation services.</li> </ul>

### 10.3 SUMMARY OF VFM ISSUES: PERSONS WITH AN INTELLECTUAL DISABILITY

CONTRIBUTING TO VFM	LIMITING VFM
<ul style="list-style-type: none"> <li>• The National Intellectual Disability Database which provides a comprehensive set of population data together with an analysis of service provision and future requirements.</li> <li>• On-going policy development and review.</li> <li>• “Enhancing the Partnership” and “Widening the Partnership” which defined the relationship between the Health Boards and the voluntary sector in the provision of services including the implementation of the service planning process.</li> <li>• On-going initiatives to measure service outcomes / quality and costs, although many of these are at an early stage of development.</li> <li>• On-going efforts to transfer persons with an intellectual disability from psychiatric hospitals to a more appropriate care setting.</li> <li>• The provision of additional residential, respite and day care services to meet population needs, although gaps still remain. Recent funding under the NDP has assisted in this area.</li> <li>• The recent establishment of the National Educational Psychological Service.</li> <li>• The clarification of roles between The Department of Health &amp; Children and FAS in the provision of training.</li> </ul>	<ul style="list-style-type: none"> <li>• Uneven geographic spread of services.</li> <li>• Disparities in eligibility criteria for services and benefits and in some areas lack of access to information on services and entitlements. (These areas are currently being addressed.)</li> <li>• Inadequate communication at primary level in ensuring that lines of communication and information are kept open to assist and support parents.</li> <li>• The limited availability of capital funds to support additional respite care places.</li> <li>• Underdeveloped community therapy services.</li> <li>• Decreasing availability of home support services.</li> <li>• The lack of a co-ordinated set of performance indicators.</li> </ul>

### 10.4 SUMMARY OF VFM ISSUES: CHILDCARE

CONTRIBUTING TO VFM	LIMITING VFM
<ul style="list-style-type: none"> <li>• The development of a childcare strategy.</li> <li>• On-going efforts to improve the identification of reporting, assessment, treatment and management of child abuse including the publication of “The Children First – National Guidelines for the Protection and Welfare of Children”.</li> <li>• Database for Childcare implemented.</li> </ul>	<ul style="list-style-type: none"> <li>• A historical lack of consistency in how childcare issues are handled.</li> <li>• Inadequate funding for the development of services up until more recent years.</li> <li>• Inadequate information and information systems to support decision-making.</li> <li>• The lack of a developed set of performance indicators including a systematic process review of the quality of childcare nationally.</li> <li>• Staff recruitment problems.</li> <li>• Underdeveloped social worker services although steps are being taken to address this.</li> </ul>

## **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 than 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 also the case in the health services. Value for money relates to the issues of 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**

- (c) 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.
- (d) 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***

- (i) Commitment by Boards to increased conjoint working and collaboration through HeBE and otherwise, including in the area of information systems specification, selection and implementation.
- (j) 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.
- (k) 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.

- (l) 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.
- (m) 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.
- (n) Commitment to implementation of meaningful structures to involve clinicians in management.
- (o) With clinicians, to promote and develop comprehensive systems of clinical audit.
- (p) Strong commitment by CEOs to supporting the Health Materials Management Board, including promoting cost reduction targets.