Deloitte & Touche

Value for Money Audit of the Irish Health System

Appendices

DELOITTE & TOUCHE

IN CONJUNCTION WITH
THE YORK HEALTH ECONOMICS CONSORTIUM

VALUE FOR MONEY AUDIT OF THE IRISH HEALTH SYSTEM

VOLUME III: APPENDICES

JUNE 2001

THE DEPARTMENT OF HEALTH & CHILDREN

Deloitte & Touche

VOLUME III: APPENDICES

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APPENDIX I

List of Contacts

THE DEPARTMENT OF HEALTH AND CHILDREN

- Members of MAC including:
  - Michael Kelly
  - Dermot Smyth
  - Frank Ahern
  - Paul Barron
  - Donal Devitt
  - Tony Enright
  - Dr Jim Kiely
  - Tom Mooney
  - Frances Spillane

- Others
  - Chris Costello
  - Tadhg Delaney
  - Frances Fletcher
  - Charlie Hardy
  - Paul Howard
  - Hugh Magee
  - Dermot Magan

HEALTH BOARDS

- The Eastern Regional Health Authority (ERHA) and each of the area health boards:
  - The East Coast Area Health Board
  - The Northern Area Health Board
  - The South-Western Area Health Board
- The Midlands Health Board
- The Mid-Western Health Board
- The North-Eastern Health Board
- The North-Western Health Board
- The South-Eastern Health Board
- The Southern Health Board
- The Western Health Board

THE ACUTE SECTOR

- Beaumont Hospital
- Cork University Hospital
- St James Hospital
- The Adelaide and Meath Hospital Incorporating the National Children's Hospital at Tallaght
- The Mater Misericordiae Hospital
- Tullamore General Hospital
- St Vincent's University Hospital

REPRESENTATIVE ORGANISATIONS

- Comhairle na nOispideal
- The College of General Practitioners
- The Health Services Employment Agency
- The Independent Hospitals Association of Ireland
- The Irish Dental Association
- The Irish Hospitals Consultants Association (IHCA)
- The Irish Nurses Organisation
- The Irish Medical Organisation
- The Irish Patients Association
- The Royal College of Surgeons

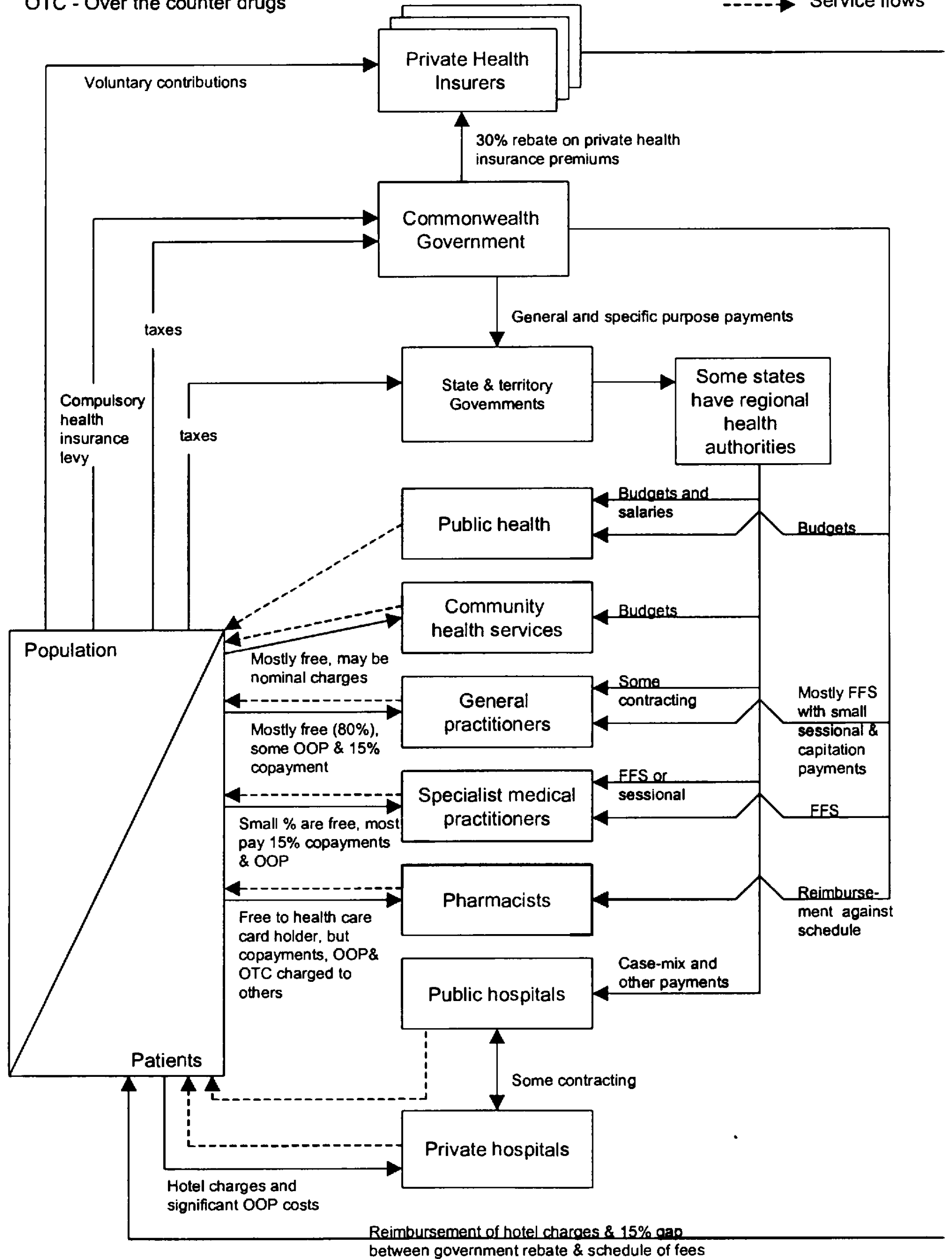
OTHER

- BUPA Ireland
- The GMS Payments Board
- The VHI
- St Michael's House

APPENDIX II

Country Models of Health Funding Systems

1. AUSTRALIA



Source: OECD Secretariat.

Background

Australia has a Federal system of government. A unique feature of its system is that the responsibility for both funding and delivery of healthcare is split between the State and Federal government. The States are responsible for Public hospitals and the Commonwealth is responsible for general practitioner services and prescribing. Revenue is raised through general taxation. However, there has always been a large private insurance market and out of pocket contributions.

Table A1: Australian Finance Statistics for 1997

Total Expenditure on Health as % of GDP	Public Expenditure as % of Total Expenditure	Out of Pocket as % of Total Expenditure on Health	Per Capita Expenditure at Exchange Rate $US
7.8	72.0	16.6	1730

Table A2: Australian WHO Rankings

Health Expenditure per capita	Overall Health System Performance	Health Level	Fairness in Financial Contribution	Responsiveness
17	32	2	26-29	12-13

Reforms

In 1984 Australia became the first country to dismantle universal health insurance and then re-implement it. Since then there has been incremental reform; however, the structure of the healthcare system has remained the same since that time.

Current Situation

The Federal government has introduced a range of incentives to increase private health insurance such as: Life-time community rating and penalties for those without private insurance. However, increases in uptake have been slow.

There is a shortage of GPs in rurals area and oversupply in the city. The government has implemented a range of incentives to encourage more General Practitioners. There have also been moves to improve the quality of general practice, including:

- establishment of groups of General Practitioners known as ‘divisions of general practice’;
- accreditation of general practice;
- strategies to increase information systems.

The use of contracting out to private hospitals for the provision of services is encouraged. A range of payment methods have been experimented with in the various states from case mix funding to per diem rates.

Co-ordination of care is an important agenda item. For the last few years there have been co-ordinated care trials whereby GPs, Specialists and hospitals pool budgets for the treatment of patients.

Initiatives include:

- early discharge schemes and improved communication;
- faxing of patient records on discharge;
- promotion of schemes such as 24-hour general practice to decrease the pressure on accident and emergency departments.

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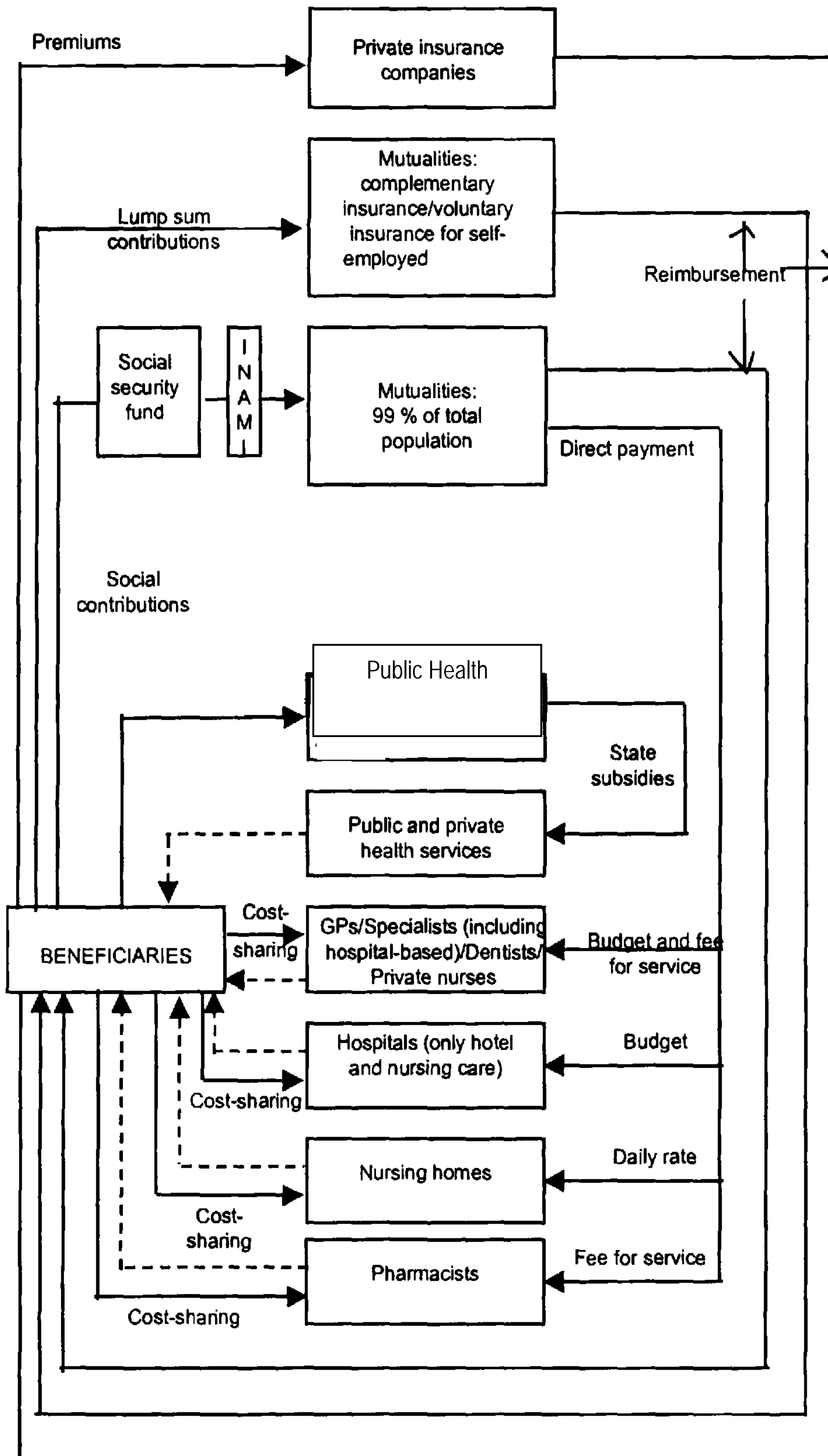
Department of Health and Aged Care website: http://www.health.gov.au

2. BELGIUM



Source: Adapted from *The Reform of Health Care - A Comparative Analysis of Seven OECD Countries*, Health Policy Studies No. 2.

Background

Since 1945, Belgium has had a compulsory national insurance package covering major risks such as hospitalisation for all the population and minor risks for 88% of the population. The self-employed are excluded. The administration of these insurance packages is the responsibility of sickness funds, which are non-governmental, non-profit making organisations. Local sickness funds are grouped into 6 national associations. However, three of these associations have a 90% market share. The role of the government is limited to regulation and partial funding.

Table A3: Belgian Finance Statistics for 1997

Total Expenditure on Health as % of GDP	Public Expenditure as % of Total Expenditure	Out of Pocket as % of Total Expenditure on Health	Per Capita Expenditure at Exchange Rate $US
8.0	83.2	14.7	1918

Table A4: Belgian WHO Rankings

Health Expenditure per capita	Overall Health System Performance	Health Level	Fairness in Financial Contribution	Responsiveness
15	28	16	3-5	16-17

Reforms

In the early 1990s there was growing recognition of the lack of competition in the sickness funds market. Sickness funds had little incentive to contain costs or stimulate efficiency, the reason being a lack of competition between the sickness fund providers who offered similar packages of care and price combinations. However, in contrast, the voluntary insurance sector for the self-employed had a completely free market for insurance premiums. As a result there developed a situation of adverse selection whereby those perceived to be a low risk, such as the young, were offered cheaper health insurance. This resulted in a migration of the young and healthy to the voluntary sector hence worsening the risk pool of the sickness funds and inflating premium costs.

The Belgian government decided to intervene introducing an incremental reform process. The emphasis of these reforms has been on the notion of efficiency gains derived from making all parties more financially accountable. By changing the remuneration systems of healthcare providers and raising the degree of cost sharing for patients, the reforms are primarily driven by reinforcing the traditional role of the sickness funds as purchasers of healthcare.

Current Situation

Since 1995, the composition of sickness funds budgets that they receive from the government has gradually been altered from the original purely retrospective basis to increasingly greater prospective payments based on a risk adjusted capitation formula.

One of the potential advantages of the Belgian implementation of a capitation formula is that sickness funds face both individual and collective responsibility. The reason for this is that each sickness fund not only gains from any surpluses between budgeted and actual expenses, but also through other sickness funds.

Possible future measures for reducing healthcare expenditure include:

- further developing the general medical file concept whereby each person has a medical file;
- increasing the importance of group practices (in primary care);
- the introduction of an organised peer review system for doctors;
- more attention to preventive care and health promotion;
- the rationalisation of hospital service provision (so that certain specialised services would only be available in a few hospitals);
- changes in hospital budgeting so that differences in Case-mix are better taken into account and strong links with historical costs are avoided;
- further devolution of healthcare financing, which some observers feel could address regional differences in healthcare expenditure and financing;

In the future hospitals may be financed not by bed number but according to the programmes (coherent interventions for well-defined patient groups) and functions (sets of hospital services) which they provide.

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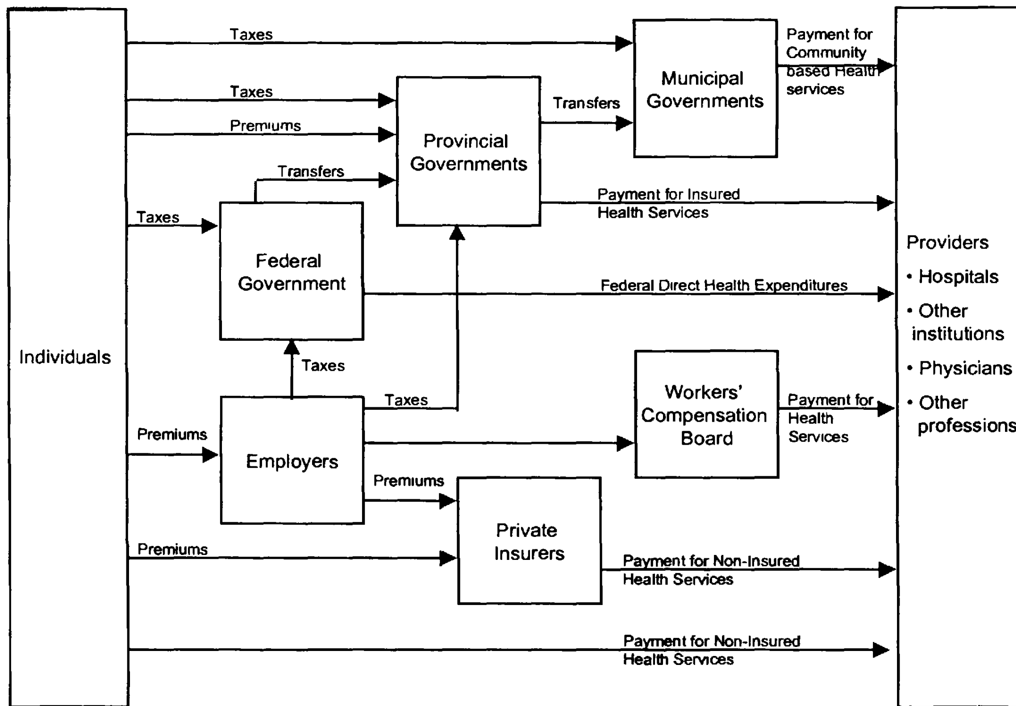
3. CANADA



Source: Adapted from *Health Care Systems in Transition. Canada*, WHO, 1996

Background

Canada had a predominantly publicly financed, privately delivered healthcare system. At the federal level there are a set of national principles on healthcare delivery. However, the provision of healthcare is under the jurisdiction of the local provinces and territories. The development of a national health insurance scheme began over 50 years ago initially with hospital insurance and followed by medical care insurance.

Table A5: Canadian Finance Statistics for 1997

Total Expenditure on Health as % of GDP	Public Expenditure as % of Total Expenditure	Out of Pocket as % of Total Expenditure on Health	Per Capita Expenditure at Exchange Rate $US
8.6	72.0	17.0	1783

Table A6: Canadian WHO Rankings

Health Expenditure per capita	Overall Health System Performance	Health Level	Fairness in Financial Contribution	Responsiveness
10	35	16	3-5	7-8

Reforms

During the 1980s and early 1990s nearly all the provinces implemented reforms for the delivery of healthcare. There have been several common themes of reform across the provinces.

- Shifting the current system emphasis on the institutional based medical model to health promotion, prevention and alternative non-institutional delivery models.
- Regional governance and management structures;
- Funding health systems at sustainable levels;
- Comprehensive management of regional resources;
- Needs and evidence-based decision-making;
- Adoption of a determinants of health framework;
- Enhanced accountability.

Current Situation

In a recent poll 8 out of 10 Canadians believed that their healthcare system was in crisis (February 2000). There have been complaints of overcrowding in emergency rooms, shortages of doctors and nurses and reports of doctors being overworked.

The Federal Government has announced plans to help the healthcare system by paying half the cost of a national home care programme. This aims to increase the amount of care at home as opposed to nursing homes.

Some Provincial Governments have been proposing plans for greater private provision to take the load off the public sector. This has been rejected by the Federal Government because of fears of creating a two-tier system. It conflicts with the national principles on the delivery of healthcare.

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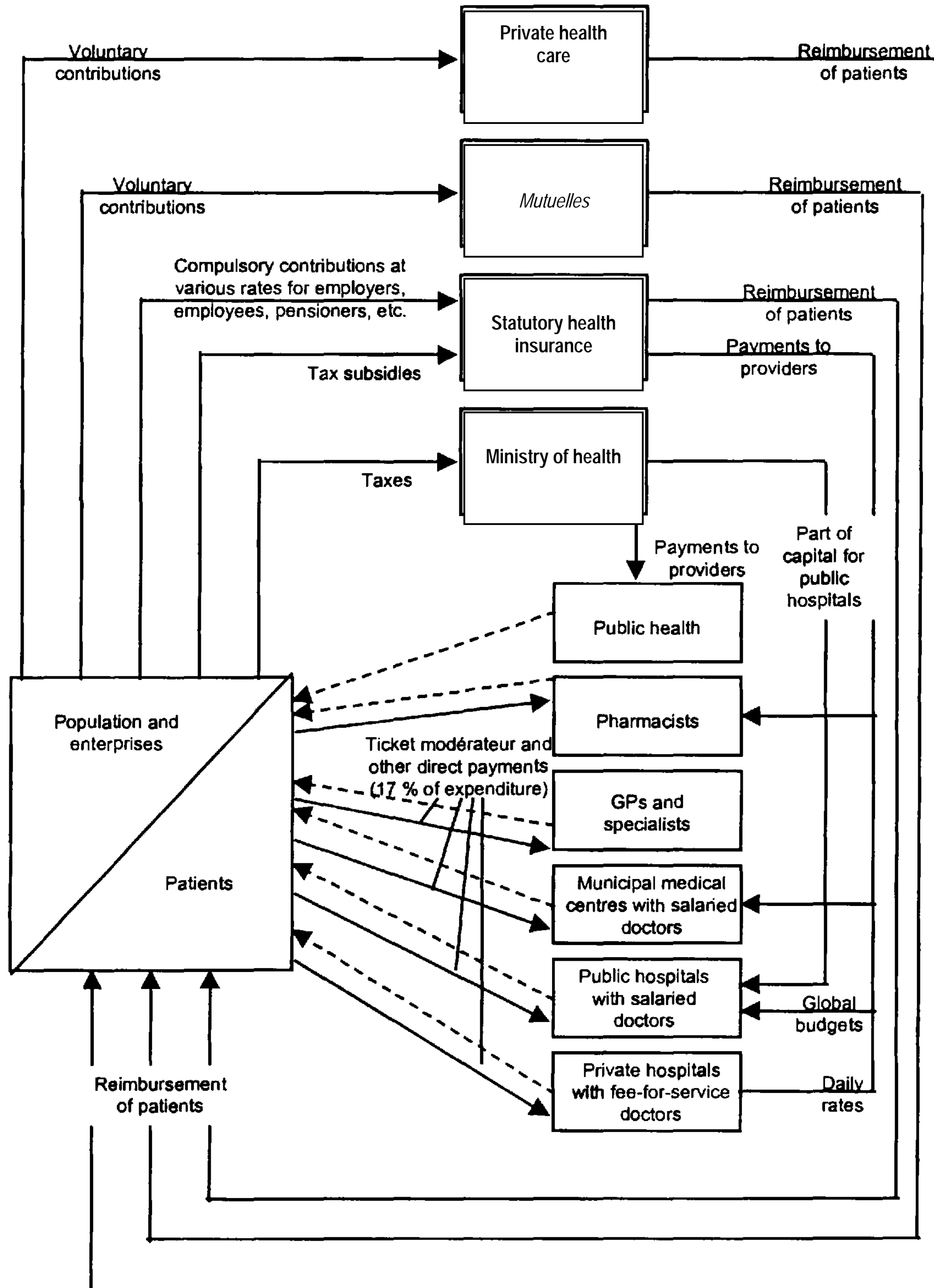
4. FRANCE



Source: The Reform of Health Care - A Comparative Analysis of Seven OECD Countries, Health Policy Studies No. 2

Background

The French healthcare system is based on a national universal compulsory insurance system linked to employment and financed by both employers and employees (roughly a 65-35 ratio). Funds cover pensions, family benefits and medical care (assurance maladie). There is no competition between the sickness funds as they are organised strictly along occupational lines.

Table A7: French Finance Statistics for 1997

Total Expenditure on Health as % of GDP	Public Expenditure as % of Total Expenditure	Out of Pocket as % of Total Expenditure on Health	Per Capita Expenditure at Exchange Rate $US
9.8	76.9	20.4	2639

Table A8: French WHO Rankings

Health Expenditure per capita	Overall Health System Performance	Health Level	Fairness in Financial Contribution	Responsiveness
4	1	3	26-29	16-17

Reforms

Reforms were first introduced by the right wing minister Alain Juppé in 1995 and have been continued by the socialist Jospin after he came to power in 1998.

The aim of these reforms has been to resolve the problem of rising health expenditure and a levelling off in health sector income. Changes in regulation sought to strengthen quality whilst improving professional practice. In addition, the reforms aimed to encourage greater interaction both between professionals and between different parts of the system.

Cash limited budgets have been brought in at both national and regional levels along with various management and organisational changes, including market contracting, co-operation, grouped activities and care networks.

There are plans to finance an increasing proportion of collective health expenditure from a direct tax based largely on household incomes.

Current Situation

French Case Study (Source: Dr J de Kervasdoué, Professeur Titualire au Conservatoire National Des Arts et Metiers).

General Practice

In France there is not a strong concept of general practice. Patients are free to choose between seeing a generalist doctor or alternatively going directly to a specialist and it is not necessary to have a referral. Both specialists and generalists tend to be independent private practitioners and there is relatively little government intervention into the provision of these services. Recently the government has tried to employ a system to encourage patients to go primarily to a general practitioner, however this measure has had relatively little success.

On going to the doctor the patient makes an out of pocket payment (ticket moderateur) and the government reimburses the rest of the fee. This involves a bureaucratic reimbursement process for each item.

Elective surgery

In France there are very few waiting lists for elective surgery. The main reason identified for this is the extra capacity in the system. A patient needing surgery is likely to get treated relatively quickly. The hospitals have global budgets and are there are regional hospital associations who allocate these budgets. Surgeons and Consultants are paid on a fee for service basis and this provides an incentive for them to keep waiting times to a minimum.

Integration of elderly care

The structure of elderly care provision in France is complex and the financing of the services by both national and local government as well as social health insurance provides a barrier for integrating services. There is currently inequity between the elderly who are ill and those who are simply poor in terms of the amount of funding that they receive.

References

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Kervasdoue (2000) Le Carnet de Sante de la France en 2000.

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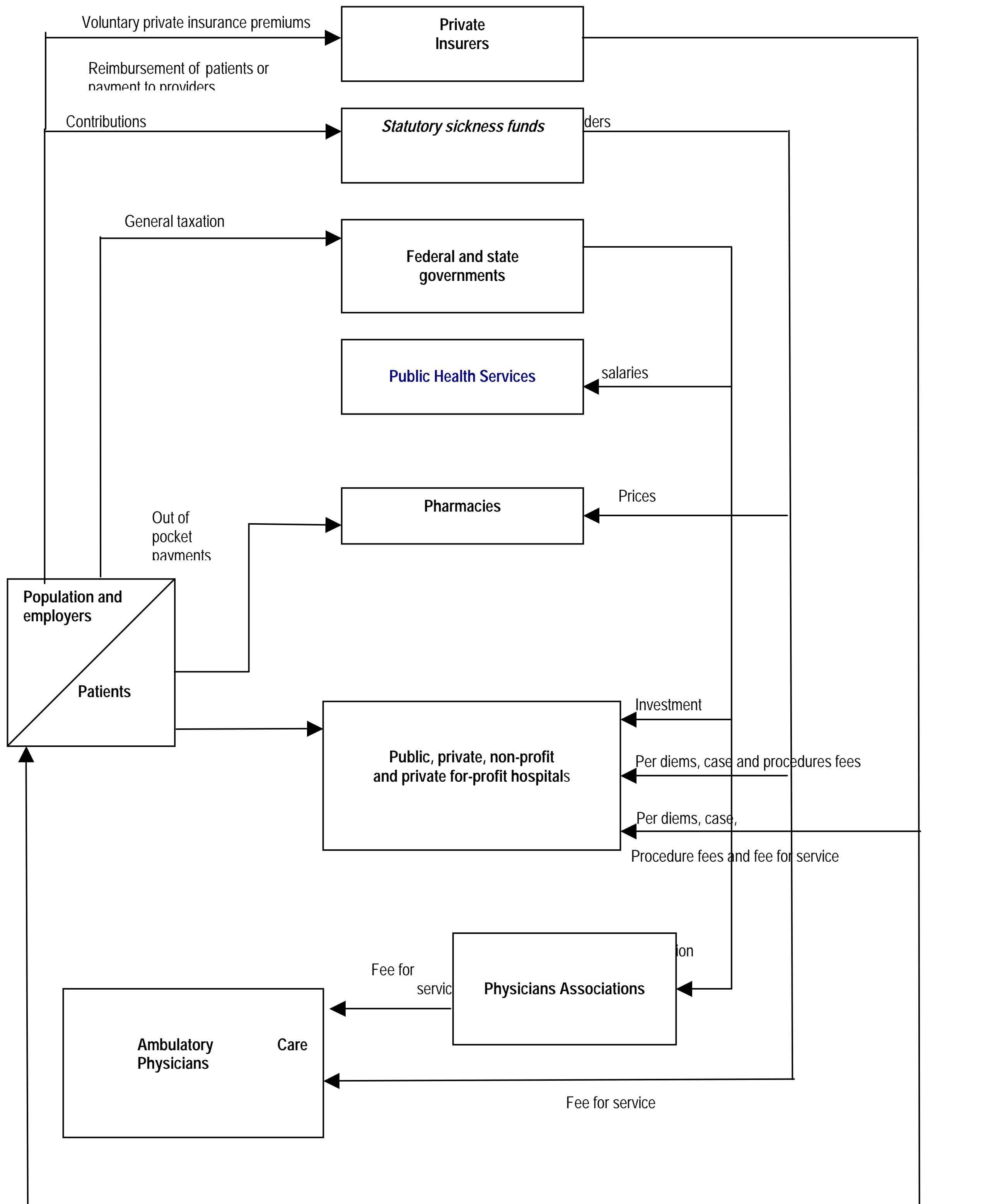
5. GERMANY



Source: European Observatory of Health Care Systems (2000) Germany.

Background

The Länder (regional governments) have the main responsibility for health policy. Health services are financed mainly by social insurance with mixed public and private providers. The healthcare system in Germany encompasses all institutions and people contributing to the health of the public.

Table A9: German Finance Statistics for 1997

Total Expenditure on Health as % of GDP	Public Expenditure as % of Total Expenditure	Out of Pocket as % of Total Expenditure on Health	Per Capita Expenditure at Exchange Rate $US
10.5	77.5	11.3	2713

Table A10: German WHO Rankings

Health Expenditure per capita	Overall Health System Performance	Health Level	Fairness in Financial Contribution	Responsiveness
3	25	22	6-7	5

Reforms

There have been a series of reform Acts in Germany throughout the 1990s including: The Health Care Structure Act (1992), Health Insurance Contribution Rate and Exoneration Act (1996) the First and Second Statutory Health Insurance Restructuring Act (1997) the Act to Strengthen Social Solidarity in Statutory Health Insurance (1998).

The Health Care Structure Act of 1992:

- legally fixed budgets or spending caps for major sectors of healthcare;
- partially introduced prospective payments in the hospital sector;
- loosened strict separation of the ambulatory and hospital sector;
- introduction of positive list for pharmaceuticals;
- gave the freedom to choose a sickness fund for most of the insured population.

The Health Insurance Contribution Rate and Exoneration Act (1996) and the First and Second Statutory Health Insurance Restructuring Act (1997) represent a shift from cost containment strategies towards an expansion of private payments. Co-payments were viewed as a way to put new money into the system.
There have been increased co-payments for inpatient care, rehabilitative care, pharmaceuticals, medical aids, transportation (to hospital) and changes within dentistry.

The Act to Strengthen Solidarity in Statutory Health Insurance (1999) reversed almost all these changes. The new government perceived that a statutory health insurance system should share contributions between employers and employees, dependent on income alone and not on risk or service utilisation.

Current Situation

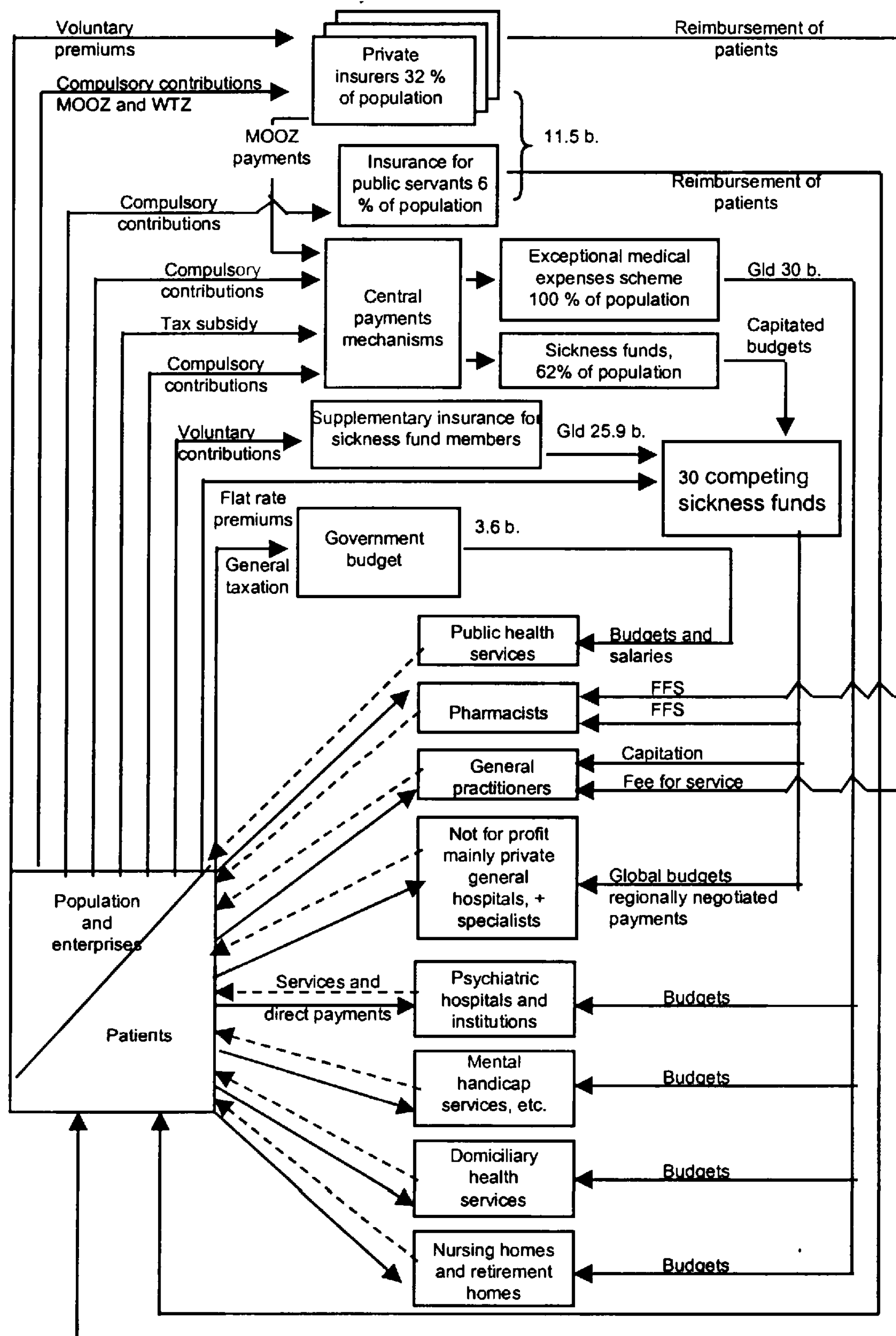
The Reform Act of Statutory Health Insurance 2000 does not have one central theme but rather tries to address a range of perceived weaknesses by:

- Strengthening primary care;
- Opening opportunities for overcoming strict separation between the ambulatory and inpatient care sectors;
- Introducing new requirements for health technology and quality assurance;
- Support for patient's rights;
- Changing the hospital payment system.

References

European Observatory of Health Care Systems (2000) Germany.

6. NETHERLANDS



Source: Adapted from *The Reform of Health Care - A Comparative Analysis of Seven OECD Countries*, Health Policy Studies No. 2.

Background

The healthcare system in the Netherlands is financed by a mixture of risk-based private insurance and income-based social insurance.

Table A11: Dutch Finance Statistics for 1997

Total Expenditure on Health as % of GDP	Public Expenditure as % of Total Expenditure	Out of Pocket as % of Total Expenditure on Health	Per Capita Expenditure at Exchange Rate $US
8.8	70.7	16.8	2041

Table A12: Dutch WHO Rankings

Health Expenditure per capita	Overall Health System Performance	Health Level	Fairness in Financial Contribution	Responsiveness
9	17	13	20-22	9

Reforms

In 1987, “Managed Competition” was proposed by the Dekker Commission and endorsed by the government.

The proposal included the following features:

- A compulsory comprehensive national insurance scheme;
- Free universal access to 'basic' services;
- Regulated competition among health insurers and among providers;
- Incentives for insurers and providers to improve efficiency and delivery.

The reforms were not realised but the following steps towards this model were made:

The Sickness Fund Act was revised allowing sickness funds to contract with healthcare professionals and compete for subscribers. Sickness funds moved from retrospective reimbursement to prospective risk, adjusted per capita for each patient.

In 1995, the idea of a comprehensive basic health insurance scheme was abandoned. Instead there was a focus on reforming the insurance scheme. The plan aimed for a complete convergence of sickness funds and private health insurers, although it did not state how this should be achieved. Although provider fees for private health insurance and the mandatory health insurance scheme were equalised, the legal separation remained. The share of prospective payments has increased from 0% in 1992 to 35% in 1999. The capitation formula takes into account age, gender, geographic region, employment/social security systems.

Current Situation

Waiting lists have appeared in some areas and are generally regarded as the major drawback of the system. European legislation and the tightening of Dutch competition policy require a reconsideration of the regulations.

Holland Case Study (Source: Erik Schut)

General Practice and Elective Surgery

Sixty percent of the population in Holland have social insurance and their healthcare is provided by a sickness fund (there is one sickness fund in each area). However, if a person earns more than a certain amount then it is compulsory to have private insurance.

Regardless of whether they have social or private insurance, if a patient needs a cataract operation he or she will go first to their General Practitioner (GP). For socially insured patients the GPs have contracts with the sickness funds, which pay a yearly flat capitation fee (the full tariff for the first 1,600 publicly insured patients on the list and a lower tariff for those exceeding this number). GPs are paid under a mixed payment scheme and in addition they receive payment from the sickness fund in the form of other elements such as: net income, pension contributions and practice costs. The Tariffs are officially negotiated between the LHV (General Practitioners Association) and the sickness funds (VNZ). However, the tariff set is also subject to regulation from the Ministry of Health.

If the patient is privately insured then he or she will pay the GP a fee-for-service, which will be reimbursed by their insurance company if GP services have been chosen in the package, after possible deductibles are taken into account. The proportions of publicly and privately insured patients on the list differ per GP, dependent on the level of prosperity of the practice area. However, there is no evidence that there is discrimination by GPs when treating privately and socially insured patients. This is mainly because private insurance schemes are strongly regulated by the government as too are the tariffs that they can pay GPs.

Elective Surgery

When the GP refers the patient for an operation it is likely he or she is faced with a waiting list. The length of the list will depend on where the patient lives. However, he or she can choose to be referred to any hospital in the country although he or she must pay their own travel expenses. Over the last five years there have been increasing problems with waiting lists in Dutch hospitals. There are a number of reasons for these problems:

There have been government measures to increase regulation and enforce cost containment on the system. This has resulted in a fall in Dutch healthcare spending as a proportion of GDP from 8.9% to 8.3%. The cost containment policies have not only affected the price, but also restrictions have been placed on the capacity of the system. For example, the Government restricts the number of specialist training places and only registers a certain number of specialists in each geographical area.

Prior to 1999, specialists were paid as independent contractors on a fee for service basis. However, hospitals now pay specialists a salary based on a contract between themselves and the hospital, to perform a certain number of operations per year.

Integration of Care - Elderly care

There is a catastrophic illness scheme for the whole population, the so-called General Act on Exceptional Medical Expenses (AWBZ). This a compulsory scheme paid for through general taxation. The AWBZ is for psychiatric hospital care, outpatient mental care, community nursing and nursing home care. It was introduced as part of the healthcare reforms of 1996.

The provision of services for the elderly in Holland has traditionally been very institutionally based, in hospitals and nursing homes. In recent years, a variety of policies have been used to increase the use of care at home. In Holland there are problems with the elderly being treated in inappropriate locations as there is a shortage of places. For example, there are long waiting lists in the home healthcare sector, leading to delay in the discharge of elderly patients acute hospital.

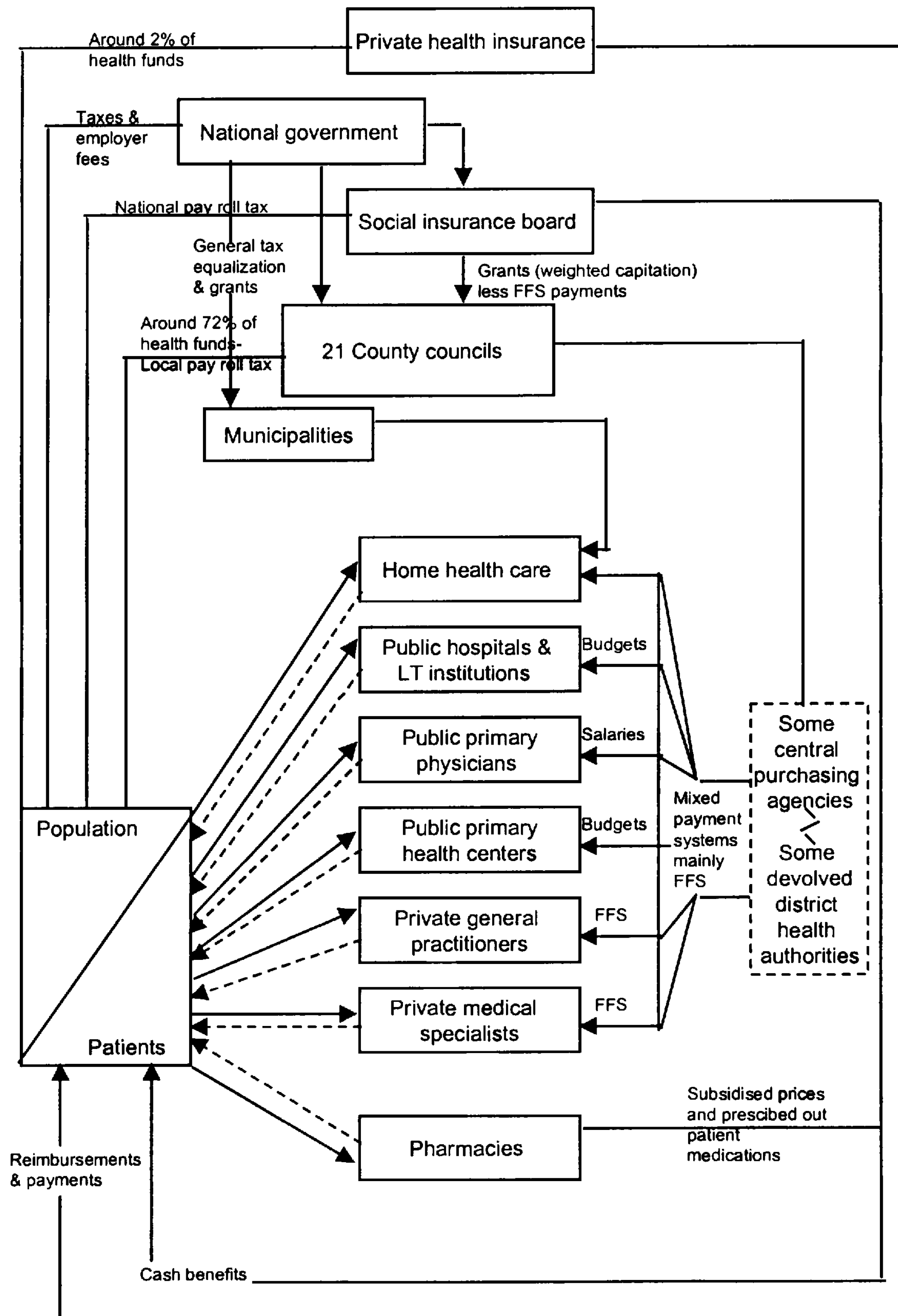
Emergency care

Emergency care is provided either in the hospital accident and emergency department or at the hospital. The utilisation of accident and emergency departments is not perceived as a problem and as there are no co-payments at the family practitioner, there is little incentive for patients to access emergency departments as opposed to the GP.

7. SWEDEN

Sweden, 1999

Sweden: The Health Care System, 1999



Background

The Swedish healthcare system is mainly financed through general taxation. The system is comprehensive and all citizens and health services are covered. The system is a public one with respect not only to financing but also production and ownership of health facilities. In Sweden, locally elected councils have the responsibility for both financing and procurement of healthcare.

Table A13: Swedish Finance Statistics for 1997

Total Expenditure on Health as % of GDP	Public Expenditure as % of Total Expenditure	Out of Pocket as % of Total Expenditure on Health	Per Capita Expenditure at Exchange Rate $US
9.2	78.0	22.0	2456

Table A14: Swedish WHO Rankings

Health Expenditure per capita	Overall Health System Performance	Health Level	Fairness in Financial Contribution	Responsiveness
7	23	4	12-15	10

Reforms

At the beginning of the 1990s Sweden introduced a purchaser-provider split. This followed a long-term policy movement from the early 1950s towards decentralisation, management by objectives and need-orientation.

In addition to the purchaser-provider split a number of other reforms have been introduced.

- In 1989, patients were given the freedom to choose a doctor at the primary or secondary care level.

- In 1991, maximum waiting times were introduced for certain operations. The scheme has developed, making it more general and guaranteeing patients with chronic diseases a standard quality of care.

- In 1990, the elderly care system was reformed whereby local councils took over the responsibility for nursing homes, which were formally the responsibility of county councils. These local municipalities also have responsibility for bed blockers.

Current Situation

- There has been a move away from the purchaser provider split towards long-term stability. Contracts tend to be longer and contestability remains instead of competition.

- Planning has been revised and has regained its popularity. However, this time the focus is on needs, priorities and strategic issues.

- There is a wariness of professionals towards changes in the organisation. Instead the focus is on improving the process through patient orientation, improving flows and enhancing collaboration between different parts of the system to use the resources in the best way.

References

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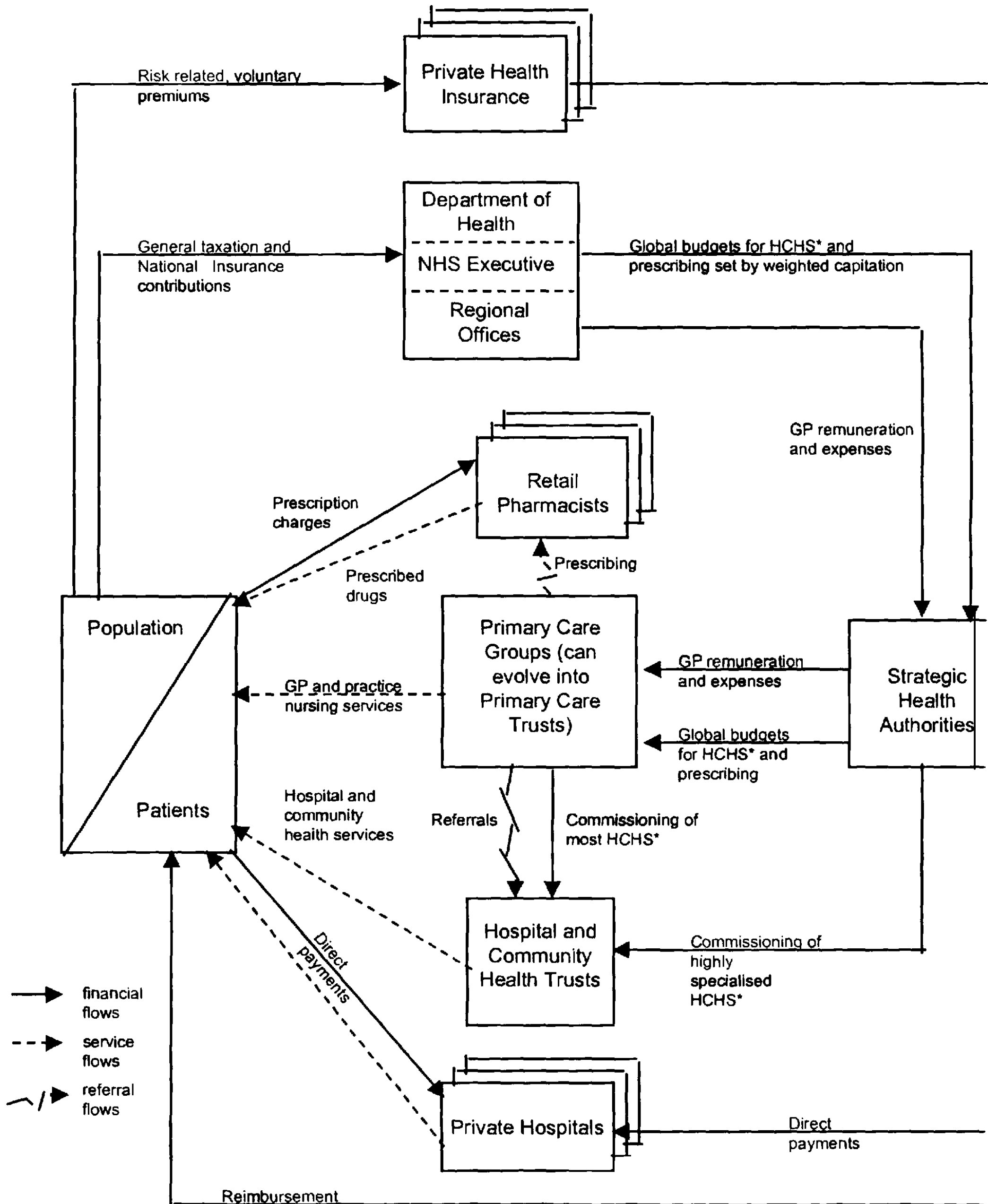
8. UNITED KINGDOM



*HCHS: Hospital and Community Health Services

Source: Department of Health, England.

Background

Healthcare in Britain is mainly financed through general taxation. Britain has a strong tradition of publicly financed healthcare provided through a national health service. There are slight differences between the four countries that form the United Kingdom and the focus in this section will remain on England and Wales.

Table A15: British Finance Statistics for 1997

Total Expenditure on Health as % of GDP	Public Expenditure as % of Total Expenditure	Out of Pocket as % of Total Expenditure on Health	Per Capita Expenditure at Exchange Rate $US
5.8	96.9	3.1	1303

Table A16: British WHO Rankings

Health Expenditure per capita	Overall Health System Performance	Health Level	Fairness in Financial Contribution	Responsiveness
26	18	14	8-11	26-27

Reforms in the United Kingdom

In the early 1990s there was significant reform to the structure of the National Health Service. A purchaser-provider split and internal market was introduced. There was a separation of responsibilities for the purchasing of care by the health authority (and in part General Practitioners) and provision by Acute and Community Health Trusts. In addition in primary care, General Practitioners were given the opportunity to become fund-holders, whereby groups of GPs with a total population of 11,000 or more on their lists could join together and hold a group budget for prescribing and hospital services. Throughout the 1990s there has been a development of the General Practitioners' role with many experimental schemes such as Total Purchasing Pilots and Commissioning Groups.

Current Situation

In the last five years there has been little change in the financing of healthcare. However, there have been changes to the organisation of healthcare services.

In 1997, the Labour party was elected and replaced the Conservative Government who had been in power since 1979. Prior to 1997 there had been a quasi market-orientated approach to the healthcare system with significant reform in 1990. An internal market had been introduced into the NHS with a purchaser/provider split between Health Authorities and Community and Acute Trusts. In addition, fundholding had been introduced for General Practitioners which gave rise to a global budget for some items such as prescription drugs and, in addition, allowed GPs to take some responsibility for purchasing decisions (e.g. non-urgent treatment in hospital).

In 1997 the internal market was officially abolished and so was the concept of fund-holding. Instead there has now been an emphasis on primary care and the establishment of Primary Care Groups (PCGs). Fundholding was voluntary but PCG membership is compulsory for GPs. Gradually PCGs are to join together as they are being encouraged to form Primary Care Trusts (PCTs). PCTs will have greater power than PCGs and will be involved not only in the delivery of primary care but also have a greater commissioning role for secondary care services.

In terms of health policy the issues currently very much on the agenda are as follows:

- Evidence based medicine. In 1998 the National Institute of Clinical Excellence was set up to monitor the cost effectiveness and clinical effectiveness of both new and current interventions.
- Clinical Governance ensuring accountability.
- Equity in healthcare is becoming a more important health policy issue.
- Demand management issues.
- National Service Frameworks have been set up to try and tackle issues such as mental health, coronary heart disease and to increase quality of care and evidence base for interventions.
- How to fund the healthcare system into the future with increasing cost and the increase in availability of new drugs.
- The opposition party is considering a plan to allow more private financing of healthcare.

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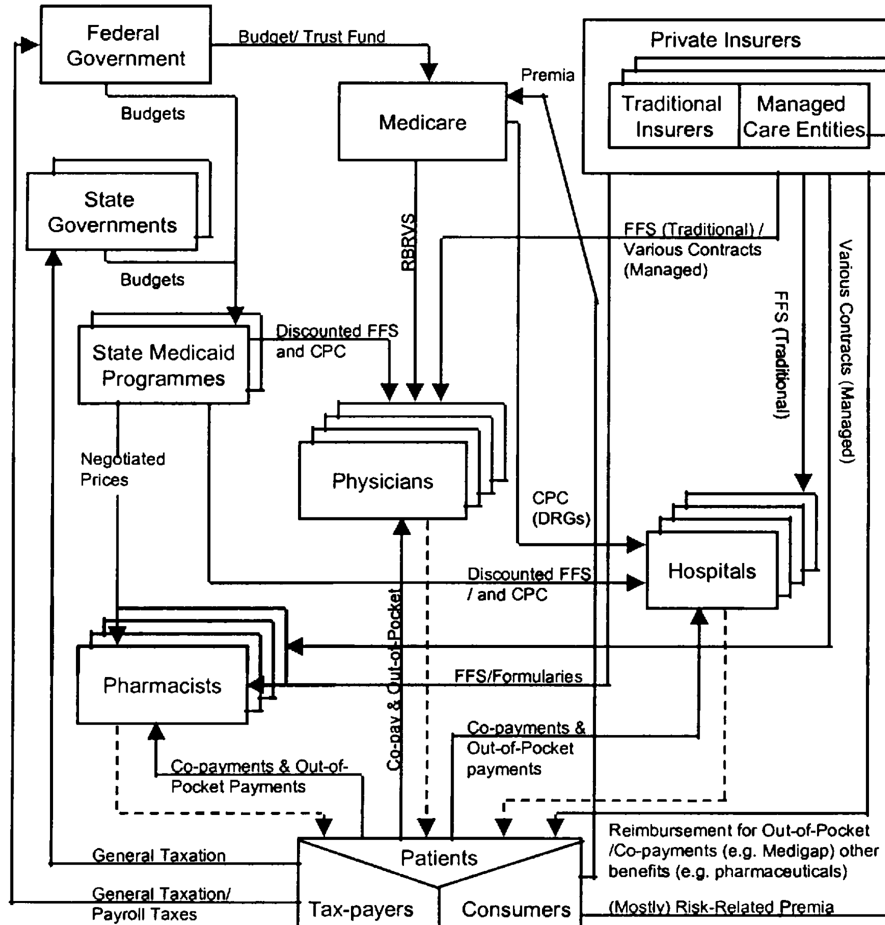
9. UNITED STATES OF AMERICA



CPC: Cost-per-case

FFS: Fee-for-service

RBRVS: Resource-based relative value scale

Adapted from financing health care Hoffmeyer & McCarthy ,(1994)

Background

The United States differs from other countries being considered in that it is based mainly on private health insurance. However, there is some provision of healthcare for the elderly and poorer citizens through the Medicare and Medicaid schemes.

Table A17: American Finance Statistics for 1997

Total Expenditure on Health as % of GDP	Public Expenditure as % of Total Expenditure	Out of Pocket as % of Total Expenditure on Health	Per Capita Expenditure at Exchange Rate $US
13.7	44.1	16.6	4187

Table A18: American WHO Rankings

Health Expenditure per capita	Overall Health System Performance	Health Level	Fairness in Financial Contribution	Responsiveness
1	37	24	54-55	1

Reforms

In the United States there has been a move since the 1980s to control healthcare costs. The perception was that costs were being inflated because doctors were being paid on a fee-for-service basis and there was an incentive for excessive treatment of patients. This led to rising insurance premiums as rising costs were not managed by insurance companies but passed on to the public.

In the United States, managed care has been seen as a partial solution to increasing healthcare costs. People pay an annual fee to a managed care organisation to provide a package of healthcare. The managed care organisation has a capped budget to provide care for its client population. This has proved unpopular with the American public for a number of reasons: choice of healthcare has been restricted for patients; doctors have financial incentives to undertreat; managed care organisations can exclude those patients with a high risk of healthcare costs or charge them higher premiums.

The structure of the United States system of healthcare has remained much the same throughout the 1990s. In 1994, there were proposals to move towards a Universal System of health insurance with the Clinton reforms. However, these reforms failed to be implemented due to opposition from key stakeholders.

Current Situation

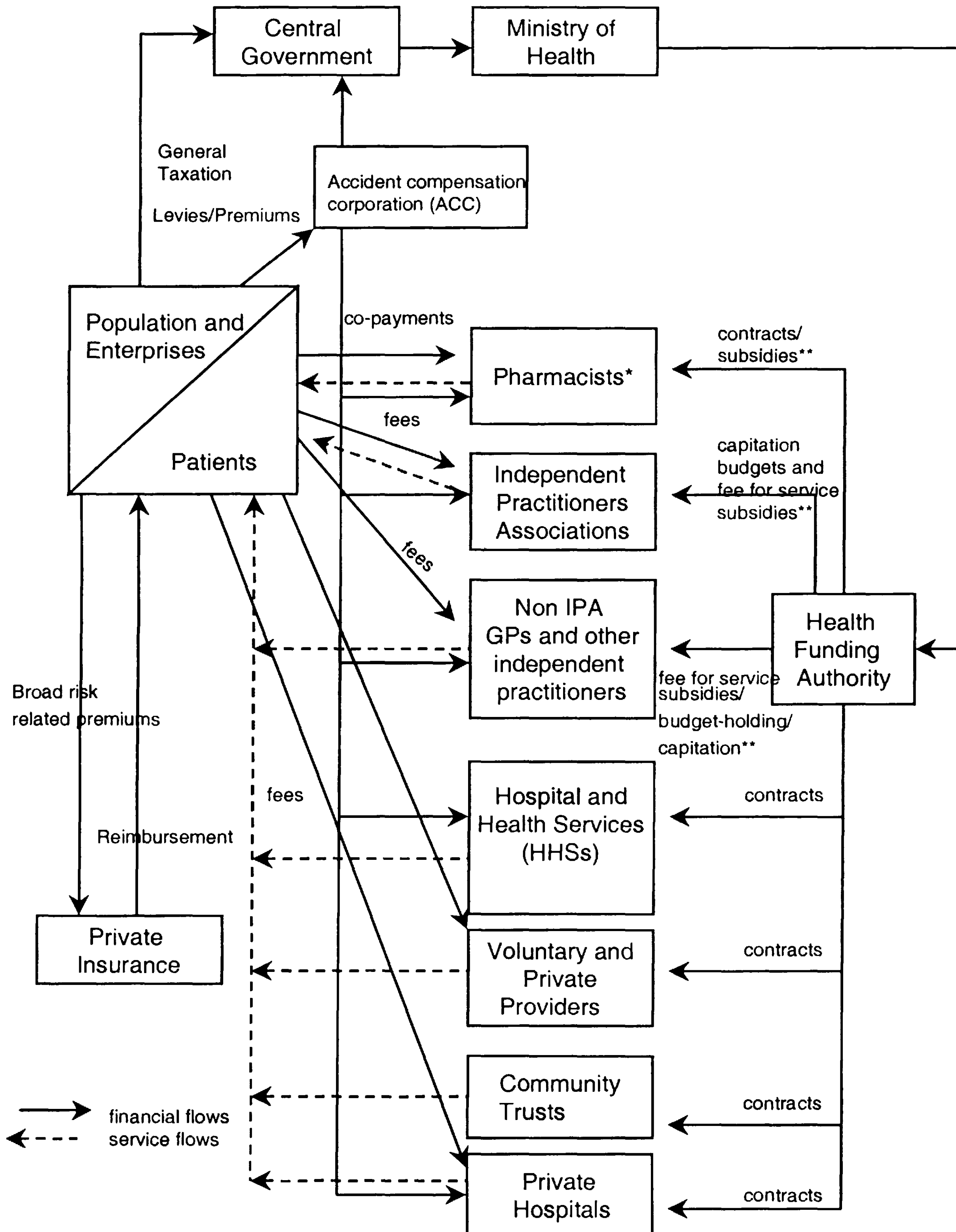
In 1998, 44 million people in America were uninsured (16% of the population). Of these, 11 million were children (Robert Wood Foundation, 1999). They have neither private insurance nor the right to access Medicaid or Medicare. Although these uninsured have access to some healthcare this is mainly provided by charitable organisations. The Robert Wood Foundation comment that the uninsured experience major delays and receive inadequate care.

References

Folland, Goodman and Stano (2000) The Economics of Health and Health Care (3rd Edition).

Robert Wood Johnson Foundation (1999) Americans without health insurance: myths and realities.

10. NEW ZEALAND



*and other providers such as laboratories and radiology clinics
**relating to contracts with the Health Funding Authority

Background

The New Zealand healthcare system is mainly financed through general taxation. However, since the early 1980s there has been a programme to reduce the size of the public sector and there have been increases in the amount of user charges and private sector spending.

Table A19: New Zealand Finance Statistics for 1997

Total Expenditure on Health as % of GDP	Public Expenditure as % of Total Expenditure	Out of Pocket as % of Total Expenditure on Health	Per Capita Expenditure at Exchange Rate $US
8.2	71.1	22.0	1357

Table A20: New Zealand WHO rankings for 1997

Health Expenditure per capita	Overall Health System Performance	Health Level	Fairness in Financial Contribution	Responsiveness
20	41	31	23-25	22-23

Reforms

In New Zealand the public sector in general has undergone a large amount of deregulation and reform since the early 1980s. One element of this has been within the healthcare sector. New Zealand introduced a purchaser-provider split in 1993 in an attempt to introduce market forces. The purchasers of services are Health Funding Authorities at the regional level and some of the hospitals have been transformed into autonomous non-governmental organisations. One of the problems of this system in a country like New Zealand is the population density. As a result there tends to only be one supplier of health services in an area leading to little actual competition.

At the time of introduction of the purchaser provider split there was also a proposal to introduce ear marked taxes for healthcare. But this was extremely unpopular with the general public who perceived the ear-marked tax to be an additional tax and in the end was never implemented.

Current Situation

The 1998 Commonwealth Fund Survey found that almost one third of patients said that their system was in need of complete rebuilding. There have been a variety of cost containment measures imposed in New Zealand and these have lead to growing concerns about the quality of care that is being provided (Donelan, 1999). New Zealand relies on substantial private heath insurance to relieve pressure on public hospitals. A waiting list booking system has been introduced which uses explicit criteria for prioritising cases. This system has been developed in conjunction with the medical profession.

In New Zealand general practice, there has been a movement similar to the UK whereby groups of General Practitioners assume responsibility for a budget. In New Zealand the system is called “budget holding” and groups of General Practitioners assume the financial risk for providing an array of services.

Currently a left-wing government is in power. The internal market has been abolished and there is no longer a purchaser-provider split. There are now 21 district health boards and there have been changes to the organisational structure. Current concerns in the health policy arena are as follows:

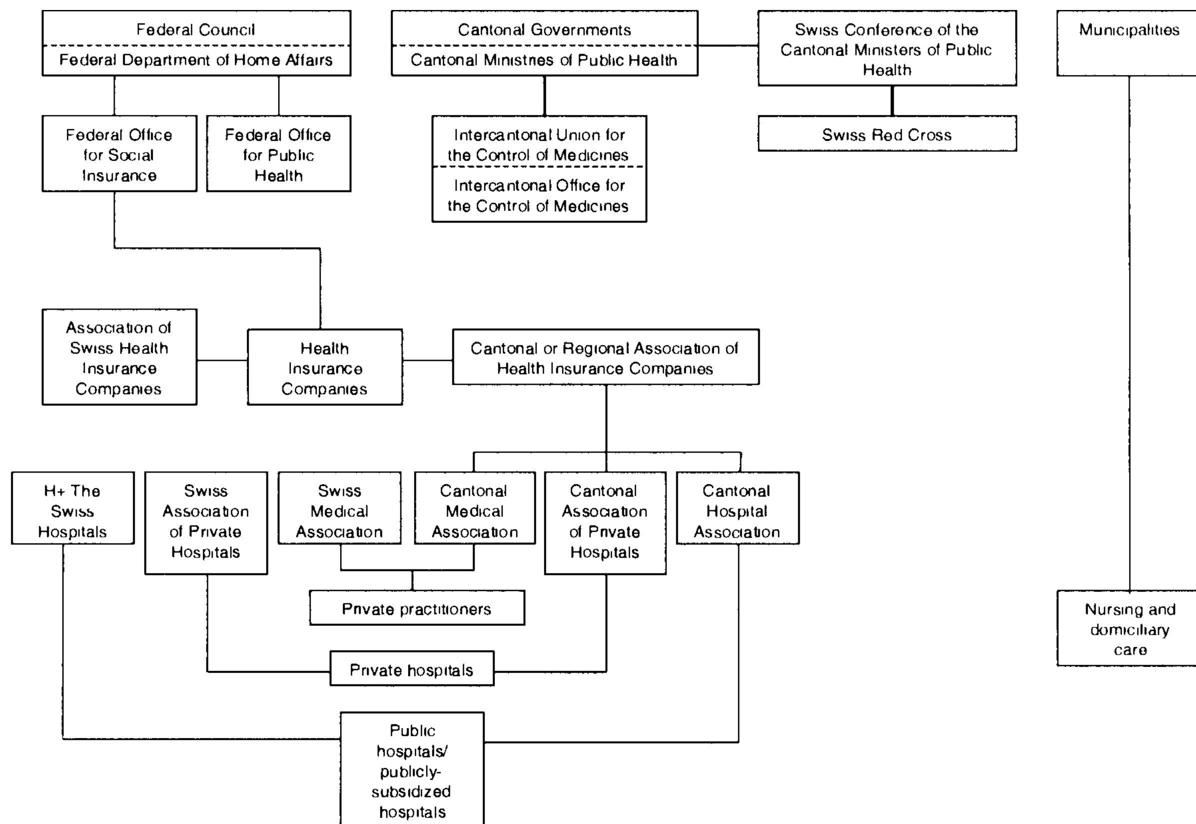
- No-fault accident insurance has been long established in New Zealand. However, there are concerns about the cost of this to employers.
- New Zealand is facing increasing healthcare costs with the rise in the elderly population.

References

Donelan K, Blendon R, Schoen (1999). The cost of health system change: public discontent in five nations.

Discussion with N Devlin, University of Ottago 2000.

11 SWITZERLAND



Source: European Observatory on Health Care Systems (2000) Switzerland.

Background

Switzerland's healthcare system is largely financed through compulsory health insurance premiums. All permanent residents in Switzerland are legally obliged to purchase compulsory health insurance policies. In 1999, there were 109 insurance companies that offered compulsory health insurance policies in Switzerland (this compares to 207 companies offering statutory health insurance in 1993). Individuals or their legal representatives purchase insurance policies for which the premiums are community rated (i.e. the same for each person taking out insurance with a particular company within a canton (region) or sub-region of a canton regardless of individual risk rating).

Table A21: Switzerland Finance Statistics for 1997

Total Expenditure on Health as % of GDP	Public Expenditure as % of Total Expenditure	Out of Pocket as % of Total Expenditure on Health	Per Capita Expenditure at Exchange Rate $US
10.1	69.3	29.7	3564

Table A22: Switzerland WHO rankings for 1997

Health Expenditure per capita	Overall Health System Performance	Health Level	Fairness in Financial Contribution	Responsiveness
2	20	8	38-40	2

Reform

The main reason Swiss healthcare reform was initiated was the significant increase in expenditure. The other problem in the healthcare system was that solidarity was being undermined by the possibility that insurance companies could discriminate based on risk. This problem became more and more important given constantly rising costs. In 1996, a new health insurance law was introduced. Instead of allowing insurance companies to set charges according to risk, community rating was introduced.

Current Situation

The Federal Council has proposed to Parliament a partial revision of the health insurance law in two stages.

Introduction of a global budget also applicable to outpatient care, would promote generic dispensing and would increase the federal subsidies for compulsory health insurance premiums for the years 2000 to 2003. This attempt to introduce a global budget for outpatient care has been met with enormous resistance from many political parties.

The current health insurance law requires the cantons (regional government) to pay at least half the costs of operating general wards in public and publicly subsidised hospitals, their capital expenditures in full and the costs of teaching and research. However, the hospitals do not receive any subsidies for areas covered by supplementary insurance. The provisions of the law covering fees also apply only to hospitalisation in general wards. The revision would extend the cantons' responsibility to include subsidising private hospitals on the cantonal hospital list. This would mean considerable extra expense for the cantons.

The proposals before Parliament are numerous and varied. These include:

- promoting competition in pharmaceuticals and in particular promoting generic drugs; transferring cover for nursing care from compulsory health insurance to a separate insurance scheme;
- national planning of hospital structures and planning of high-technology medicine and centres of medical excellence at the federal level;
- removing responsibility for hospital financing from the cantons;
- instituting an official price freeze on healthcare services and health insurance premiums;
- reducing the benefits package covered by compulsory health insurance;
- revising the risk adjustment formula used to balance payments between different insurance funds;
- allowing health insurance companies to make a profit on compulsory health insurance as well as setting insurance premiums according to the income and assets of subscribers.

References

European Observatory on Health Care Systems (2000) Switzerland.

APPENDIX III
Healthcare Employment

International Comparisons of Health Care Staffing Levels

Table 1: General Practitioners-density per 1000 population

	1990	1991	1992	1993	1994	1995	1996	1997
Australia		1.5		1.3	1.3	1.4	1.4	1.4
Belgium	1.5	1.5	1.5	1.5	1.5	1.5		
Canada	1	1	1	1	1	1	0.9	0.9
France	1.4	1.4	1.4	1.4	1.4	1.5	1.5	1.5
Germany	1.2	1.1	1.1	1.1	1.1	1.1	1.1	1
Ireland	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.4
Netherlands	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5
New Zealand	0.7	0.7	0.8	0.8	0.8	0.8	0.8	0.8
Sweden		0.4	0.5	0.5	0.5	0.5	0.6	
United Kingdom	0.6	0.6	0.6	0.6	0.6	0.6	0.6	
United States			0.7			0.7	0.7	0.8

OECD Health Data 1999

Table 2: Practising specialists-density per 1000 population

	1990	1991	1992	1993	1994	1995	1996	1997
Australia		0.8		0.9	0.9	0.8	0.9	0.9
Belgium	1.4	1.4	1.5	1.5	1.5	1.6		
Canada	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9
France	1.3	1.3	1.3	1.4	1.4	1.4	1.5	1.5
Germany	1.7	1.8	1.8	1.9	1.9	2	2.1	2.2
Ireland	0.3	0.3	0.3		0.3	0.3	0.3	0.3
Netherlands	0.8	0.9	0.9	0.9	0.9	0.9	1	
New Zealand	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.7
Sweden		1.8	2	2	2.1	2.2	2.2	
United Kingdom								
United States			1.3			1.3	1.4	1.5

OECD Health Data 1999

Table 3: Practising physicians-density per 1000 population

	1990	1991	1992	1993	1994	1995	1996	1997
Australia		2.2		2.4	2.4	2.5	2.5	2.5
Belgium	3.2	3.2	3.3	3.3	3.4	3.4		
Canada	2.1	2.2	2.2	2.2	2.2	2.1	2.1	2.1
France	2.6	2.7	2.7	2.8	2.8	2.9	2.9	3
Germany	3.1	3.1	3.1	3.2	3.3	3.4	3.4	3.4
Ireland	1.6	1.7	2	2	2	2.1	2.1	2.1
Netherlands	2.5	2.6						
New Zealand	1.9	1.9	2	2	2	2.1	2.1	2.2
Sweden	2.9	2.9	2.9	3	3	3.1	3.1	
United Kingdom	1.5	1.5	1.5	1.5	1.6	1.6	1.7	
United States	2.4	2.5	2.5	2.5	2.6	2.6	2.6	2.7

OECD Health Data 1999

Table 4: Practising dentists-density per 1000 population

	1990	1991	1992	1993	1994	1995	1996	1997
Australia		0.4		0.4	0.4	0.4		
Belgium	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7
Canada	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
France	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7
Germany	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.8
Ireland	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.5
Netherlands	0.5	0.5	0.5	0.5	0.5	0.5	0.5	
New Zealand	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Sweden	1	1	1	1.1	1	1	0.9	
United Kingdom	0.4	0.4	0.4	0.4	0.4	0.4	0.4	
United States	0.6	0.6	0.6	0.6	0.6	0.6	0.6	

OECD Health Data 1999

Table 5: Practising registered nurses-density per 1000 population

	1990	1991	1992	1993	1994	1995	1996	1997
Australia		8.5		9.4	9.8	9.6	9.5	
Belgium								
Canada	11.1	11.2	11.1	8.1	8	7.9	7.6	7.6
France	5.4	5.4	5.5	5.7	5.8	5.9	5.9	5.9
Germany		8.9		8.7		9	9.5	9.5
Ireland	11.3	12.1	12.4	13.1	13.7	14.2	14.8	15.3
Netherlands								
New Zealand	9.3	9.5	9	9.6	9.8	9.8	9.8	9
Sweden	9.2	9.4	9.6	9.9	10.1	10.2		
United Kingdom	5.2	5.2	5.2	5.1	5	5	4.5	
United States	7.2	7.3	7.5	7.7	7.8	8	8.1	8.3

OECD Health Data 1999

Table 6: Practising pharmacists- density per 1000 population

	1990	1991	1992	1993	1994	1995	1996	1997
Australia		0.6		0.6	0.6	0.6		
Belgium	1.2	1.2	1.3	1.3	1.4	1.4		
Canada	0.6	0.6	0.5	0.6	0.6	0.6	0.6	0.6
France	0.9	0.9	0.9	1	1	1	1	1
Germany	0.6	0.5	0.5	0.5	0.5	0.5	0.6	0.6
Ireland	0.6	0.6	0.6	0.6	0.7	0.7	0.7	0.7
Netherlands	0.2	0.2	0.2	0.2	0.2	0.2	0.2	
New Zealand	0.7	0.7	0.6	0.7	0.6	0.6	0.6	
Sweden	0.6	0.6	0.6	0.6	0.7	0.7	0.7	
United Kingdom	0.6	0.6	0.6	0.6				
United States	0.7	0.7	0.7	0.7	0.7	0.7	0.7	

OECD Health Data 1999

APPENDIX IV

Policy Overview

I CANCER SERVICES IN IRELAND: A NATIONAL STRATEGY

Overview

In Shaping a Healthier Future, cancer was highlighted as an area which placed a great burden on the health services.

- There are on average 1,800 new cases of cancer per year
- In 1995, there were 49,000 hospital episodes as a result of cancer
- Mortality rates are higher in Ireland than across the EU

Against the background of the above, a target was set to reduce the death rate in the under 65 year age group by 15%.

The Cancer Strategy commented that in general treatment for cancer was reasonable across Ireland, however:

- The organisation and delivery needed a clearer focus so that the finite resources could be better deployed
- The services should be re-organised to ensure greater co-ordination and effective communication
- Access and equality of access to services needs improving
- Palliative care services need improving

Strategy Objectives

The strategy aims to "*reorganise cancer services so as to":*

- Identify best uses of resources available
- Maximise the benefit that can be gained from existing resources
- Channel additional resources to the best use

The objectives of the strategy, published in 1996 are:

- To reduce morbidity and mortality from cancer in line with targets set in Shaping a Healthier Future
- For those who develop cancer to receive the most effective care and treatment and that the quality of their life is enhanced

Therefore, the strategy is aimed at ensuring there is:

- Effective prevention and screening services
- Good diagnostic practice
- Effective primary care
- Well developed treatment regimes
- Responsive counselling and follow up of patients
- Clear communication between medical staff and patients

Elements of the Strategy

There are many individual elements to the strategy, including

- Prevention
- Information for patients and the professionals
- Early detection through providing screening which is of proven value
- All patients having equitable access to effective services which are of uniformly high quality
- Improving and prolonging the quality of life
- Delivering appropriate treatment to high standards
- Improved co-ordination across primary care, hospital care, rehabilitation and palliative care

- Ensuring service delivered are cost effective
- Proving more and focused research and development

Health promotion

The risk factors for cancer are identified as:

- Smoking
- Alcohol
- Diet
- Lifestyles

In respect of health promotion activities, these need co-ordinating and targeting towards increased effectiveness, and therefore this requires:

- Improved co-ordination of activities at Health Boards, for example through the Health Board Health Promotion Units
- The development of national databases, to allow ongoing monitoring and evaluation
- Smoking restrictions and, for example, fiscal policies aimed at the reduction of smoking
- Policies in respect of alcohol consumption
- A nutrition policy
- Health promotion activities targeted at skin cancer

Screening and Early Detection

Two cancers, which are targeted, are breast cancer and cervical cancer**.**

- In respect of breast cancer, the policy objectives are to develop a strategy of routinely screening women between 50-64 years of age, following the evaluation of a pilot scheme by the Mater Foundation, this will be implemented on a phased basis.
- In respect of cervical cancer, at present there is opportunistic screening, which should move to population screening, which should be free under GMS. Implementation should begin in 1999 at the latest.

Hospital Services

The strategy noted that there are large variations in the usage of hospital services across Ireland, and whilst there are increases in the use of Day case facilities, this too is variable. Therefore, treatment needs to be:

- More co-ordinated and patient focused
- Of a more consistent quality, based on best practice
- Targeted such that resources are focused on effective and efficient services, which are capable of change

There are many challenges in respect of hospital treatment as it is delivered currently:

- Services are not always well co-ordinated between and within primary care and secondary care: there needs to be an increased focus on efficiency
- There needs to be a greater emphasis on evidence based treatment
- There is a lack of specialist medical oncology, except in the Health Boards in the Eastern Region, which may lead to inconvenience for patients due to long waiting times
- There are variations in the utilisation of cancer services

Requirements for an Integrated Service

The strategy identified the following:
- Co-ordination for identifying and implementing best practice including:
  - Protocols for diagnosis and treatment
  - Agreement across clinicians as to which cancers should be treated where
  - Agreement in respect of minimum and maximum caseloads
  - Increased emphasis on cancer in the training of professionals
- Well organised treatment services
- Closer links between GPs and all levels of care
- More rapid communication in respect of the status and progress of each patient: it is recommended that one clinician has overall and continuing responsibility for each patient
- Improved and clear information for patients and families
- A revised structure for cancer treatment services
- Provision for the evaluation of the effectiveness of services

A Four Level Structure

The strategy recommends the introduction of a four level structure, which comprises:
- Primary care
- Regional care, at designated hospitals for specific cancers with agreed protocols working to best practice guidelines
- Supra regional care, providing care for the full range of cancers and the provision of specialised therapies
- A national co-ordinating function

The Department of Health and Children's Services together with the Health Boards are the bodies, which should take the lead role in setting up the above structures.

Primary Care

The following initiatives needs to be implemented:
- GPs and hospital specialists should agree on and implement a set of guidelines in respect of the referral, management and discharge of patients across primary and secondary care, such that care is more fully integrated
- Specialists, in conjunction with GPs, should develop guidelines for individual cancers including symptom control
- Hospitals should have clear procedures for the speedy referral by GPs of patients to the most appropriate place of treatment or care
- Communication between GPs and between GPs and Hospitals must be improved in respect of individual patients
- Patients should receive better information about outreach services
- There needs to be improved liaison between members of the primary health care teams, for example public health nurses, GPs and others

Regional Hospital Services

The following initiatives require to be implemented:
- Services should be organised in a region such that one hospital has the lead role
- Each region needs a regional director, which will be a part-time post for three years: this will be a consultant who will also have support staff such that they will
  - prepare a cancer plan for each region
  - promote the use of protocols locally
  - be involved in CME (continuous medical education)

- develop the role of, and liaise with, the specialist cancer nurses

- Each lead hospital will allow the bringing together of cancer services into a single entity

Supra-regional Services

This level comprises the more specialist services. The expectation is that:

- Supra regional centres will be set up each of which provide the full range of diagnostic techniques and therapies for the majority of cancers:
- Radiotherapy is likely to be provided in two locations
- Rare cancer services will be in one location
- Services will be organised around teaching hospitals
- It is not considered necessary to have a single specialist cancer hospital, instead there will be a co-ordinated network of several hospitals, except for paediatric cancers where there will be one centre
- There will be three catchment areas comprising Cork, Galway and Dublin, each with a Director

National co-ordination

The role of a national co-ordinating body will be to ensure developments in best practice, such that they will be adopted on a national basis. It is proposed that there be a national forum or group, to which the Regional and Supra-regional directors contribute, which meets on a three monthly basis.

Rehabilitation and Palliative Care

The development of these services are at an early stage, and different models are being developed, such as hospice care, domiciliary care, and links between hospitals and these locations of care. There are four inpatient hospices across Ireland. Under the GP Development Fund, improvements to palliative care have been funded, together with training of GPs. To date, evaluation has been positive, although the Health Boards have been asked to review this more formally.

II BUILDING HEALTHIER HEARTS

Background

Cardio vascular disease (CVD) is responsible for the deaths of more than 40% of the population in Ireland, and within this group of diseases, coronary heart disease (CHD) accounts for most of this mortality. Although CHD as a cause of death is declining, and have fallen by 30% in the past 20 years, the death rates remain high when compared to other EU countries. There are also geographic variations, with age standardised death rates highest in the North Eastern and the Southern Health Boards and lowest in the North Western Health Boards.

Much cardiovascular mortality and morbidity is avoidable. The known risk factors include: smoking, high blood pressure, high cholesterol levels, physical inactivity and obesity, and evidence indicates that modification of behaviour to reduce the risk factors reduces mortality and morbidity. Thus, strategies aimed at reducing CHD should focus on impacting on the risk factors as well as reducing related conditions, which are associated with CHD such as strokes and other circulatory disorders, diabetes and cancers. More advanced interventions and therapies are also available to treat CHD after onset, and these also are able to contribute to a reduction in morbidity and mortality.

The Cardiovascular Disease Strategy

The cardiovascular disease strategy, Building Healthier Hearts, was issued in March 1999, and was produced by the Cardiovascular Health Strategy Group (CHSG) established in March 1998 by the Minister for Health and Children. The strategy was explicitly underpinned by the basic principles of SHF namely:

- Focus on health and social gain
- Equity of access
- Services be of high quality
- Services are effective and efficient
- Accountability for the delivery of services which are audited and evaluated

The CHSG focused on the prevention and management of CHD, and the strategy identified four key areas for action, which were:

- The standardisation of care in pre-hospital and hospital settings across Health Boards
- The establishment of protocols for primary care
- The establishment of an effective surveillance system
- The establishment of new, or the expansion of existing health promotion programmes

Standardisation of Care

The strategy focused on the lack of consistent standards between and within Health Boards.

Pre-hospital Care

The CHSG reported that there had been variable progress in implementing the findings of the Review Group on Ambulance Services, for example in respect of:

- Ambulance equipment and defibrillators
- Audits and evaluation to reduce delays from the onset of chest pains to the administration of thrombolysis
- Audits and evaluation of access to automatic debrillators and the administration of thrombolysis in remote areas by GPs

Hospital Care

Although there is strong evidence around treatment protocols and management, protocols for treatment and secondary prevention for cardiac patients have not yet been agreed. In addition, facilities for cardiac care, investigations and interventions as well as cardiac rehabilitation, vary considerably, such there are inequities of access.

The CHSG recommended that:

- Guidelines for evidence based treatments in cardiology and shared care of patients between GPs and hospital services should be implemented
- Extra consultants, support staff and facilities be funded
- Cardiac rehabilitation across centres be established or extended, with funding

Protocols for Primary Care

The CHSG recommended that primary care teams should provide pro-active primary prevention and the long term follow up for those with risk factors. The key people are GPs, public health or practice nurses, and local health promotion and occupational health teams.

Establishment of Surveillance System

The CHSG identified weaknesses in the existing systems, in that:

- there is no system for identifying deaths in a cohort of patients
- there are few dedicated morbidity records
- information should be accessible from the Public Health Information System
- better information should be available, for example building on the Irish Cardiac Surgeons Register, and the development of a national angiography and angioplasty register

Extension and Establishment of Health Promotion Programmes

The CHSG recommended that:

- there be tighter fiscal policies in respect of tobacco
- the recommendations from the Food and Nutrition Policy of 1995 be implemented
- the National Alcohol Policy implementation timetable be reviewed and hastened
- there be settings-based interventions in schools, workplaces, primary care, hospital and communities

Primary Care, Secondary Care and Evaluation

There are three areas within the strategy that are worthy of focus. These are:

- evaluation and audit
- the role of primary care and GPs
- the role of secondary care

These are discussed in more detail below.

Evaluation and Audit

The CHSG recommended that:

- funding to the Health Promotion Unit (HPU) in the Department of Health and Children's Services be earmarked for monitoring and evaluation
- a set of indicators to measure achievement of targets be established
- standards be agreed with practitioners such that process evaluation and practice audit be set up
- the HPU publish guidelines of evidence based best practice
- there be frequent audits of health behaviours

The Role of Primary Care

In the document entitled "The Future of the GP in Ireland", the ICGP acknowledged and supported the need for protocols in GP practices and between GPs and hospitals in respect of patient care and formal liaison across sectors of the healthcare continuum. However in 1996, as reported in the National GP Survey, there were still problems.

The CHSG identified a range of issues with respect to primary care, which militate against the successful implementation of the Building Healthier Hearts Strategy:

- Under the GMS scheme, GPs are not paid for preventive work, except for some vaccination and immunisation in children, therefore any care provided under this umbrella is informal and through good will
- There are many perverse incentives in the system:
  - GPs cannot prescribe nicotine replacement therapy, yet will treat the patient when ill with smoking related diseases: the UK has recently allowed the prescribing of nicotine patches under NHS funds, and will fund GPs to run anti-smoking clinics

  - GPs do not have practice lists, and therefore cannot be pro-active in developing preventive care
  - the cost of attending a GP practice acts as a disincentive if the patient is only attending for primary prevention, whilst they are likely to pay if they are ill
  - GP training may not give due importance to primary prevention
- the employment of practice nurses assists in the systematic assessment of risk amongst patients, although this is currently opportunistic: practice nurses could and should run clinics
- there needs to be structural and organisational changes to the GMS scheme and a refocusing or increased funding to realise the potential of primary prevention
- the role of the public health nurse should be developed and extended to include a preventive role
- there needs to be a systematic approach to the identification of those who are more likely to fall into the high risk categories, to include the role of:
  - practice registers
  - practice nurses
  - practice based targets and timetables
  - agreed methods of patient recruitment into practices
  - agreed methods of risk assessment

The Role of Secondary Care and Secondary Prevention

Secondary Care in a Primary Care Setting

The CHSG recommended that:

- More secondary care be provided in a primary care setting, which will require:
  - The appropriate financial and administrative arrangements
  - Patients not in GMS schemes should be in follow up schemes with commensurate financial reimbursement for the GP
  - Financial incentives for GPs to implement computerised information systems to manage follow up schemes
  - National protocols implemented at a local level
- Their proposals in respect of smoking related initiatives be implemented, such as nicotine replacement patches in primary care

Pre Hospital Care

The CHSG expressed their concern that many of the recommendations of the Review Group on Ambulance Services, plus the concerns and recommendations of the C&AG Review had not yet been implemented. These recommendations included:

- The usage of nationally agreed pre-hospital care protocols to enable the usage of structured clinical audit
- The need to strengthen the role of the National Ambulance Advisory Council (NAAC), set up in 1994, and which, by definition, is only advisory
- An improvement in response times for emergency calls, although call response times were not routinely recorded across health boards and/or they were unreliable.
- Standards are required for call to needle' response times against which actual times can be audited: such guidelines exist in the UK and Europe
- There should be standardised staff in respect of early CPR and use of defibrillators
- There should be improvements in the development of first line EMTs, but not necessarily in MCCUs, the evidence for which does not demonstrate their usefulness in the Irish context

Secondary Care

The CHSG raised several concerns in respect of the delivery of secondary care:

- There are waiting lists for cardiology which delay the access to outpatient consultations, due to a combination of:
  - capacity in respect of beds
  - a lack of space for investigations
  - lack of equipment, technicians and back up facilities
  - lack of day case facilities
- the centres which perform angioplasties and similar investigations should have critical numbers and specialist back up facilities
- there is variability in access and provisions: therefore it is necessary to ensure:
  - there are formal referral arrangements
  - protocols for referrals
- Ireland has the lowest number of cardiologists for the population in the EU: the mean is 49 per million population, Ireland has 5 per million. In addition there is also a shortage of cardiac technicians
- Rehabilitation has patchy provision, with low numbers of patients in Ireland, 10% are considered for rehabilitation, whilst the figure is 50% for Finland, 60% for Netherlands and 95% for Austria
- Audit should be carried out more systematically, for example in respect of patient satisfaction, service effectiveness, efficiency and outcomes

Information and Audit

The CHSG made recommendations in respect of information needed to improve service delivery.:

- To implement good surveillance systems there needs to be improved and systematic collection of:
  - Mortality and morbidity data
  - HIPE data which lacks data from private hospitals, and does not enable the follow up of individual patients, and is not routinely published to enable comparisons to be made
  - Prescription data
  - Prevalence data
- To set up population based registers, to cover coronary care, for example and investigations and interventions
- To undertake more health surveys
- To undertake improved and systematic audit, which requires improved co-ordination at a local and national level
- To improve the level of research and development, the total funding for which is low, although there are individual examples of audits in the field of CHD

III THE NATIONAL HEALTH PROMOTION STRATEGY

Introduction

The NHPS was published in 2000, the first Health Promotion Strategy was published in 1995

The purpose of the new NHPS is to "set out a broad policy framework within which action can be carried out at an appropriate level to advance the strategic aims and objectives". The strategy aims to promote a holistic approach by focusing on:

- The link between health promotion and the determinants of health
- Inter-sectoral and multi-disciplinary planning
- Evaluation of initiatives

- The national and international context
- The rationale for further development of health promotion activities
- Utilisation of a wide range of information
- Identifying the pre-requisites to support and sustain health promotion at national and local levels.

The NHSP draws on and is linked to previous strategies such as Building Healthier Hearts, the strategy for Women's Health and the National Alcohol Policy. It also points to the need for 'health proofing' policies from other Government departments.

1995 Health Promotion Strategy

"Shaping Healthier Future" paved the way for the 1995 Strategy which identified priority issues, topics, settings and population groups and it identified goals and targets for national and local levels. Since 1995, there have been some developments, for example in respect of policy formulation, service delivery, research, professional training and multi-sectoral action.

The Determinants and Levels of Health

A number of factors impact on the physical, mental and social well-being of the population. These social, economic and environmental factors include poverty, unemployment and low income, education, access to health services and environmental factors.

As far as access to health services is concerned, although availability and access have improved, some population groups are still disadvantaged, for example those who live in rural areas and in physical isolation, those with poor literacy skills, and degrees of discrimination.

The NHPS asserts that there is a need for greater inter-sectoral and multi-disciplinary approaches: the National Alcohol Strategy is an example of a strategy which does this.

Individual behaviour also impacts on health, and the main findings from the SLAN and HBSC reports relate to smoking, food and nutrition, alcohol consumption, exercise, accidents, dental care, drug use and sexual behaviour. This data also highlighted social variations between the higher and lower socio-economic groups: the challenge for the strategy is to narrow the gap. Life expectancy for both Irish men and women has improved in recent years due to better health and social provision, however many health indicators still compare badly, for example, heart diseases and cancer, which are the focus of the major health strategies.

Strategic Aims and Objectives

Health promotion is generally carried out within the strategic framework of three approaches:

- population groups the groups being children, young people, women, men, older people and then other groups (31 objectives)
- settings, which include schools and colleges, the youth sector, the community, the workplace and the health services (22 objectives)
- topics, which include positive mental health, being smoke free, eating well, good oral health, sensible drinking, avoiding drug misuse, being more active, safety and injury prevention and sexual health (38 objectives)

For each of the identified groups, settings and topics above, a strategic aim and a number of objectives are set. In total, there are twenty strategic aims and 91 separate objectives. The emphasis is on working in partnership to support the implementation of the strategic aims and objectives and on the role that research and evaluation can play in determining the effectiveness of health promotion initiatives, as well as being in an inter-sectoral and multi-disciplinary approach.

The Infrastructure

The strategy has identified a number of pre-requisites to ensure that it is successful. These are:

- developing a health proofing policy
- strengthening partnerships
- establishing a National Health Promotion Forum
- re-orienting the health services
- securing resources
- supporting research, monitoring and evaluation
- strengthening health promotion structures
- consulting with the consumer.

Two of the above pre-requisites discussed in more detail below are re-orienting the health services and strengthening health promotion structures.

The strategy asserts that:

- within the health services there needs to be a better balance between curative services and those services which promote and protect health
- it will be the responsibility of the Health Promotion Departments within the Health Boards to plan, implement and evaluate at a regional level, all 91 objectives: in order to achieve this, existing regional health promotion structures will need to be developed and strengthened.

IV ORAL HEALTH

The Department of Health and Children issued a four-year Dental Health Action Plan in 1994. "Shaping Healthier Future" states there should be "an integrated dental development plan," and that there should be phased increasing eligibility for children aged less than 16 years of age

The aims of primary dental health services are:

- to reduce the level of dental disease in children
- increase the level of oral health in the population
- ensure there is adequate treatment services for children and all card holders, prior to this, it was confined to those in pre-school and primary school age groups.

A dental strategy will include:

- increasing the efficiency of water fluoridation
- increasing the use of fluoride by the population, e.g. fluoride rinsing and toothpaste
- oral health education programmes
- increased eligibility
- an improvement in primary and secondary orthodontic care for children
- an expansion of hospital oral surgery services for those who require specialised treatments
- the introduction of the provision of dental care to eligible adults
- the improvement of school dental services leading to the systematic screening of children
- the establishment of a standardised database for each HB for monitoring changes in oral health

Goals were established for the year 2000, which included :

- first teeth having no dental caries for 85% of five year olds in optimally fluoridated areas (OFAs) and in 60% from less than optimally fluoridated areas(LOFAs)
- no more than 1 DMF tooth in 12 year olds in OFAs and 2 DMF teeth in LOFAs
- on average, 27.7 natural teeth in 16-24 year olds (from 27.2) a gain of 1 tooth per 2 people
- less than 2% of 35-44 year olds with no teeth and less than 42% of the over 65s

The Dental Treatment Services Scheme managed by the Health Boards was set up in 1994, with the objectives of:

- improving oral health of the adult medical card holders
- reduce the equity gap of this population and the population as a whole
- increasing the amount of high quality dental services
- NB the scheme excludes the 35-64 year olds

In March 1997, there was a proposal for an expenditure review which was part of the SMI financial management system reforms. The initial objective was to determine the value of the programme. Both The Dental and the DTSS schemes have been reviewed: the dental scheme is administered by the health boards and are delivered by the private dental sector.

V THE NATIONAL ALCOHOL POLICY

Introduction

The alcohol policy, whilst published by the Department of Health in September 1996 and coming out of the SHF plus the subsequent Health Promotion Strategy, is a multi-sectoral policy. Much of the policy is directed at either government departments other than the Department of Health, such as the Department of Education, or outside government altogether, such as towards the Drinks Industry.

The summary below of this policy will focus on the implications for health and health services, whilst making reference to other aspects of the policy as necessary.

The main objective of the policy is to:
"*promote moderation in alcohol consumption, for those who wish to drink, and reduce the prevalence of alcohol related problems in Ireland, thereby promoting the health of the community"*

Alcohol use in Ireland

"The drinking of alcohol is an integral part of Irish social life and is accepted as such by most people".

Ireland was ranked as 11th across EU for quantity of alcohol consumed per head of population, but if this rate is adjusted for age, Ireland ranks as 8th, although Ireland has a high rate of under age drinkers.

The adverse affects of alcohol consumption impact on physical, mental and social health and well being. Excessive drinking can damage the drinkers own health such as cancer, stroke and cirrhosis of the liver, other peoples' health such as through car crashes or violence, and can impact on whole families through debt, homelessness and disruption of family life.

On the other hand, the alcohol industry makes a significant contribution to the Irish economy:

- Employment in the production of alcohol and the retail industry
- Contribution to government revenues through taxation, yielding some 4% of government receipts
- Positive impact on the balance of payments through the export of alcohol related products

Key Strategies

There are four overall strategies, which contribute to the policy:

- Individual oriented strategies, such as awareness of alcohol usage.
- Health promotion interventions, including health education campaigns for schools, family initiatives, community initiatives for example for training for those who work in local community groups, workplace initiatives such as employee assistance programmes, and the preparation and training of professionals such as those in health care, the judiciary and education.

- Provision of treatment services, including focus on the role of the GP, and treatment services within mental health services both on an inpatient and outpatient basis and for the family as well as the individual.
- Environmental strategies, including economic strategies and fiscal policies, licensing codes, restriction of alcohol to teenagers, implementation of road traffic acts, and adoption of codes and conduct in respect of advertising and sponsorship.

Plan of Action

Only the plan of action as it impacts on the Health Services are discussed below, although the plan of action itself is multi-sectoral and expects a degree of intersectoral working, for example between Health Boards and local communities.

Alcohol awareness

The Department of Health and Children is required to implement initiatives to:

- Increase understanding of the health effects of alcohol
- Increase awareness amongst GPs of sensible drinking guidelines
- Increase awareness of the early signs of dependency across the population
- Contribute to a decrease in the proportion of those who exceed moderate alcohol consumption

Professional Training

Whilst the greatest responsibility is placed on other agencies, the Health Boards will be encouraged to ensure:

- An adequate network of professionally trained staff to provide resources, co-ordination and support to local and voluntary initiatives aimed at the prevention of drug and alcohol misuse

Targeting at Risk Groups

The Department of Health and Children is expected to:

- Work with the Department of Education in developing health education programmes and resources for teachers, youth workers, parents and young people
- Encourage pregnant women and women planning to become pregnant to avoid alcohol consumption at critical times during the pregnancy
- Support initiatives for at risk youths, children of substance abusers and other vulnerable groups in society
- Support the role of primary health care professionals in relation to early detection of drinking

Treatment Services

The policy acknowledges that treatment services are only one part of the multi-faceted approach, and that treatment programmes will be more effective if supported by other policies directed at helping people avoid the health damaging behaviour. However, in respect of provision of treatment, Health Boards will be required to:

- Establish at least one alcohol or drug resource centre in each community or catchment area to be managed by the appropriate psychiatric services, and with a designated consultant psychiatrist who has responsibility for this service
- Provide comprehensive therapy and aftercare services for the client and family
- Ensure that services are provided as far as possible on an outpatient and domiciliary basis by a multi-disciplinary team working with primary care
- Establish alcohol treatment programmes for travellers, in prisons, and for the homeless

- Develop the quality control mechanisms to monitor programmes provided by voluntary organisations through subsidies and funding

The Department of Health will recommend to health insurance companies that they provide cover for the treatment of alcohol dependence, which would cover outpatient treatment policies

Research and Monitoring

The Department of Health and Children is required to:

- Establish a national surveillance function to monitor and co-ordinate the Policy
- Undertake comprehensive lifestyle surveys
- Request other government departments and agencies to monitor the impact of the policy in various settings such as schools and workplaces
- Investigate the availability and accessibility of treatment services on a regional basis through the Health Boards, plus the effectiveness of different treatment regimes
- Commence investigation of the economic, social and psychological causes and effects of alcohol consumption
- Investigate the possibility of introducing a surveillance reporting system to examine the role of alcohol in all types of accidents

VI A PLAN FOR WOMEN'S HEALTH

Background

The policy builds on the Shaping a Healthier Future and the Report of the Second Commission on the Status of Women. The plan was preceded by a discussion document entitled Developing a Policy for Women's Health issued in June 1995.

The discussion document focused on overall health indicators in respect of Irish women compared to both Irish men and EU women. It showed that, for example:

- At the age of forty, Irish women have the lowest life expectancy in the EU
- Mortality from ischaemic heart disease in Irish women is 70% above the EU average
- Female mortality from malignant neoplasms are amongst the highest in the EU, only exceeded by the rates in Denmark and Scotland
- Are more likely to be adversely affected by inequalities in the provision of health care, and unequal access rates, for example through confusion as to entitlement under GMS.

Amongst the measures proposed within the document, the priorities suggested for improving the health of Irish women were:

- A reduction in smoking
- The introduction of national screening programmes for breast and cervical cancer
- Improvements in maternity services
- Better services for victims of domestic violence and rape
- Better access for traveller women to health services
- Increased representation of women in the health services
- Increased research on may aspects of women's health

In April 1997, the policy document, A Plan for Women's Health was published.

An Overview of the Plan

The aim of the plan is to provide a coherent framework for the improvement of women's health and health services. Its success will be measured by improvements in women's health and a reduction in the gap against other EU countries, plus an improvement in the health services.

The plan has four main objectives:

- To maximise the health and social gain of Irish women
- To create a woman-friendly health service
- To increase consultation and representation of women in the health services
- To enhance the contribution of the health services to promoting women's health in the developing world

Choosing a Healthier Lifestyle

Initiatives flowing from the health promotion strategy, issued in 1995 will enable women to choose a healthier lifestyle. Health promotion teams and units at health board level will be encouraged to work with women's organisations and other groups to develop and enhance health promoting activities focused on women's health and that of their families.

Diseases Affecting Women

The principal causes of avoidable mortality for women are cancer and ischaemic heart disease. These issues are in part recognised in the two health strategies: Building Healthier Hearts and the Cancer strategy.

Coronary Heart Disease

If the targets in Building Healthier Hearts in respect of avoidable mortality were achieved, they would have a dramatic impact on women's health. The strategy also acknowledged that whilst women appear to be more conscious of the risks impacting on health than do men, the risks associated with smoking do not appear to be fully appreciated. In particular emphasis must be placed on the need for women, especially pregnant women, to stop, or not start, smoking. Increased awareness of nutrition is also important, especially as women can impact on the nutritional standards of the whole family.

Cancer

20% of all avoidable deaths in women are from cancer, and the potential for reducing mortality is the greatest in respect of cancers of the breast, cervix and lung. Thus, almost all deaths from lung cancer would be prevented if women did not smoke. Between 20-30% of deaths from breast cancer and 60% of deaths from cervical cancer could be prevented with the introduction of national screening programmes. Initiatives will flow from the Strategy on Cancer, published in November 1996.

The successful evaluation of the pilot for the breast screening programme has led to the programme being expanded. The first phase was targeted in the Eastern, North Eastern and Midlands Health Boards. The programme will be accompanied by the appropriate planning and management structures such as accurate population registers, agreed screening and referral protocols and the implementation of quality assurance mechanisms.

A national screening programme has been developed for cervical cancer. Cervical cytology laboratories will be given the appropriate support to cope with the increased work-load.

Pregnancy and Childbirth

A working group examined infant and maternity care, and made a number of recommendations, which were accepted by the Minister. In particular, pilot schemes will be established to evaluated home against hospital births. Following the recommendations for other improvements in maternity services, Health Boards will be required to:

- Encourage women to attend antenatal services: particular attention will be paid to high-risk mothers such as travellers, women living in remote areas, teenagers and women from ethnic backgrounds. In addition, the availability of antenatal classes will be improved and increased
- Provide appointment systems for antenatal clinics
- Provide more domestic type accommodation for delivery of babies, and allowing women to have the partner of choice of a friend to accompany them during labour and birth
- Make available a wider range of pain relief, plus information about the options
- Making hospital environments more baby friendly, and encouraging breast feeding
- Improving consultation with women such that the planning and delivery of services is more responsive to local voices
- Improving links between the hospital services, midwives and the primary care teams, in particular the public health nurse.
- Providing information and supporting women in times of difficulty such as those with post natal stress, or with difficult home environments

In addition the Department of Health is working with the independent hospitals so that they offer more comprehensive services to women.

Family Planning

Surveys conducted by several Health Boards have indicated that women find the level of availability of family planning services poor, and the general level of satisfaction with the services is low. The same surveys also found that 44% of women between 18-45 years of age did not use any form of contraception, and another survey found a general low level of understanding about issues around reproduction and fertility.

The Women's Health Plan however argues that family planning services are not just about contraception but are also about enabling women to make informed choices. Such initiatives should contribute to a reduction the number of unwanted pregnancies, and hence the number of teenage pregnancies and women who have abortions (outside Ireland, where this procedure is not legal).

The Department of Health will be undertaking a review of the Guidelines on Family Planning, issued in 1995, to ensure an improvement in family planning services and also to ensure that they contribute more to the overall health and well being of women. Health Boards are also encouraged to look at other services in respect of reproductive health, such as assisted fertilisation, and services for women with the menopause, and for women with problems of incontinence.

Women with Particular Needs

There are a number of health related areas where health boards are being encouraged to improve their services, and work across a number of agencies.

Mental Health Services

Whilst the move towards community based services are more conducive for the treatment of women, women's groups themselves are critical of health care agencies in that they focus on treatment to the detriment of prevention. Women are particularly susceptible to depression, the roots of which may be in the stress experienced by women due to their lifestyle, for example poverty, lack of control over her fertility and low self-esteem. Health services as currently organised are not able to offer support to women who are suffering from crises in their lives, rather than illnesses.

Thus, a number of measures are recommended with respect to mental health and mental health services for women, including:

- The Department of Health will commission research on factors associated with mental health in women
- The Health Promotion Strategy will incorporate issues around promoting women's health
- Health board will provide appropriate mental health services for women

Women with Special Needs

Health services need targeting in a different and client focused way to, for example, prostitutes, drug abusers and travelling women, such that these women feel the services are relevant for them and access them.

Women with disabilities and older women must not feel discriminated against, and younger women also must have relevant services provided for them. The Department of Health states a commitment to all these groups, and much of the service planning for these groups is explored in particular strategies such as those for travellers and for older women. Women who have Hepatitis C, are being focused through the whole strategy following the problems with blood related products

Involvement with Health services

There will be a continued partnership between Health Boards and the Women's Council following the consultation over the earlier document. Each health board was required to complete a document which responded to criticisms in respect of the their services, and many health boards have made permanent the advisory committees set up during the consultation phase. At a national level, a Women's Health Council will develop a centre for expertise on women's health and foster research and good practice.

The consultation document also highlighted the lack of representation by women in positions of responsibility in the health services. Whilst most senior positions in nursing are held by women, most consultant and senior management posts are held by men, which may lead to a lack of women's focus in the delivery of health services.

In response, the Department of Health is establishing an Equal Opportunities Policy for the health services, together with a programme for action.

Finally, each Health Board is required to prepare a regional plan for women's health to implement the commitments of the National Plan and issues identified during the consultation process. Health Boards are also required to review their training and staff development programmes to ensure that staff are more sensitive to women's issues amongst staff and the clients and users of services.

VII THE ELDERLY

The National Council on Ageing and Older People (previously the National Council for the Aged) is the principal advisory body to the Minister for Health on all aspects of the health and social welfare of older people. Since 1988, it has prepared two major policy documents for the Government both of which examine the issues associated with the care of the elderly and outline recommendations to realise improvements in service provision.

The first report "The Years Ahead…A Policy For The Elderly" was published in 1988. It outlined a framework to guide service development and provision centred upon four underlying principles.

- To maintain older people in dignity and independence at home in accordance with the wishes of older people as expressed in many research studies.
- To restore to independence at home those older people who become ill or dependent.
- To encourage and support the care of older people in their own community by family, neighbours and voluntary bodies in very way possible.
- To provide a high quality of hospital and residential care for older people when they can no longer be maintained in dignity and independence at home.

The report made recommendations along ten key areas:

(1) The Provision of a Co-ordinated and Comprehensive Service.
The Council proposed that services should be organised and delivered in a district setting which would be the ultimate responsibility of a district liaison nurse. District teams would be formed and each health board would appoint a Co-ordinator of Services for the Elderly– ideally a community physician and an Advisory Committee. Improved co-ordination of activities and policies between the Department of Health, the Department of the Environment and the Department of Social Welfare was also advocated.

(2) Health Promotion
This focused on the development of a health education policy for the elderly and the promotion of more positive attitudes towards caring for the elderly and towards ageing in general. It was also recommended that professorial chairs of geriatric medicine be established in all medical schools.

(3) Housing
The fourteen recommendations that fell under housing addressed the role of the Department of the Environment / local authorities and the Department of Health / Health Boards in ensuring that adequate and suitable housing provision is provided for the elderly. In particular, it was considered important that the elderly should have the means to make a choice between adopting their own homes to their requirements or moving to accommodation suited to their needs. Where it was not feasible to maintain people at home, sheltered housing should be considered as the first choice.

The role of the voluntary sector was also highlighted in meeting housing needs and it was suggested that its role should be expanded primarily through the provision of assistance from the Department of the Environment.

(4) Care at Home
Twenty individual but inter-related recommendations were made under this area, the thrust of which focused on the adequate provision of paramedic and support services to the elderly and their families. Particular emphasis was placed on the role of the GP and district liaison nurses in managing medical and social risk. Public health nurses were also seen as playing a pivotal role in terms of anticipatory care and health promotion. The expansion of the home-help scheme was advocated in terms of resources and the services it provides.

(5) Care in the Community
The key areas focused on by the Council were the provision of a suitable transport service and the expansion of day care facilities.

(6) Care in General Hospitals
A review of the admission and discharge procedures and policies in general hospitals was proposed. Processes to improve communication between hospitals and GPs / district nurses were outlined in relation to patient discharges from wards and A&E. The report also recommended that additional geriatric departments be established in addition to the allocation of beds for assessment and rehabilitation purposes and the provision of day hospital facilities.

(7) Community Hospitals
It was proposed that all existing geriatric hospitals / homes, long-stay district hospitals and welfare homes be developed as community hospitals which would provide assessment and rehabilitation services, convalescent care, respite care services, facilities for nursing high dependent patients and general information and advice for persons at home. As part of this, it was recommended that physicians in geriatric medicine should be appointed to community hospitals. GPs were also envisaged as playing a key role.

Standards of nursing homes operated by voluntary bodies as well as the subvention of care by the health boards to nursing homes was reviewed in light of the rapid expansion of this area.

(8) Care of the Elderly Mentally Ill and Infirm
Responsibility for screening elderly people at risk from dementia was allocated to GPs and public health nurses. The Council highlighted that an adequate supply of appropriate accommodation and day care facilities be provided. At community level, it was recommended that a consultant psychiatrist with special responsibility for the elderly be appointed.

(9) Partnership Between Carers, Volunteers and Statutory Agencies
The Council recognised the role played by carers and the voluntary sector in the provision of services to the elderly and how these roles could be better co-ordinated and supported.

(10) Implementation
It was recommended that a legislative framework be put in place for the development and co-ordination of services, which broadly envisaged:

- Health Boards and local authorities promoting the well-being of older people within their areas of responsibility.
- An obligation on Health Boards to provide services to support dependant elderly people and their carers at home. The health boards would also be obliged to appoint Co-ordinators of Services for the Elderly and Advisory Committees on the Elderly.
- Local authorities providing for the automatic repair and adoption of dwellings for older people.
- Distinguishing between elderly people subvented in a nursing home by a health board and an elderly person placed in a private home by a health board. The framework sought to empower Health Boards to make boarding out arrangements.

In 1997, the Department initiated a review of the Years Ahead Report by the National Council on Ageing and Older People and to examine the extent to which its recommendations were implemented and remained valid. The report of the Council established that:

- The Years Ahead Report was no longer an adequate blueprint for the development of services for older people.
  - It had been superseded by national and regional policy developments in many areas.
  - It paid inadequate attention to the role of older people and their carers in the decision-making process which forms an inherent component of the principles of Shaping a Healthier Future.
  - It underestimated the growth in size of the older population which in turn had implications for the service levels originally recommended.
  - The considerable growth in the private nursing home sector that has taken place since 1988 was not envisaged.
  - A number of the recommendations made were unsuitable and needed to be revised, particularly in relation to the emphasis placed on on-going care versus therapeutic treatment services.

- Many of the recommendations contained in the Years Ahead Report have either not been implemented or have been implemented but not in the manner defined by the report. In turn, regional variations exist in service provision. The Council suggests that these issues are attributable to the fact that the legislative framework has not been put in place and also because the regional Health Board structure does not support common service delivery models.

- The cutbacks that occurred during the 1980s had a significant impact on the implementation of the strategy.

In light of the above, the Council proposed that a new strategy should be developed which would:

- be underpinned by the principles of Shaping a Healthier Future;
- provide guidance to the Health Boards on the principles governing co-ordination at different levels rather then the detail of particular posts or structures;
- outline a planning and funding model;
- provide guidelines the on-going measurement of health and social gain.

The strategy produced has been formally adopted by the Department of Health and Children and resources are actively being channelled into addressing the actions outlined. A significant increase in both capital and revenue funding for services for the elderly has occurred particularly over the last two years, and equally important additional increases in funding have been committed for the future.

The new strategy has identified the following as requiring priority development in the future. The core objective is to have over 90% of people over 75 years of age residing in the community.

- The home-help service
- Respite services for carers
- Sheltered housing
- Day care centres with adequate transport provision
- Paramedical services at home and in the community
- A social work service dedicated to older people
- Services for older people with mental disorders
- The development of community hospital services.

Many of the core recommendations contained in the Years Ahead Report to support the above have been re-advocated albeit re-developed and tailored to address the current shortcoming in the present service including:

- Reviewing the establishment of district teams.
- Improving the level of co-ordination between Health Boards and local authorities.
- The role of the GP and district nurses in preventive care and managing a risk register.
- Improved geographic spread of public health nurses.
- The adequate provision of services and resources in the acute sector including day hospitals, assessment and rehabilitation beds and consultant geriatrics.
- The development of a strategy for mental health services to older people.
- Improved recognition of the role of carers and the voluntary sector.
- Health promotion.
- Review of spend in private nursing homes.

The new strategy continues to support the development of a legislative framework to govern the provision of essential services. Among the services which have been prescribed as essential and which should therefore be provided as an automatic entitlement are; meals on wheels; day care, respite care both inside and outside of the home, paramedical services and sheltered housing. It is also proposed that the legislative framework should incorporate the development of national guidelines on eligibility criteria and charges for health and social care services, the quality of care provided by the voluntary sector and the rights of carers.

In addition to the work undertaken by the National Council on Ageing and Older People, it is also certainly worth noting that considerable emphasis was also placed on the provision of services to the elderly in the Programme for Government – "An Action Programme for the Millennium", the Programme for Prosperity and Fairness and in the Department of Health & Children's strategy "Shaping a Healthier Future".

Funding

Within the context of discussing national policy, it is also important to comment on funding allocations and commitments to support that policy. As highlighted previously, over the last two years we have seen a considerable increase in the level of funding allocated to the elderly. This trend looks set to continue into the future as the recommendations of the new strategy are rolled out.

The changes in revenue funding since 1997 are set out in the table below. In line with the strategy, the key focus of this spend has been on respite services, day care services and community nursing.

Revenue Spend

1997	1998	1999	2000	2001
£3m	£7m	£12m	£28.5m	£40m (est)

Capital investment has also increased significantly:

Capital Spend

1997	1998	1999	2000-2006
£6.75m	£14m	£17m	£200m plus

The additional funding for 2000 and 2001 is being allocated to the following areas:

Additional Funding 2000, 2001		
	2000	**2001**
Support for carers	£1m	£2m
Nursing home subvention	£5m	£14.3m
Improvement of pay to home-help service	£10.4	£11m
Extension of home-help services	£800,000	£2m
Alzheimer Society – to support elderly with dementia	£1m	£0.6m
Two units for the elderly mentally infirm	£500,000	
Staff recruitment to geriatric units	£1m	
Medical card extension policy	£4	£11m
Improvement of community support structures		£5m
Contribution to voluntary groups		£0.23
Improvement of staff ratios in extended care facilities		£3.65m
Contracting beds in private nursing homes		£10m
Enhancement of existing services		£15.7m

VIII PSYCHIATRIC SERVICES

Policy Background

The thrust of national policy for psychiatric services centres on the provision of a comprehensive and community-oriented service that upholds the rights of the patients.

Planning for the Future, 1984

The 1984 report marked a key milestone in the development of mental health services insofar as it endeavoured to advance from an institutional to a community-focused model of service delivery. The rationale for this centred on the premise that the majority of patients did not in fact need to be in hospital or were in fact inappropriately placed. Although, the report preceded the timeframe of this review, it has been adopted by successive governments during the 1990s and as such has been to the fore of policy development.

The main findings of the report are summarised below:

- All individuals as required should have access to a comprehensive psychiatric service. The components of this service should include:
  - Prevention and early identification
  - Assessment, diagnostic and treatment services
  - In-patient care
  - Day care
  - Out-patient care
  - Community-based residences
  - Rehabilitation and training

  The report also recommended that services should be available locally in a co-ordinated manner. Psychiatric teams were envisaged as having the lead role in forming effective working relationships between key professionals. The make-up of such teams should comprise a consultant psychiatrist and would have at its disposal the services of psychiatric nurses as well as clinical psychologists, social workers, occupational therapists and a health administrator.

- The provision of a community-based service would require increased emphasis on out-patient treatment and day care to allow patients live in their own homes. It would also necessitate the provision of a range of community residential facilities such as houses, hostels and boarding out. The need for professional services to support families and carers was advised in terms of assistance from the psychiatric team, respite services and support during times of crisis.

- The development of a local based service would ideally require the provision of a service to a defined population within geographic boundaries - "sectorisation". The principle advantage associated with this approach was the potential to break down barriers between hospital and community services. A population size of 25,000 to 30,000 was proposed around which multidisciplinary psychiatric teams would be organised. It was acknowledged that in some areas, it maybe more appropriate to develop larger sectors in line with population density. This has by and large taken place.

- Close communication and liaison would be required between the members of the psychiatric team and GPs given that GPs undertook the majority of medical treatment for diagnosed mental illness, a practice that was likely to continue for the foreseeable future.

- In-patient facilities (across both psychiatric and general hospitals) would in the short-term provide services to a sector. However, the growing availability of community services would result in the majority of patients being discharged within a reasonable period of time. In particular, the provision of additional day places was recognised as an important step forward in reducing the number of in-patient admissions. Accordingly, it was recommended that the types of services provided by day facilities should be in line with the needs of the sector it served.

- In-patient treatments for all admissions should ideally be provided in psychiatric units in general hospitals. This was defined as a long-term goal.

- The provision of more appropriate facilities for long-stay patients should be considered by health boards, including geriatric patients. For a small group of new long-stay patients, the provision of high support hostels was considered as an alternative to hospital treatment.

- The intellectually disabled housed in psychiatric hospitals should be segregated from the mentally ill and tailored programmes of care should be provided for their needs.

- Psychiatric hospitals and psychiatric units in general hospitals should all have proper screening procedures to prevent inappropriate admissions. Psychiatric teams in each sector should hold out-patient clinics incorporating an assessment and diagnostic service.

- Psychiatric hospital patients, where possible, should be provided with housing in the community or be provided with the support to allow them return to their own homes. This in turn would require an assessment off patients' needs, the provision of patient training / rehabilitation and the acquisition of several types of accommodation.

- Provision would have to continue to facilitate the adequate maintenance of psychiatric hospitals and to resource therapy and rehabilitation services until such time as more community services were in place.

- The needs of special groups such as the elderly, children and adolescents and persons with alcohol and drug related problems should be appropriately provided for. Among the recommendations made was a review of policy for the elderly. The primary care sector was seen as playing a lead role in prevention and diagnosis across all groups. A comprehensive psychological services for primary schools was proposed in addition to the referral of children with autism to specialised assessment centres.

- Staff should be consulted at every level in the move to the new service model. In turn, staff would be required to spend more of their time in community services thus requiring further training. Each Health Board should establish catchment area management committees with responsibility for the planning and development of services in each area.

- Each Health Board should draw up a plan for psychiatric services, including an outline of targets to be reached over a 10 to 15 year time-frame. The planing process should incorporate a continuous review of the plan and its implementation. Evaluation was defined as an essential part of this. The report proposed that the process of evaluation should include the definition of performance indicators (a number of which were outlined including quality of care) which would facilitate comparisons regionally and nationally. To further the evaluation process, greater effort would be required to collate more data including budgetary and accounting information.

The total capital requirements to implement the recommendations of the report were estimated at £50m over a 10 to 15 year period. It was not expected that additional revenue expenditure would be required above that already provided for in 1984 i.e. £145m. Very little progress was made in implementing the report during the 1980s because of cutbacks in expenditure. In many ways, it is now seen as necessary to revisit the recommendations of the report and review and update them in line with current and future requirements.

The Green Paper on Mental Health, 1992

The Green Paper on Mental Health built on the recommendations of "Planning for the Future". The key policy objectives advocated by the Green Paper on Mental Health were as follows:

- To provide a comprehensive and community-oriented psychiatric service.
- To integrate psychiatric services with general hospital, general practitioners, community care and voluntary services.
- To improve the standard of care in psychiatric hospitals pending the transfer of services to alternative locations in general hospitals and in the community.
- To improve services to meet the special needs of particular target groups, such as the elderly mentally ill, persons with a mental handicap in psychiatric hospitals and children and adolescents with psychiatric problems.

Shaping a Healthier Future, 1994

Shaping a Healthier Future upheld the objectives of the Green Paper through the broader principles of equity, quality and accountability. The key actions underpinned by the strategy were to:

- Promote mental health in co-operation with the voluntary mental health bodies.
- Provide departments of psychiatry in general hospitals.
- Integrate mental health and primary health services and in particular to strengthen the role of general practitioners in the care of the mentally ill.
- Provide comprehensive specialist assessment and community support services in each health board for people suffering from dementia, including Alzheimer disease and their carers.
- Provide appropriate facilities for the care of the mentally ill whose behaviour is a risk to themselves or to others.
- Introduce a new Mental Health Act to give greater protection to the civil rights of the small number of people with a mental illness who have to be detained for treatment and to bring our legislation into conformity with the European Convention on Human Rights.

White Paper, A New Mental Health Act, 1995

The White Paper was produced in response to a need to further define the legislative procedures and standards of care for detained patients.

- Section 208 of the Mental Treatment Act 1945 specified the procedures to transfer patients from local psychiatric services to the Central Mental Hospital in Dundrum. However, the Act did not make any obligation to detail the purpose of the transfer and concerns were raised that transfers were in fact being made for reasons of convenience. In turn, there were fears that local services were reluctant to accept patients back from the Central Mental Hospital.

  In a further effort to address the legislative gaps, the Inspectorate of Mental Health Hospitals set down guidelines to be followed including informing the Inspectorate when the transfers took place. However, despite this it was widely believed that the procedures were not always adhered to.

- The Green Paper on Mental Health (1992) had also put forward general proposals for new criteria for involuntary detention in addition to safeguards against improper detention to stimulate discussion and debate on the subject area. Over one-hundred submissions were received in response to these proposals.

The submissions received in response to the Green Paper on Mental Health formed the core input to the White Paper on a new mental health act, which addressed:

- The European Convention on Human Rights and changes required to Irish Law to bring it in line with EU legislation.
- Criteria for detaining a person with a mental health disorder without consent.
- Procedures to be followed.
- The length of time an order should last for the detention of a person and whether such orders should be for the purpose of assessment or treatment.
- How decisions to retain would be reviewed by an independent body and how the detention of a person for longer than one year would be assessed.
- Safeguards in relation to patients unable or unwilling to give consent to certain forms of treatment.
- Proposals for improved relations between the courts, prisons and mental health services for defendants and offenders.
- Proposals for adult care orders.
- The rights of detained persons to information, representation and legal aid.

In December 1999, the Mental Health Bill was published incorporating the above areas. The Bill also provided for the establishment of a Mental Health Commission. The Commission would be an independent agency primarily responsible for raising standards and practices in the delivery of services and for ensuring that the rights of the detained persons were upheld across all hospitals and in-patient facilities providing psychiatric care and treatment.

Through the mechanism of mental health tribunals, the Bill provides that the Commission can automatically organise for the review of decisions made to detain patients on an involuntary basis. This is achieved through an independent assessment completed by a consultant psychiatrist and a lawyer within twenty-eight days of a person being admitted. Based on the output of the assessment, the Commission is empowered, where it feels appropriate, to release a patient. The person who has been admitted involuntarily will also has the right to be informed about any hearing and to attend and put their case to the tribunal in person or through a legal representative.

A further function of the Commission will be the maintenance of a register of approved centres for the detention and treatment of patients. The Commission will also be required to employ an Inspector of Mental Health Services to publish an annual review of the mental health services. The Inspector of Mental Health Services will in fact replace the current office of the Inspector of Mental Hospitals.

Other key elements incorporated into the Bill include:

- Where a person is admitted to psychiatric care on an involuntarily basis, the consultant psychiatrist who makes the decision to admit is obliged to inform the person of his or her legal rights under the legislation.
- The regulation of procedures in relation to a patient's consent to certain treatments and the conditions under which consent may be given in-order to bring Irish law in line with international standards.

The Bill is expected to be enacted during 2001 with an allocation of £1.98m being made for the establishment of the Mental Health Commission.

The Interim Report of the National Task Force on Suicide, 1996

The purpose of the report was to define numerically and qualitatively the nature of suicide problems in Ireland together with the problems of attempted suicide and parasuicide. An analysis of associated costing was also completed. Among the findings of the report were that:

- Between 1994 and 1995, the rate of suicide in Ireland rose from 2.38 per 100,000 population to 10.69 per 100,000.
- Suicide was the second most common cause of death among 15 to 24 year old males equal to a rate of 19.5 per 100,000 population. This compared to 2.1 per 100,000 population for females in the same age group. A significant increase in suicide was also taking place in elderly males i.e. over 65 years of age.
- Data on attempted suicides is difficult to collate although on-going work and progress is being made particularly by the Suicide Research Foundation.

Report of the National Task Force on Suicide, 1998

The Report of the National Task Force on Suicide built on the work of the 1996 report. Its focus was to:

- Make recommendations on how services could address the problems of attempted suicide and parasuicide in the most cost-effective manner.
- Identify the various authorities with jurisdiction in suicide prevention strategies and their respective responsibilities.
- Formulate a National Suicide Prevention / Reduction Strategy.

The report made over 80 recommendations under the following areas:

- The provision of structures of services relating to suicide and to attempted suicide
- The prevention of suicide and parasuicide
- Intervention
- Aftermath and aftercare
- Research and evaluation

Since the publication of the report, there has been a positive and committed response among both the statutory and voluntary sectors towards finding ways of tackling the problem of suicide.

- A Suicide Research Group was established by the Health Boards, whose membership includes experts in the areas of mental health, public health and research. The main responsibilities of the Suicide Research Group are to review ongoing trends in suicide and parasuicide, to coordinate research into suicide and to make appropriate recommendations to the Chief Executive Officers of Health Boards. The first annual report of the Suicide Review Group was published in 1999.

- The National Suicide Research Foundation which was founded back in January 1995 and was initially funded by the Department of Health and Children, the Southern Health Board and the Mid-Western Health Board, became part of the Health Research Board in 1997. In 1999, £200,000 was provided to the NSRF to establish a National Parasuicide Register.
- In 2001, £830,000 will go towards suicide prevention programmes in the Health Boards and towards research aimed at improving understanding of the problem.

Report of Working Group on Child and Adolescent Psychiatry, 2001

The report was commissioned with the objective of making recommendations on the development of child and adolescent psychiatry. It contains proposals for the development of services for the management and treatment of attention deficit hyperactivity disorders/ hyperactivity kinetic disorders for the development of child (6 to12 year olds) and adolescent (12 to 16 year olds) psychiatric in-patient units. The report recommends:

- the enhancement and expansion of child and adolescent psychiatric services. As part of this it recommended that a total of seven inpatient psychiatric units for children ranging from 6-16 years be established;
- that priority should be given to the recruiting suitably qualified individuals to the consultant-led multi-disciplinary teams.
- closer liaison and interaction with the education system and other areas of the community health services.

The total cost associated with implementing the recommendations of the Working Group was circa £90 million.

Based on the report, additional funding of £3.25m was made available for the establishment of consultant-led multidisciplinary teams and for the enhancement of existing teams. We understand that each Health Board has now has in place a minimum of two consultant-led child and adolescent multi-disciplinary teams. Five new child and adolescent psychiatric inpatient units are also planned under the National Development Programme (2000-2006) and it is anticipated that a further two will be provided for within the next decade.

Funding

Funding to psychiatric services has greatly increased since 1996 as highlighted by the table below:

Mental Health Funding 1996 to 1999

	1996	1997	1998	1999
Capital Funding	£1.145m	£1.489m	£6.974m	£2.5m
Revenue Funding	£0.973m	£1.392m	£4.5m	£5.4m

Source: Department of Health and Children

Over the period extending from 2001 to 2006, £150m has been allocated in capital funding to psychiatric services. The focus on this development will be on:

- Acute psychiatric units attached to general hospitals
- The provision of additional day care facilities and hospitals
- Community residences
- Child and adolescent in-patient units
- Purpose built secure units for the disturbed mentally ill.

A sum of £18.64m is being provided in 2001 for improvements in mental health services. Priority is being given to the further development of community based mental health services; the further expansion of Child and Adolescent Psychiatry and the Psychiatry of Old Age; and the implementation of the recommendations of the Task Force on Suicide. Alongside developments in service provision, priority is being given to the introduction of new mental health legislation. Provision is also being made for additional funding to voluntary bodies. A further breakdown is provided below:

Community-Based Services: £8.255m will be allocated towards the further development of community-based mental health services, primarily for the establishment of additional multi-disciplinary teams and the recruitment of additional staff to strengthen existing services.

Hospital Services: An additional £1.75m will be provided to enhance the level of psychiatric services available in hospitals. This includes the establishment of two new-consultant led teams in liaison psychiatry in the ERHA and Mid-Western Health Board areas.

Child and Adolescent Psychiatry: An additional £3.225m is being allocated to further developments in Child and Adolescent Psychiatry services. This funding will provide for the appointment of additional consultants in Child and Adolescent Psychiatry, and for the further development of multi-disciplinary.

Old Age Psychiatry: An additional £1.87m is being allocated in 2001 in response to the increase in the number of people living to advanced old age.

Suicide and Suicide Prevention Programmes: £830,000 is being allocated towards suicide prevention programmes in the Health Boards and towards research. This includes an additional £100,000 for the National Suicide Research Foundation to support its work in the development of a National Parasuicide Register.

The Voluntary Sector: An additional £730,000 will be made available through health boards in 2001 to assist voluntary bodies such as the Mental Health Association of Ireland, Schizophrenia Ireland and Bodywhys.

IX THE INTELLECTUALLY DISABLED

Policy Background

The key thrust of policy for people with an intellectual disability has focused on four core areas with a particular emphasis on allowing people live as full and independent a life as possible in the community. The four areas include:

- Preventive support and health promotion.
- Anticipatory support in terms of monitoring the needs of those most at risk during pregnancy, assessment of all babies by a Paediatrician prior to discharge from hospital, public health nurses' visits to new borns, the role of pre-school and school health services, etc.
- Home and community support in terms of allowing individuals live independently in the community and providing the appropriate level of support to carers. It also includes expanding the number of work experience opportunities accessed by individuals.
- Residential / respite support primarily in terms of (a) crisis respite (b) planned respite short-breaks and (c) long-term residential care.

Since the 1980s and more especially during the 1990s, a considerable amount of work has been completed in drafting policies and procedures that seek to support the above four areas. The multitude of issues and areas addressed reflects in many ways the complexities and challenges of delivering an efficient and effective service to the intellectually disabled.

Towards A Full Life – Green Paper on Services for Disabled People, 1984

Probably the first fundamental review of services needs and requirements was completed in 1984, "Towards A Full Life – Green Paper on Services for Disabled People". The key objective of the document was to provide a clear indication of Government policy and to initiate a constructive public debate on the areas requiring further attention and on the strategy to be adopted in meeting these objectives. The report which looked at all areas of disability, including intellectual, physical and sensory addressed and made recommendations along the following key areas:

- The disabled population
- Prevention and health care
- Education
- Vocational training and employment
- Income support services
- Welfare services
- Housing
- Access and mobility
- Residential care
- "Towards Full Participation and Equality"

Fundamentally, the report made recommendations and stimulated debate and thought along the following areas:

- The need to concentrate hospital maternity services in hospitals with appropriate specialist staff. It proposed the extension (as permitted by available resources) of paediatric examination service and in particular that examinations should be carried out at all recommended ages.
- A proposal to increase the level of grants to finance aids to employment. In conjunction with this, it proposed the establishment of a working group to advise on the introduction of uniform training allowances for persons in special training centres.
- It advocated a formal scheme of allowances for persons in long-term residential care who had no income of their own.
- It upheld the important contribution made by home-help and meals on wheels services and advocated that both of these should be steadily increased.
- The need to give consideration to the improvement of the public health nurse / population ratio and also an increase in the resources towards the development of social work services and day care services.
- Direction was given to the OPW to ensure that all new buildings were fully accessible and that a programme for the modification of existing buildings was implemented. This effort is on-going.
- The expansion of the role of the National Rehabilitation Board. This has recently taken place with part of the NRB now incorporated into the NSA.

The 1984 document marked the foundation stone for development of future policy during the 1990s.

Needs & Abilities, 1990

The report made recommendations along the following areas:

- The term "mental handicap" should no longer be used.

- The report distinguished between the range of services required by persons with an intellectual disability and those who suffered from a learning disability. It highlighted that responsibility for the provision of services to pupils with a learning difficulty did not in fact rest with service providers for people with an intellectual disability and that further support was required by the Department of Education and the Department of Labour in this area.

- With regard to educational and training services for people with an intellectual disability, among the report's recommendations were:

  - The piloting of a number of educational and support programmes
  - The establishment of special child development centres as an alternative option for pre-school for certain groups of children.
  - The promotion of links between child education and development centres and special / ordinary schools.
  - Liaison between multi-disciplinary support teams at pre-school level and their counterparts in the school programme.
  - The provision of a small number of alternative homes staffed to meet intensive medical needs.
  - All pupils availing of special educational programmes should have access to pre-vocational and vocational training.
  - The further development of sheltered employment services and the setting up of local committees to promote employment opportunities.

- The Health Boards pre-school developmental service should be directed to children in districts with cultural, social, emotional and material disadvantages. The requirement for training for community personnel including GPs in screening and detection was highlighted in addition to communication skills for advising and supporting parents. Liaison between maternity and community services for children and the need for specialist intervention teams also formed part of these recommendations.

- All people with an intellectual disability over forty years of age should have a multi-disciplinary assessment.

- With regard to residential provision:
  - Large numbers of highly dependent intellectually disabled should be placed in small clusters of three to four houses at a number of locations.
  - Persons seeking to return to a residential centre for retirement should be allowed do so.

- Health Boards should be responsible for establishing a comprehensive database.

- A multi-disciplinary approach is required to service the needs of this group. Other recommendations were made in relation to staff training and structures.

- Co-ordination in the planning and development of services should be facilitated through the regional co-ordinating committees established in 1988 (statutory and non-statutory sectors). As part of this it was recommended that the committees should produce a progress report every two years against the Health Board's plan. It was also suggested that a national co-ordinating body be established to set priorities for the overall development of services.

- A programme to transfer persons with an intellectual disability from inappropriate institutional care should be completed at a rate of 250 per annum.

Total costs to implement the reports recommendations were broadly estimated at £22.5m in capital costs and £27.5m in revenue costs over a four year period extending from 1990 to 1994. Following the report, an additional £56.8m was provided between 1990 and 1996, enabling the creation of over 1,000 residential / respite places and 2,300 new day care places. Over the same timescale the home help service was established and a range of other services were developed and enhanced.

The Report of the Special Education Review Committee, 1993

In 1993, the Report of the Special Education Review Committee was published. The report assessed the educational provision for children with special needs, the arrangements which should be put in place in order to provide for the educational requirements of such children, the range of support services that may be required and the linkages that should exist between Government Departments and service providers. The Committee's recommendations were built around the following framework:

- All children including those with special educational needs have a right to an appropriate education.
- The needs of the individual child should be the paramount consideration when decisions are being made concerning the provision of special education for that child.
- The parents of a child with special educational needs are entitled and should be enabled to play an active part in the decision-making process.
- A continuum of services should be provided for children with special educational needs ranging from full-time education in ordinary classes, with additional support, as may be necessary, to full-time education in special schools.
- Except where individual circumstances make this impracticable, appropriate education for all children with special educational needs should be provided in ordinary schools.
- Only in the most exceptional circumstances should it be necessary for a child to live away from home in order to avail of an appropriate education.
- The State should provide adequate resources to ensure that children with special educational needs can have an education appropriate to those needs.

In 1990, it became EU and Government policy that no further special schools would be established for children with a mild intellectual disability and that these children would be integrated into the mainstream school system by expanding the number of special primary and post-primary level classes.

Report on Services for Persons with Autism, 1994

Considerable debate took place in the early 1980s focusing on the appropriate mix of care and services that should be provided to people suffering from autism. The 1984 report assessed the types of diagnostic facilities and treatments together with the range of support services that were necessary to support children, adolescents and adults with autism. The report's main recommendations included:

- The establishment of regional diagnostic clinics that would also provide teaching programmes for staff across a variety of disciplines.
- The provision of a range of pre-school placement options.
- The further assessment of the needs of adolescents with autism.
- Epidemiological studies on outcome in autism with emphasis on the relationship between treatment interventions in childhood and resultant adult conditions. Research on life expectancy was also highlighted as being required.
- The majority of adults with autism can benefit from facilities provided for persons with an intellectual disability. However, a minority will need specialist units.
- Health Boards plans for autism should indicate proposed timescales and costs for implementation.
- Health boards should be required to prepare written protocols for staff on the management of children with autism.
- A separate and dedicated database should be established for persons with autism in each health board region.

Shaping a Healthier Future, 1994 and revised in 1996

Shaping a Healthier Future defined key principles and recommendations of strategy that stretched across intellectual, physical and sensory disabilities. The key principles recognised as under-pinning services to the intellectually disabled were as follows:

- Prevention, treatment and care services will be more clearly focused on improvements in health status and the quality of life, and will place an increased emphasis on the most appropriate care.
- The management and organisational structures will provide for more decision-making and accountability at regional level, allied to better methods of performance measurement.
- Greater recognition will be given to the key role of those who provide the services and there will be greater sensitivity to the right of the consumer to a service which responds to his/her needs in an equitable and quality-driven manner in an appropriate setting (1996).

The Strategy also outlined an action plan for specific services to be implemented over 1994 to 1997 period, which in many instances linked back into the 1984 Green Paper on Services for Disabled People". These included a commitment to:

- Further develop services on the basis of locally assessed need.
- Provide extra facilities for day care, respite care, home care, personal support services and residential care/independent living.
- Improve the organisation and co-ordination of services.
- Build up information on the service needs of clients.
- Employ additional occupational therapists, speech and language therapists and physiotherapists.
- Improve the counselling and psychological support services for persons with disabilities and their families.
- Improve vocational training standards and facilities with a view to greater economic integration of people with a disability in society.
- Improve the availability of technical aids and appliances.
- Continuing the relocation of persons with a learning disability from Psychiatric Hospitals to more appropriate settings.
- Providing genetic counselling services.
- Developing and implementing services for persons with Autism.

Discussion Document on the Mental Health Needs of Persons with Intellectual Disability, 1996.

A Strategy for Equality – Report of the Commission on the Status of People with Disabilities, 1996

In 1996 "A Strategy for Equality – Report of the Commission on the Status of People with Disabilities" was published. Once again this focused on all areas of disability. Its terms of reference were to:

- Advise the Government on practical measures necessary to ensure that people with a disability could exercise their rights to participate in economic, social and cultural life.
- Examine the current situation of people with a disability and the organisation and adequacy of existing services, both public and voluntary to meet their needs.
- Make recommendations setting out necessary changes in legislation policies, organisation, practices and structures and to ensure that the needs of people with disabilities are met in a cohesive, comprehensive and cost-effective way.
- Establish the costs of the recommendations made.

The Commission made in excess of 400 recommendations, which they based on three guiding principles:

- Equality
  The Commission recommended that the State should provide for programmes of affirmative action and positive discrimination to address past inequalities.

- Maximising Participation
  The principle implies that people with disabilities have the right to participate in all areas of life to the fullest extent and conversely the State should have regard to the needs and interests of people with disabilities.

- Enabling Independence and Choice
  Principle implies that persons with disabilities have the right to be able to achieve their full potential including the right to make their own choice concerning the conditions of their lives and the right to quality services.

Enhancing the Partnership, 1997

In 1995, the then Minister for Health established a working group to review the arrangements for a national framework to ensure the smooth transfer of responsibility for funding of voluntary mental handicap agencies from the Department of Health to the health boards.

The basis for the change in structure was founded in the view that the direct funding of some voluntary agencies by the Department impeded the proper co-ordination and development of services at a local level and the development of links between statutory and voluntary services. The framework initially applied to those agencies directly funded by the Department, of which there were fourteen. However, it was extended to all members of the Federation provided they met with certain criteria, under "Widening the Partnership".

The key proposals made by the working group were as follows:

- The new partnership between the Health Boards and the individual voluntary mental handicap agencies should find specific expression in service agreements.
- Service agreements should indicate
  - the links with mental handicap services plan for the region
  - the linkages with the other services
  - the measures in relation to efficiency and effectiveness
- Mental handicap agencies should be encouraged in service agreements to take initiatives in the improvement of the quality of their services. It was identified that some mental handicap services had already developed quality standards around the UN Standard Rules, the Q Mark, ISO 9000, Pass, and the Framework to Accomplishment and NRB SI/95.
- Each agency should continue to have in place systems, procedures and controls which mirror the best practices of accountability in expending public funds. In this regard agencies should continue to develop their own appropriate internal audit /service evaluation expertise.
- The Social Services Inspectorate to be established by the Department of Health should work closely with the Health Boards and voluntary agencies to monitor standards, to identify projects of excellence and to encourage the replication of good practice throughout the mental health services.
- Action should be taken to establish a mechanism to accurately cost the broad range of services required by persons with a mental handicap at a national level. In turn, the Department should continue to provide management support and direction for the development of service agreements and of new methodologies for costing services.
- Two separate committees should be established in each health board:
  - The Mental Handicap Services Consultative Committee (MHSCC) – to provide for a broadly based forum for the exchange of information and ideas on all matters pertaining to mental health in the region. Also to be involved in service quality.

  - The Mental Handicap Services Development Committee (MHSDC) – to look at the provision and development of services. The health boards must consult with their respective committee to agree future plans and priorities against spend allocation.
- Recommendations were also proposed for personnel that would enable the detailed communication and analysis of staffing in the voluntary sector.

An Assessment of Need Report 1997 to 2001.

The Department of Health published an assessment of need for service provision to persons with learning disabilities for the 1997 to 2001 period, based on data from the first annual report of the National Intellectual Disability Database produced in 1996. In the publication the Minister of State of the Department declared that "*The Government is committed to the development of services to persons with a mental handicap, within the overall resource parameters and based on the needs identified by the National Intellectual Disability Database, as set out in Partnership 2000 for Inclusion, Employment and Competitiveness.*

The report marked an important step forward in the planning and development of services insofar as it was based on accurate regional information that quantified resource needs, unmet needs and future priorities. As a result of the report, each Health Board has prepared a five-year plan for the development of services.

Report of Planning Group on a National Educational Psychological Service, 1998

The then Minister for Education and Science established a planning group to prepare proposals for a National Educational Psychological Service.

In its report, the Planning Group estimated that 2% of the school population had significant disabilities excluding those with a milder degree of disability or those on the immediate borderline of a disability. When the latter was included the percentage rose to 5%.

One of the key findings of the report was that many students particularly those in ordinary classes and in special classes were not adequately served by a psychologist or had limited access to psychologist services. It also found that there was a lack of consistency in service provision in so far as children with the same disability may or may not have access to a service dependent on the school in which they are enrolled. Part of the difficulty associated with service provision is that historically responsibility was largely perceived to rest with the health boards rather than the Department of Education. While the Health Boards have endeavoured to provide resources to the area it has been sporadic due to resource constraints.

The Committee recommended that a full and comprehensive National Educational Psychological Service be developed in the education sector, co-ordinated with psychological services in the health sector to minimise duplication. As part of this, it recommended that service provision in the educational and health sectors be co-ordinated through the establishment of a new agency that would initiate the procedures and systems for liaison and co-ordination firstly at central level and subsequently at regional level.

The National Educational Psychological Service has been established and it is accepted that it will take some time before it becomes fully operational. It does, however, mark a huge step forward for health services.

Report on the National Forum for Early Childhood Education, 1998

In accordance with the Childcare Act 1991, the Department of Health & Children has responsibility for early intervention services for children up to 3 years of age and the Department of Science has responsibility for education provision to those in 3 to 5 age group. The Forum recommended that a continuum of service provision in the 0-6 age group should be developed given that there was an insufficient level of co-ordination in education services for this age group. It also recommended the establishment of an Early Years Development Unit (EYDU) as a joint enterprise between both departments.

Early intervention strategies to support the optimal development of children with disabilities are widely believed to improve quality of life. Finally, the Forum recommended that children with disabilities should be educated to the maximum degree possible with their non-disabled peers.

Funding

Since 1990, the funding allocated to the intellectually disabled has increased considerably.

Revenue Funding

In 1990, a total revenue allocation of £131.84m was made, which rose to £279m in 1998. Additional revenue funding in the order of £93.8m was provided over the same time-frame primarily for the provision of additional residential and day care places. During the 1990 to 1998 period, a concentrated effort was also made to develop home-support services. Total revenue funding for 1999 was £18m and £24m for 2000.

Capital Expenditure

For the 1990 to 1998 time-frame, a total of £31.4m in capital funding was provided during which time 1,600 new residential places and 3,200 new day places were created. Between 1998 and 2001, the focus of programme expenditure will centre on:

- New residential and day care facilities and upgrading existing facilities.
- The provision of alternative accommodation for people currently housed in inappropriate care settings, primarily psychiatric hospitals. This also includes the upgrading of existing facilities that will continue to be used in the medium to long term.
- The provision of facilities for persons with an intellectual disability who require specialist services in a secure environment.

2001

In 2001, a total spend of £450m was allocated to the intellectually disabled and autism services, including an additional spend £83m. The key service developments planned for 2001 include:

- 450 new residential places.
- 110 new respite places.
- 40 specialist respite places.
- 600 new day places
- An increase in health related support services for children with an intellectual disability, including Autism.

Significant increases in funding have also been allocated to persons with a physical and sensory disability the focus of which is to allow them to live as independent a life in the community as possible.

X CHILDREN

The Department issued the National Children's Strategy in November 2000, "Our Children - Their Lives". The strategy is an important milestone focussing on the needs of children on a cross Departmental basis and to prepare children for adulthood.

The Strategy is grounded in six operational principles:

1. Child centred:
   The best interests of the child shall be a primary consideration and children's wishes and feelings should be given due regard.

2. Family-oriented:
   The family generally affords the best environment for raising children and external intervention should be to support and empower families within the Community.

3. Equitable:
   All children should have quality of opportunity in relation to access, participation in derive benefit from the services delivered and have the necessary levels of quality support to achieve this. A key priority in promoting a more equitable society for children is to target those most at risk.

4. Inclusive:
   The diversity of children's experiences, cultures and lifestyles must be recognised and given expression.

5. Action orientated:
   Service delivery needs to be clearly focussed on achieving specified results to agreed standards in a targeted and cost effective manner.

6. Integrated:
   Measures should be taken in partnership, within and between relevant players be it the State, the Voluntary/Community sector, services for children and families. Services should be delivered in a co-ordinated and coherent and effective manner through integrated needs analysis, policy planning and service delivery.

The strategy seeks to establish a "Whole Child" perspective at the centre of policy development and service delivery. The "Whole Child" perspective has been used to shape three National Goals for children:

(1) Children will have a voice in matters which affect them and their views will be given due weight in accordance with their age and maturity

(2) Children's lives will be better understood; their lives will benefit from evaluation, research and information on their needs, rights and the effectiveness of services

(3) Children will receive quality supports and services to promote all aspect of their development

The strategy sets out a new framework to bring the key players and their knowledge and experience together in ways which will encourage co-operative working and add to a shared understanding of children's issues.

The aim of the National goal "Children will have a voice" is to ensure that the views of children are given due weight in accordance with their age and maturity. The objectives to achieve this goal are:

1. to put in place new mechanisms in the public sector which achieve participation in matters that affect children;

2. to promote and support the development of a similar approach in the voluntary and private sectors;

3. to ensure that children are made aware of their rights and responsibilities;

4. to support children and organisation to make the most of the new opportunities provided;

5. to target additional resources and supports to enable marginalised children to participate equally;

6. to support research into and evaluation of the new mechanisms to give children a voice;

The aim of the National goal "Children's Lives will be Better Understood" is to achieve a better understanding of how children grow up in Ireland including their individual and shared needs. The objectives to be achieved under this goal are:

1. to build up a more coherent understanding of children's development and needs amongst those working with children;

2. to develop an evidence-based approach to decision making at all levels down to the point of service delivery

3. to improve the commissioning, production and dissemination of research and information

4. to improve evaluation and monitoring of children's services.

The aim of the National goal "Children will Receive Quality Support and Services" is to focus the supports and services provided to children so that they address children's basic needs, provide for the additional needs of some children and support families and communities supporting children. There are 14 objectives associated with this National goal regarding the need to encourage a comprehensive response to children's needs, which are grouped under three headings:

1. Group 1: All children have a basic range of needs

    - Children's early education and developmental needs will be met through quality childcare services and family friendly employment measures;
    - children will benefit from a range of educational opportunities and experiences which reflect the diversity of need;
    - children will be supported to enjoy the optimum, political, mental and emotional well-being;
    - children will have access to play, sport, recreation and cultural activities to enrich their experience of childhood;
    - children will have opportunities to explore information and communication technologies in ways which are safe and developmentally supportive;
    - children will be safeguarded to enjoy their childhood free from all forms of abuse and exploitation;

2. Group 2: Some children have additional needs

   - Children will be provided with the financial supports necessary to eliminate child poverty;
   - Children will have access to accommodation appropriate to their needs;
   - Children with behavioural problems coming before the courts, or in trouble with the law, will be supported in the least restrictive environment while having their needs addressed;
   - Children with a disability will be entitled to the services they need to achieve their full potential;
   - Children will be educated and supported to value social and cultural diversities so that all children, including Travellers, and other marginalised groups achieve their full potential.

3. All children need the support of family and community

   - Children will have the opportunity to experience the qualities of family life;
   - Children will benefit from and contribute to vibrant local communities;
   - Children will benefit from a built and natural environment which supports their physical and emotional well-being.

The National Children's Strategy provides a vision, sets targets and establishes an engine for change to improve supports for children and develop children's services over the next ten years. The key challenge will be in the effective implementation of a complex multifaceted strategy and ensuring the necessary funding for effective implementation is available on a multi-annual basis.

APPENDIX V

Programme Analysis of Provisional Outturn

Appendix V

PROGRAMME ANALYSIS OF PROVISIONAL OUTTURN

Programme and Service	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
1. Community Protection Programme:										
Prevention of infectious disease	8,808	9,249	13,525	14,265	14,745	16,495	19,277	24,790	26,070	30,040
Child health examination	7,289	7,831	8,159	8,615	8,766	9,659	9,824	10,507	10,791	12,716
Food hygiene and standards	3,776	4,057	4,743	6,957	7,583	8,658	8,805	13,127	14,284	19,531
Drugs Advisory Service	985	1,068	1,414	1,415	1,450	1,801	0	0	0	0
Health Promotion	1,085	1,131	1,168	1,696	2,270	2,822	3,399	4,389	4,493	5,961
Other preventative services	2,685	2,884	3,002	3,683	5,418	8,793	13,433	20,492	23,096	38,883
Programme Total	24,428	26,210	32,011	36,631	40,232	48,218	54,738	73,305	78,684	107,131
2. Community Health Services Programme										
General practitioner service (including prescribed drugs) (Choice of Doctor)	158,051	176,688	207,931	236,140	250,026	261,646	271,661	287,891	319,081	431,788
Subsidy for drugs purchased by persons ineligible under GP service including	16,400	19,963	25,036	31,415	39,057	48,704	60,999	72,906	99,455	123,725
Refund of cost of drugs for long-term illness	8,700	11,132	14,516	16,438	17,159	19,154	21,384	23,610	27,345	27,703
Home nursing service	24,662	26,888	28,609	30,039	30,669	31,713	32,288	37,160	38,182	44,463
Domiciliary maternity services	1,921	2,102	2,237	2,349	2,390	2,479	2,524	2,764	3,041	3,724
Family Planning	160	165	170	172	175	1,283	2,395	2,430	2,476	3,544
Dental Services	16,971	18,363	19,111	20,698	25,799	33,348	34,740	37,888	42,202	50,385
Opthalmic Services	4,205	4,512	4,749	4,926	5,368	6,502	6,834	7,086	8,252	9,080
Aural Services	910	977	1,026	1,065	1,083	1,119	1,133	1,174	1,203	1,447
Programme Total	231,880	260,780	303,385	343,142	371,626	405,948	433,948	472,907	541,237	695,839
3. Community Welfare Programme										
Cash payments and grants for disabled persons	66,160	74,200	81,960	89,960	96,176	60,447	0	0	0	0
Mobility allowance for handicapped persons	430	469	496	532	646	806	1,040	1,091	1,217	1,376
Cash payments to persons with certain infectious diseases	610	657	695	746	759	769	840	829	862	100
Maternity cash grants	40	30	32	33	34	27	27	27	27	28
Domiciliary care allowances for handicapped children	6,160	6,645	7,026	7,547	7,796	8,106	8,729	9,483	10,677	12,180
Cash payments to blind persons	1,200	1,293	1,366	1,467	1,515	1,649	1,837	2,006	2,221	1,960
Home-help services	8,295	9,379	10,064	10,517	10,703	11,081	11,468	13,461	15,813	20,974
Meals-on-wheels services	1,690	1,751	1,804	1,869	1,903	1,945	1,949	2,386	2,749	2,824
Grants to voluntary welfare agencies	21,304	22,443	25,382	30,221	30,860	33,957	34,036	44,416	36,347	43,630
Supply of milk to expectant and nursing mothers and children under five covered by medical cards	941	968	997	1,063	1,072	1,095	1,097	1,116	1,139	1,166
Pre-school support services	570	587	688	911	1,564	1,688	1,691	1,723	3,217	3,613
Boarding out of children	3,020	3,131	4,265	5,649	9,634	9,845	10,490	10,689	13,457	15,125
Payment for children in residential homes	7,180	8,395	11,524	15,264	26,032	36,308	46,777	66,102	76,080	90,967
Welfare homes for the aged	8,679	9,884	10,604	11,116	11,312	11,724	12,623	14,261	17,886	21,446
Adoption services	588	660	698	731	744	770	703	0	0	0
Programme Total	126,867	140,500	157,590	177,616	200,729	180,217	133,377	167,584	181,692	215,279
4. Psychiatric Programme										
Service for the diagnosis, care and prevention of psychiatric ailments	168,562	183,390	197,263	209,381	215,860	227,852	233,199	257,408	273,666	310,730
Programme Total	168,562	183,390	197,263	209,381	215,860	227,852	233,199	257,408	273,666	310,730
5. Programme for the Handicapped										
Care in special homes for the mentally handicapped	98,216	107,034	119,210	132,396	144,869	161,099	167,747	194,109	213,486	247,176
Care of mentally handicapped persons in psychiatric hospitals	23,000	24,821	26,033	27,643	31,298	32,052	32,633	34,430	36,637	38,750
Care in day centres for the mentally handicapped	9,886	10,643	12,763	15,743	17,143	20,008	20,871	26,491	28,943	33,062
Assessment and care of persons otherwise handicapped	14,542	15,699	16,756	19,216	22,060	24,929	26,151	32,047	41,663	59,057
Rehabilitation service	3,670	4,014	4,242	4,364	4,077	15,442	15,597	16,143	16,984	25,509
Programme Total	151,924	164,920	181,793	202,203	223,756	267,742	267,619	308,426	343,876	410,191
6. Hospital Programme										
Services in regional hospitals	193,837	222,156	248,446	279,719	294,214	314,236	337,360	395,076	432,486	509,762
Services in public voluntary hospitals	328,937	367,544	408,439	456,674	475,383	507,124	518,024	586,133	650,430	758,144
Services in health board general hospitals	146,392	168,009	182,219	194,956	200,320	216,733	228,309	262,896	285,353	331,687
Contributions to patients in private hospitals	16,402	16,698	17,699	21,927	27,326	30,325	30,380	39,163	43,163	49,673
Services in district hospitals	28,826	31,166	34,566	36,022	37,350	39,353	40,046	45,010	48,205	53,641
Services in health board long-stay hospitals	67,696	73,161	80,411	85,229	87,398	91,493	93,536	102,993	111,093	126,263
Ambulance services	19,113	20,336	22,042	22,924	24,618	27,246	28,893	36,081	38,473	45,821
Programme Total	801,162	897,060	993,821	1,097,451	1,146,609	1,226,510	1,276,548	1,466,354	1,609,203	1,874,991
7. General Support Programme										
Central Administration	9,579	12,385	16,856	11,806	13,233	14,315	16,024	16,186	19,391	20,307
Local Administration (Health Boards)	38,510	40,693	42,116	43,990	44,997	47,386	47,566	56,879	63,424	69,627
Research	1,300	1,631	1,700	1,802	2,769	3,038	3,411	7,029	8,490	9,086
Superannuation	17,838	19,465	21,143	22,626	23,026	25,246	31,142	37,764	53,687	64,069
Finance Charges (including interest on borrowings)	3,860	4,966	8,615	13,830	8,831	9,246	9,454	9,454	8,455	7,900
Programme Total	71,087	79,140	90,430	94,144	92,856	99,231	107,597	127,314	153,447	171,788
GROSS NON-CAPITAL TOTAL - ALL PROGRAMMES	1,575,900	1,752,000	1,956,263	2,160,568	2,290,658	2,445,718	2,506,926	2,873,298	3,181,794	3,786,049
8. Income										
Charges for maintenance in private and semi-private accommodation in public hospitals	40,500	43,860	45,460	55,097	58,441	58,441	60,441	67,046	72,647	80,245
Other income	71,500	77,140	81,140	88,869	86,459	88,296	92,269	94,345	101,334	103,563
Total Non-Capital Income	112,000	121,000	126,600	143,966	144,900	146,737	152,710	161,391	173,981	183,808
NET NON-CAPITAL TOTAL - ALL PROGRAMMES	1,463,900	1,631,000	1,829,683	2,016,602	2,145,758	2,298,981	2,354,216	2,711,907	3,007,813	3,602,241

APPENDIX VI

Regional Information on Health Boards

1. Eastern Health Board

Activity and Funding:

The Eastern Health Board was the dominant region in terms of funding and activity in the Irish health system during the 1990s. Based on 1997 to 1999, we estimate the Eastern Health Board accounted for 43% of national non capital expenditure (including the voluntary sector and GMS Expenditure in the region). It accounted for between 47.5% and 51.2% of non capital expenditure within the Acute Hospital Programme during the decade. This compares with a share of the population of approximately 36% during the period. It also accounted for c.42% of total acute hospital inpatient beds during the period.

The number of inpatient beds per thousand of population in the region reduced from 4.0 in 1990 to 3.6 in 1999, in excess of the national average of 3.4 in 1990 and 3.1 in 1999. This indicates the dominance of the Eastern regional in the provision of acute hospital care. The rate of inpatient admission per 1,000 in the region of population reduced from 162 in 1990 to 138 in 1999, compared to a national average of 147 in 1990 and 142 in 1999. Day cases increased from 27% of total cases in 1990 to 44% in 1999, (compared to the national average of 20% and 36% in 1990 and 1999 respectively).

Casualty attendances per one thousand of population reduced from 435 to 387 per annum in the period, compared to a national position of 319 in 1990 and 327 in 1999. Casualty attendances in the Eastern region have reduced from 541,818 in 1998 to 478,595 in 2000.

Personnel:

The Eastern Health Board Region consistently accounted for c.41% of healthcare professionals and 40% of all staff in Boards and voluntary hospitals nationally (excluding mental handicap homes).

The Eastern Region enjoyed an increase in the number of medical/dental personnel per thousand of population over the ten years, increasing from 1.49 to 1.85 in the period. A corresponding change in nursing personnel was 7.1 to 6.9 and in paramedics 1.6 to 2.4. In overall terms the numbers engaged in the health board and voluntary hospitals in Dublin increased from 17.27 to 19.8 per thousand population in the period. This compares with a national average of 15.4 to 17.6. Again, this points to the high level of resources dedicated to the Eastern Region.

The number of public health nurses per ten thousand of population in the Eastern Region increased slightly from 3.48 to 3.49 over the ten years. This compares with a national average of 3.87 and 4.1 in 1990 and 1999 respectively. The Eastern Region would therefore appear under provided in terms of public health nurses.

The relative change in the Eastern Region compared to the national position is shown below under a range of indicators.

Change in Period 1990-1999	**Eastern Region %**	**National %**
Growth in net non capital expenditure	169	159
Growth in net current expenditure to acute Hospital sector	149	142
Growth in inpatient beds available	-3	-1
Growth in inpatient admissions	-8	3
Change in average length of stay	-	-3
Increase in numbers of day beds	157	148
Increase in number of day cases treated	104	140
Increase in total number of patients	22	30
Increase in Casualty attendances	-3	9
Increase in staffing levels:		
Medical/dental personnel	35	35
Nursing	5	9
Paramedical	69	69
Management in Admin	62	60
All staff	25	24

Eastern Health Board	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Total Net Current Expenditure										
General Hospital Programme	60.8	68.2	73.4	79.9	92.7	99.6	108.2	126.6	136.1	158.3
Special Hospital Programme	62.8	70.0	78.7	86.6	94.5	105.4	108.0	123.2	144.7	171.8
Community Care Programme	88.3	103.1	117.9	130.6	146.6	155.4	156.0	195.7	213.6	254.8
Central Services	14.7	16.3	17.6	19.8	13.1	11.1	13.8	22.4	23.2	24.0
Total Net Current Expenditure	**226.6**	**257.6**	**287.6**	**316.9**	**346.9**	**371.5**	**386.0**	**467.9**	**517.6**	**608.9**
Acute Hospital Programme	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Expenditure Data	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	41.4	45.5	50.3	54.4	62.5	66.3	71.1	82.0	90.5	99.5
Non Pay	25.0	28.5	29.3	32.0	40.1	44.6	49.6	58.4	59.4	72.4
Gross Expenditure	66.4	73.9	79.6	86.4	102.6	110.9	120.7	140.4	149.9	171.9
Income	5.6	5.7	6.2	6.6	9.9	11.3	12.6	13.8	13.8	13.6
Net Expenditure	60.8	68.2	73.4	79.9	92.7	99.6	108.2	126.6	136.1	158.3
Voluntary Acute Hospitals	235.3	271.8	302.9	339.2	378.6	396.9	436.1	457.5	516.1	579.5
	296.1	**340.0**	**376.3**	**419.1**	**471.3**	**496.5**	**544.3**	**584.1**	**652.2**	**737.8**
Non capital expenditure as % of national expenditure	47.7%	48.3%	48.2%	49.0%	52.4%	50.7%	51.2%	49.2%	49.5%	49.1%
Acute Hospital Data	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Total Beds Available	4,987	5,107	5,038	4,937	4,920	4,951	4,970	4,947	4,884	4,827
In.Patient Admissions	200,263	197,290	192,736	194,164	188,973	189,220	193,899	190,999	188,589	184,991
% Occupancy	87.6%	85.5%	86.1%	86.2%	85.0%	85.0%	84.7%	85.6%	86.6%	86.8%
Average Length of Stay	7.7	7.6	7.4	7.6	7.6	7.7	7.6	7.6	7.6	7.7
Day Beds Available	137	211	296	312	299	314	321	328	348	362
Day Cases	73,379	80,347	92,800	117,485	121,358	125,570	127,469	133,899	142,490	147,703
Total Cases	272,842	277,639	285,536	311,639	310,331	314,790	321,068	324,898	331,087	332,694
Casualty Attendences	536,299	542,420	536,542	527,731	526,796	547,385	540,567	540,342	541,010	518,622
Dialysis Treatments	13,864	7,121	19,493	19,018	23,858	24,383	26,529	27,397	30,049	32,836
% of national acute beds	42.0%	42.6%	41.5%	41.8%	41.5%	41.4%	41.6%	41.7%	41.4%	41.0%
% of national acute admissions	38.9%	38.6%	37.7%	37.1%	36.1%	35.7%	36.0%	35.6%	35.0%	34.8%
Day cases as a % of total cases	27%	29%	33%	38%	39%	40%	40%	41%	43%	44%
per 1000 of population										
Number of inpatient beds	4.0	4.1	4.0	3.9	3.9	3.9	3.8	3.8	3.7	3.6
Rate of inpatient admission	162	158	153	153	148	147	149	146	142	138
Number of day beds	0.11	0.17	0.24	0.25	0.23	0.24	0.25	0.25	0.26	0.26
Casualty attendances	435	436	426	416	413	426	417	413	409	387
Personnel data	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Medical/Dental personnel	1,836	1,861	1,904	2,001	1,993	2,032	2,082	2,212	2,320	2,486
Nursing	8,778	9,107	9,308	9,636	9,956	9,966	9,939	9,943	9,386	9,236
Paramedics	1,919	1,971	2,011	2,154	2,320	2,425	2,637	2,830	3,044	3,245
Healthcare professionals	**12,532**	**12,939**	**13,223**	**13,791**	**14,268**	**14,423**	**14,658**	**14,985**	**14,750**	**14,967**
Management/admin	2,656	2,757	3,000	2,901	3,018	3,121	3,249	3,540	3,865	4,311
Other	6,129	5,962	5,780	5,987	6,093	6,102	6,292	5,529	7,018	7,325
Total Health Board and Voluntary Hospitals	**21,317**	**21,648**	**21,991**	**22,679**	**23,379**	**23,646**	**24,199**	**24,054**	**25,633**	**26,603**
% of national healthcare professionals	40.8%	41.1%	41.2%	41.9%	42.1%	41.5%	41.9%	41.3%	41.1%	40.6%
% of national personnel	39.6%	39.6%	39.7%	40.1%	40.1%	39.8%	40.5%	39.6%	40.4%	40.3%
% of national population	35.2%	35.3%	35.4%	35.5%	35.6%	35.7%	35.7%	35.8%	35.8%	35.8%
per 1000 of population										
Medical/Dental personnel	1.49	1.49	1.51	1.58	1.56	1.58	1.61	1.69	1.75	1.85
Nursing	7.11	7.31	7.40	7.60	7.80	7.76	7.67	7.60	7.08	6.88
Paramedics	1.56	1.58	1.60	1.70	1.82	1.89	2.03	2.16	2.30	2.42
Healthcare professionals	10.16	10.38	10.51	10.87	11.19	11.23	11.31	11.45	11.12	11.15
Management/admin	2.15	2.21	2.39	2.29	2.37	2.43	2.51	2.70	2.91	3.21
Other	4.97	4.79	4.58	4.72	4.78	4.75	4.86	4.22	5.29	5.46
	17.27	17.38	17.47	17.88	18.33	18.42	18.67	18.37	19.33	19.83
Number of public health nurses	429	443	430	437	449	435	454	472	482	468
% of national PHN total	31.6%	32.4%	31.5%	31.6%	32.3%	30.9%	32.0%	32.6%	32.7%	30.6%
Per 10000 of population	3.48	3.56	3.42	3.45	3.52	3.39	3.50	3.61	3.63	3.49
Expenditure per 10,000 of population	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
General Hospitals	2399	2731	2990	3304	3606	3987	4200	4462	4918	5499
Special Hospitals	509	562	625	683	741	821	833	941	1081	1280
Community Care	716	828	937	1030	1149	1210	1204	1496	1611	1899

2. Southern Health Board

Activity and Funding:

Based on 1997 to 1999, we estimate the Southern Health Board accounted for 14% of national non capital expenditure (including the voluntary sector and GMS Expenditure in the region). It accounted for 14% of non capital expenditure within the Acute Hospital Programme during the decade. This compares with a share of the population of approximately 15% during the period. It also accounted for c.15% of total acute hospital beds during the period.

The number of inpatient beds per thousand of population in the region has been 3.2 in the period, in line with the national average of 3.4 in 1990 and 3.1 in 1999. The rate of inpatient admission per 1,000 in the region of population reduced from 152 in 1990 to 143 in 1999, compared to a national average of 147 in 1990 and 142 in 1999. Day cases increased from 14% of total cases in 1990 to 32% in 1999, (compared to the national average of 20% and 36% at 1990 and 1999 respectively).

Casualty attendances per one thousand of population reduced from 302 to 274 per annum in the period, compared to a national position of 319 in 1990 and 327 in 1999. Between 1998, casualty attendances reduced from 157,252 to 151,686 in the region.

Personnel:

The Southern Health Board Region consistently accounted for c.14% of healthcare professionals nationally and approximately 13.5% of all personnel engaged in health boards and voluntary hospitals (excluding mental handicap homes).

The Southern Region enjoyed an increase in the number of medical/dental personnel per thousand of population over the ten years, increasing from 1.1 to 1.3 in the period. The corresponding change in nursing personnel was 6.3 to 6.5 and in paramedics 0.8 to 1.3. In overall terms the numbers engaged in the health board and voluntary hospitals in the region increased from 13.7 to 15.88 per thousand population in the period. This compares with a national average of 15.4 to 17.6.

The number of public health nurses per ten thousand of population in the Southern Region increased from 3.4 to 3.7 over the ten years. This compares with a national average of 3.87 and 4.1 in 1990 and 1999 respectively. The region would therefore appear under provided in terms of public health nurses.

The relative change in the Southern Region compared to the national position is shown below under a range of indicators.

Change in Period 1990-1999	**Southern Region %**	**National %**
Growth in net non capital expenditure	148	159
Growth in net current expenditure to acute Hospital sector	132	142
Growth in inpatient beds available	5	-1
Growth in inpatient admissions	1	3
Change in average length of stay	-1	-3
Increase in numbers of day beds	154	148
Increase in number of day cases treated	187	140
Increase in total number of patients	28	30
Increase in Casualty attendances	-3	9
Increase in staffing levels:		
Medical/dental personnel	31	35
Nursing	12	9
Paramedical	62	69
Management in Admin	51	60
All staff	23	24

Southern Health Board	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Total Net Current Expenditure										
General Hospital Programme	75.4	81.9	90.1	96.5	107.4	119.0	122.2	143.9	158.4	174.4
Special Hospital Programme	24.5	27.6	29.4	31.0	35.3	38.6	41.1	46.5	74.7	85.0
Community Care Programme	38.8	44.2	49.4	54.4	63.0	62.4	57.4	64.9	74.2	104.3
Central Services	11.5	13.2	14.2	16.1	3.7	4.0	3.8	5.4	6.5	7.9
Total Net Current Expenditure	**150.2**	**166.8**	**183.8**	**198.0**	**209.4**	**224.0**	**224.5**	**260.7**	**313.8**	**372.4**
Acute Hospital Programme	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Expenditure Data	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	60.3	66.2	73.2	80.5	90.5	97.2	100.5	115.6	126.0	145.3
Non Pay	24.1	26.5	29.2	32.3	33.8	38.7	40.3	47.2	54.8	53.0
Gross Expenditure	84.4	92.6	102.4	112.8	124.3	135.9	140.8	162.8	180.8	198.3
Income	9.0	10.8	12.3	16.3	16.9	16.9	18.6	18.9	22.4	23.9
Net Expenditure	75.4	81.9	90.1	96.5	107.4	119.0	122.2	143.9	158.4	174.4
Voluntary Acute Hospitals	13.4	15.7	17.2	19.2	20.1	22.0	23.8	25.0	28.6	31.6
	88.8	**97.6**	**107.3**	**115.7**	**127.5**	**141.0**	**146.0**	**168.9**	**187.0**	**206.0**
Non capital expenditure as % of national expenditure	**14.3%**	**13.9%**	**13.7%**	**13.8%**	**14.2%**	**14.4%**	**13.7%**	**14.2%**	**14.2%**	**13.7%**
Acute Hospital Data	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Total Beds Available	1,720	1,755	1,808	1,758	1,771	1,793	1,795	1,771	1,778	1,798
In-Patient Admissions	80,349	80,196	81,022	82,560	83,774	83,901	85,203	83,423	82,843	80,990
% Occupancy	83.7	80.8	81.9	81.4	81.4	80.8	79.6	80.8	78.9	79.1
Average Length of Stay	6.4	6.4	6.4	6.3	6.3	6.3	6.1	6.3	6.2	6.4
Day Beds Available	28	32	36	43	51	50	46	68	67	71
Day Cases	13,552	19,671	18,806	17,213	17,037	16,399	31,508	32,714	35,037	38,957
Total Cases	93,901	99,767	99,828	99,773	100,811	100,300	116,791	116,137	118,880	119,947
Casualty Attendances	159,929	136,009	138,400	138,701	135,166	140,044	141,460	142,771	157,262	164,417
Dialysis Treatments	4,548	6,757	6,515	6,470	7,943	8,065	8,449	9,758	10,904	11,295
% of national acute beds	14.5%	14.8%	15.1%	14.5%	15.0%	15.1%	15.0%	14.8%	15.0%	15.3%
% of national acute admissions	15.6%	15.8%	15.8%	16.1%	16.0%	16.0%	16.1%	15.5%	15.4%	15.0%
Day cases as a % of total cases	14%	20%	19%	17%	17%	16%	27%	28%	30%	32%
per 1000 of population										
Number of inpatient beds	3.2	3.3	3.4	3.3	3.3	3.3	3.3	3.2	3.2	3.2
Rate of inpatient admission	152	151	151	153	155	154	156	151	148	143
Number of day beds	0.05	0.06	0.07	0.08	0.09	0.09	0.08	0.12	0.12	0.13
Casualty attendances	302	257	258	257	250	263	259	259	282	274
Personnel data	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Medical/Dental personnel	565	559	571	580	634	662	675	680	713	738
Nursing	3,311	3,291	3,387	3,430	3,399	3,637	3,626	3,618	3,459	3,696
Paramedics	440	448	458	478	526	555	568	601	656	711
Healthcare professionals	**4,316**	**4,298**	**4,416**	**4,488**	**4,559**	**4,854**	**4,869**	**4,902**	**4,828**	**5,145**
Management/admin	829	794	805	857	904	957	1,016	1,078	1,075	1,248
Other	2,112	2,150	2,146	2,139	2,244	2,314	2,334	2,343	2,513	2,568
	7,257	**7,242**	**7,367**	**7,484**	**7,707**	**8,125**	**8,219**	**8,323**	**8,416**	**8,961**
% of national healthcare professionals	**14.0%**	**13.7%**	**13.7%**	**13.6%**	**13.4%**	**14.0%**	**13.9%**	**13.5%**	**13.5%**	**14.0%**
% of national personnel	**13.5%**	**13.3%**	**13.3%**	**13.2%**	**13.2%**	**13.7%**	**13.8%**	**13.5%**	**13.3%**	**13.6%**
% of national population	**15.1%**	**15.1%**	**15.1%**	**15.1%**	**15.1%**	**15.1%**	**15.1%**	**15.1%**	**15.1%**	**15.1%**
per 1000 of population										
Medical/Dental personnel	**1.07**	**1.05**	**1.06**	**1.08**	**1.17**	**1.22**	**1.23**	**1.24**	**1.28**	**1.31**
Nursing	**6.25**	**6.18**	**6.31**	**6.36**	**6.28**	**6.70**	**6.63**	**6.56**	**6.19**	**6.55**
Paramedics	**0.83**	**0.84**	**0.85**	**0.89**	**0.97**	**1.02**	**1.04**	**1.09**	**1.17**	**1.26**
Healthcare professionals	**8.15**	**8.07**	**8.23**	**8.32**	**8.43**	**8.94**	**8.91**	**8.88**	**8.64**	**9.12**
Management/admin	**1.56**	**1.49**	**1.50**	**1.59**	**1.67**	**1.76**	**1.86**	**1.95**	**1.92**	**2.21**
Other	**3.99**	**4.04**	**4.00**	**3.97**	**4.15**	**4.26**	**4.27**	**4.25**	**4.50**	**4.55**
	13.70	**13.61**	**13.73**	**13.88**	**14.25**	**14.96**	**15.03**	**15.08**	**15.07**	**15.88**
Number of public health nurses	**182**	**176**	**172**	**174**	**162**	**180**	**183**	**181**	**190**	**207**
% of national PHN total	**13.4%**	**12.7%**	**12.5%**	**12.4%**	**11.2%**	**12.8%**	**13.0%**	**12.5%**	**12.9%**	**13.6%**
Per 10000 of population	**3.44**	**3.31**	**3.21**	**3.23**	**3.00**	**3.31**	**3.35**	**3.28**	**3.40**	**3.67**
Expenditure per 10,000 of population	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
General Hospitals	1677	1833	2000	2146	2397	2596	2871	3061	3348	3550
Special Hospitals	482	516	548	575	652	711	752	843	1338	1520
Community Care	732	830	920	1009	1165	1149	1050	1176	1329	1040

3. Western Health Board

Activity and Funding:

Based on 1997 to 1999, we estimate the Western Health Board accounted for c.10% of national non capital expenditure (including the voluntary sector and GMS Expenditure in the region). It accounted for 9% of non capital expenditure within the Acute Hospital Programme during the decade. This compares with a share of the population of approximately 10% during the period. It also accounted for between 10% and 11% of total acute hospital beds during the period.

The number of inpatient beds per thousand of population in the region reduced from 3.7 (1990) to 3.5 (1999), above the national average of 3.4 in 1990 and 3.1 in 1999. The rate of inpatient admission per 1,000 in the region of population increased from 160 in 1990 to 164 in 1999, compared to a national average of 147 in 1990 and 142 in 1999. Day cases increased from 8% of total cases in 1990 to 31% in 1999, (compared to the national average of 20% and 36% at 1990 and 1999 respectively).

Casualty attendances per one thousand of population increased from 240 to 321 per annum in the period, compared to a national position of 319 in 1990 and 327 in 1999. Between 1998, casualty attendances increased from 108,371 to 118,715 in the region.

Personnel:

The Western Health Board Region consistently accounted for c.11% of healthcare professionals nationally and approximately 10% of all personnel engaged in health boards and voluntary hospitals (excluding mental handicap homes).

The Western Region enjoyed an increase in the number of medical/dental personnel per thousand of population over the ten years, increasing from 1.2 to 1.3 in the period. The corresponding change in nursing personnel was 7.9 to 7.6 and in paramedics 1.1 to 1.6. In overall terms the numbers engaged in the health board and voluntary hospitals in the region increased from 18.5 to 18.7 per thousand population in the period. This compares with a national average of 15.4 to 17.6.

The number of public health nurses per ten thousand of population in the region reduced from 5.1 to 5.0 over the ten years. This compares with a national average of 3.87 and 4.1 in 1990 and 1999 respectively.

The relative change in the region compared to the national position is shown below under a range of indicators.

Change in Period 1990-1999	**Western Region %**	**National %**
Growth in net non capital expenditure	138	159
Growth in net current expenditure to acute Hospital sector	133	142
Growth in inpatient beds available	-1	-1
Growth in inpatient admissions	9	3
Change in average length of stay	-6	-3
Increase in numbers of day beds	211	148
Increase in number of day cases treated	435	140
Increase in total number of patients	44	30
Increase in Casualty attendances	42	9
Increase in staffing levels:		
Medical/dental personnel	14	35
Nursing	2	9
Paramedical	59	69
Management in Admin	61	60
All staff	8	24

Western Health Board	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Total Net Current Expenditure										
General Hospital Programme	53.2	57.6	62.8	69.6	70.2	77.1	83.4	95.5	104	123.6
Special Hospital Programme	29.3	34.1	36.5	38.1	40	41.5	43.2	36.4	38.3	43.5
Community Care Programme	37.5	41.9	46.5	52.5	59.7	60.4	53.1	76.1	86.7	119.5
Central Services	3.8	4.4	4.7	4.3	3.9	4.7	4.5	6	5.3	7.7
Total Net Current Expenditure	123.8	138.0	150.5	164.5	173.7	183.7	184.2	214.0	234.3	294.3
Acute Hospital Programme	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Expenditure Data	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	42.8	47.4	51.7	56.3	57.7	62.4	66.6	78.2	84.9	97.3
Non Pay	16.6	17.1	18.6	21.9	22.3	24.7	27.5	28.6	32.3	40.8
Gross Expenditure	59.4	64.5	70.3	78.2	80.0	87.1	94.1	106.8	117.2	138.1
Income	6.2	6.9	7.5	8.6	9.8	10.0	10.7	11.3	13.2	14.5
Net Expenditure	53.2	57.6	62.8	69.6	70.2	77.1	83.4	95.5	104.0	123.6
Voluntary Hospitals	6.8	7.6	8.3	8.8	9.2	10.6	11.5	12.9	14.3	16.4
	60.0	65.2	71.1	78.4	79.4	87.7	94.9	108.4	118.3	140.0
Non capital expenditure as % of national expenditure	9.7%	9.9%	9.1%	9.9%	8.8%	9.0%	8.9%	9.1%	9.6%	9.3%
Acute Hospital Data	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Total Beds Available	1,284	1,238	1,285	1,208	1,236	1,256	1,233	1,231	1,239	1,257
In-Patient Admissions	54,864	54,341	55,672	56,067	57,864	58,551	58,007	58,086	59,495	59,655
% Occupancy	85.1	84.3	86.0	85.5	83.6	81.3	82.9	82.7	83.1	82.8
Average Length of Stay	6.7	6.5	7.0	6.7	6.5	6.4	6.4	6.4	6.3	6.3
Day Beds Available	18	24	24	26	36	25	38	36	37	56
Day Cases	4,909	6,642	6,926	8,762	10,042	11,332	13,658	17,083	19,399	26,255
Total Cases	59,773	60,983	62,498	64,829	67,906	69,883	71,665	75,169	78,894	85,910
Casualty Attendances	82,229	88,290	86,136	88,811	93,127	100,616	102,868	107,870	108,371	116,473
Dialysis Treatments	5,644	5,292	5,366	5,746	6,177	6,433	7,361	7,136	7,412	8,431
% of national acute beds	10.7%	10.3%	10.6%	10.2%	10.4%	10.5%	10.3%	10.4%	10.5%	10.7%
% of national acute admissions	10.7%	10.6%	10.9%	10.7%	11.1%	11.1%	10.8%	10.8%	11.1%	11.2%
Day cases as a % of total cases	8%	11%	11%	14%	15%	16%	19%	23%	25%	31%
per 1000 of population										
Number of inpatient beds	3.7	3.6	3.7	3.6	3.6	3.6	3.5	3.6	3.4	3.6
Rate of inpatient admission	160.4	158.4	160.8	161.3	166.0	167.3	164.6	163.4	166.4	164.3
Number of day beds	14.35	19.37	20.04	25.21	28.81	32.37	38.76	48.05	53.94	72.29
Casualty attendances	240	252	249	255	267	287	292	303	301	321
Personnel data	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Medical/Dental personnel	424	438	419	444	453	459	470	479	503	482
Nursing	2,719	2,701	2,757	2,761	2,770	2,694	2,668	2,684	2,787	2790
Paramedics	367	373	382	397	418	448	476	502	546	583
Healthcare professionals	3,510	3,512	3,558	3,602	3,641	3,601	3,614	3,665	3,836	3,825
Management/admin	608	636	659	691	741	777	816	835	887	976
Other	2,190	2,115	2,083	2,065	2,139	2,136	1,893	1,890	1,960	2,014
	6,308	6,263	6,300	6,358	6,521	6,514	6,323	6,390	6,683	6,817
% of national healthcare professionals	11.4%	11.2%	11.1%	10.9%	10.7%	10.4%	10.3%	10.1%	10.7%	10.4%
% of national personnel	11.7%	11.5%	11.4%	11.2%	11.2%	11.0%	10.6%	10.4%	10.5%	10.3%
% of national population	9.8%	9.7%	9.7%	9.7%	9.7%	9.7%	9.7%	9.7%	9.7%	9.7%
per 1000 of population										
Medical/Dental personnel	1.24	1.28	1.21	1.28	1.30	1.31	1.33	1.35	1.40	1.33
Nursing	7.95	7.88	7.98	7.94	7.99	7.79	7.57	7.55	7.75	7.68
Paramedics	1.07	1.09	1.11	1.14	1.20	1.28	1.35	1.41	1.52	1.61
Healthcare professionals	10.26	10.24	10.29	10.36	10.48	10.29	10.26	10.31	10.67	10.53
Management/admin	1.78	1.85	1.91	1.99	2.13	2.22	2.32	2.35	2.47	2.69
Other	6.40	6.17	6.03	5.94	6.14	6.10	5.37	5.32	5.45	5.55
	18.45	18.26	18.23	18.29	18.71	18.61	17.95	17.97	18.58	18.77
Number of public health nurses	174	166	163	171	175	171	173	179	181	181
% of national PHN total	12.8%	12.1%	12.8%	12.4%	12.6%	12.1%	12.2%	12.4%	12.3%	11.9%
Per 10000 of population	5.09	4.84	4.72	4.92	5.02	4.88	4.91	5.03	5.03	4.98
Expenditure per 10,000 of population	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
General Hospitals	1754	1901	2057	2256	2277	2505	2693	3049	3290	3965
Special Hospitals	867	994	1056	1096	1147	1185	1226	1024	1065	1198
Community Care	1097	1222	1345	1611	1712	1726	1607	2140	2383	3290

4. Mid Western Health Board

Activity and Funding:

Based on 1997 to 1999, we estimate the Mid Western Health Board accounted for c8% of national non capital expenditure (including the voluntary sector and GMS Expenditure in the region). It accounted for c.6% of non capital expenditure within the Acute Hospital Programme during the decade. This compares with a share of the population of approximately 9% during the period. It also accounted for c.6% of total acute hospital beds during the period.

The number of inpatient beds per thousand of population in the region has fallen from 2.5 to 2.2 in the period, below the national average of 3.4 in 1990 and 3.1 in 1999. The rate of inpatient admission per 1,000 in the region of population increased from 117 in 1990 to 124 in 1999, compared to a national average of 147 in 1990 and 142 in 1999. Day cases increased from 16% of total cases in 1990 to 34% in 1999, (compared to the national average of 20% and 36% at 1990 and 1999 respectively).

Casualty attendances per one thousand of population increased from 309 to 326 per annum in the period, compared to a national position of 319 in 1990 and 327 in 1999. Between 1998, casualty attendances reduced from 112,229 to 110,455 in the region.

Personnel:

The Mid Western Health Board Region consistently accounted for c.7% of healthcare professionals nationally and approximately 7% of all personnel engaged in health boards and voluntary hospitals (excluding mental handicap homes).

The region enjoyed an increase in the number of medical/dental personnel per thousand of population over the ten years, increasing from 0.8 to 1.1 in the period. Nursing personnel were 5.7 per thousand of population in both 1990 and 1999, and paramedics increased from 0.8 to 1.3 per thousand in the period. In overall terms the numbers engaged in the health board and voluntary hospitals in the region increased from 12.5 to 14.2 per thousand population in the period. This compares with a national average of 15.4 to 17.6.

The number of public health nurses per ten thousand of population in the region increased from 3.6 to 3.9 over the ten years. This compares with a national average of 3.87 and 4.1 in 1990 and 1999 respectively.

The relative change in the region compared to the national position is shown below under a range of indicators.

Change in Period 1990-1999	**Mid Western Region %**	**National %**
Growth in net non capital expenditure	159	159
Growth in net current expenditure to acute Hospital sector	144	142
Growth in inpatient beds available	-6	-1
Growth in inpatient admissions	12	3
Change in average length of stay	-10	-3
Increase in numbers of day beds	113	148
Increase in number of day cases treated	218	140
Increase in total number of patients	44	30
Increase in Casualty attendances	11	9
Increase in staffing levels:		
Medical/dental personnel	42	35
Nursing	5	9
Paramedical	71	69
Management in Admin	50	60
All staff	20	24

Mid Western Health Board	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Total Net Current Expenditure										
General Hospital Programme	32.3	36.6	39	43	44.6	49.4	52.0	60.1	64.7	78.6
Special Hospital Programme	25.6	28.3	30.7	30.3	30.7	32.4	33.7	38.0	40.3	46.3
Community Care Programme	22.1	25.8	28.5	33.5	38.7	39.5	36.9	42.7	71.4	84.9
Central Services	3.6	3.6	4.0	4.2	3.9	3.1	4.7	5.0	6.9	6.5
Total Net Current Expenditure	**83.5**	**94.3**	**102.2**	**111.0**	**117.9**	**124.4**	**127.3**	**145.8**	**183.3**	**216.3**
Acute Hospital Programme	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Expenditure Data	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	27.0	30.4	33.6	36.5	39.2	41.9	44.7	51.1	53.2	63.9
Non Pay	9.9	11.0	11.4	13.5	13.5	15.8	16.0	18.3	22.3	26.9
Gross Expenditure	36.9	41.4	45.0	50.0	52.7	57.7	60.8	69.4	75.5	90.8
Income	4.6	4.8	6.0	7.0	8.1	8.3	8.7	9.3	10.8	12.2
Net Expenditure	32.3	36.6	39.0	43.0	44.6	49.4	52.0	60.1	64.7	78.6
Voluntary Acute Hospitals	3.0	3.5	3.6	4.1	4.3	4.7	5.3	6.0	7.1	7.6
	35.3	**40.1**	**42.6**	**47.1**	**48.9**	**54.1**	**57.3**	**66.1**	**71.8**	**86.2**
Non capital expenditure as % of national expenditure	**5.7%**	**5.7%**	**5.5%**	**5.6%**	**5.4%**	**5.5%**	**5.4%**	**5.6%**	**5.4%**	**5.7%**
Acute Hospital Data	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Total Beds Available	784	749	802	757	758	784	783	752	743	735
In-Patient Admissions	36,313	36,026	37,029	39,256	41,169	40,752	40,249	41,693	41,822	40,605
% Occupancy	85.8	84.6	87.1	90.5	89.4	87.0	86.7	90.8	92.5	90.5
Average Length of Stay	6.7	6.7	6.6	6.4	6.0	6.1	6.2	6.0	6.0	6.0
Day Beds Available	38	38	38	47	45	47	47	51	56	81
Day Cases	6,676	9,018	10,251	10,614	11,030	13,872	14,826	15,426	16,964	21,215
Total Cases	42,989	45,044	47,280	49,870	52,199	54,624	55,075	57,119	58,786	61,820
Casualty Attendances	95,052	92,700	96,427	99,243	103,072	109,147	110,615	110,840	112,229	106,695
Dialysis Treatments	3,418	3,306	3,094	3,504	4,195	4,704	4,216	4,550	4,680	5,257
% of national acute beds	6.6%	6.3%	6.6%	6.4%	6.4%	6.6%	6.6%	6.3%	6.3%	6.2%
% of national acute admissions	7.1%	7.0%	7.2%	7.5%	7.5%	7.7%	7.5%	7.6%	7.6%	7.6%
Day cases as a % of total cases	16%	20%	22%	21%	21%	25%	27%	27%	29%	34%
per 1000 of population										
Number of inpatient beds	2.5	2.4	2.6	2.4	2.4	2.5	2.5	2.3	2.3	2.2
Rate of inpatient admission	117	116	118	126	131	129	127	130	129	124
Number of day beds	0.12	0.12	0.12	0.15	0.14	0.15	0.15	0.16	0.17	0.25
Casualty attendances	309	298	308	316	328	346	349	346	347	326
Personnel data	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Medical/Dental personnel	269	280	278	274	263	302	304	345	361	369
Nursing	1,758	1,801	1,847	1,797	1,839	1,829	1,754	1,791	1,873	1,863
Paramedics	241	273	281	267	286	329	331	362	389	411
Healthcare professionals	**2,268**	**2,354**	**2,406**	**2,338**	**2,388**	**2,460**	**2,389**	**2,498**	**2,623**	**2,633**
Management/admin	491	503	522	539	514	505	539	604	676	735
Other	1,114	1,129	1,139	1,141	1,178	1,215	1,234	1,288	1,287	1,298
	3,873	**3,986**	**4,067**	**4,018**	**4,080**	**4,180**	**4,162**	**4,390**	**4,586**	**4,666**
% of national healthcare professionals	**7.4%**	**7.5%**	**7.5%**	**7.1%**	**7.0%**	**7.1%**	**6.8%**	**6.5%**	**7.3%**	**7.1%**
% of national personnel	**7.2%**	**7.3%**	**7.3%**	**7.1%**	**7.0%**	**7.0%**	**7.0%**	**7.1%**	**7.2%**	**7.1%**
% of national population	**8.8%**	**8.8%**	**8.8%**	**8.8%**	**8.8%**	**8.8%**	**8.7%**	**8.7%**	**8.7%**	**8.7%**
per 1000 of population										
Medical/Dental personnel	**0.84**	**0.90**	**0.89**	**0.87**	**0.84**	**0.96**	**0.96**	**1.08**	**1.11**	**1.13**
Nursing	**5.71**	**5.88**	**5.91**	**5.72**	**5.85**	**5.80**	**5.53**	**5.60**	**5.78**	**5.66**
Paramedics	**0.78**	**0.88**	**0.90**	**0.85**	**0.91**	**1.04**	**1.04**	**1.13**	**1.20**	**1.26**
Healthcare professionals	**7.32**	**7.58**	**7.69**	**7.45**	**7.59**	**7.80**	**7.53**	**7.81**	**8.10**	**8.05**
Management/admin	**1.59**	**1.62**	**1.67**	**1.72**	**1.63**	**1.60**	**1.70**	**1.89**	**2.09**	**2.25**
Other	**3.60**	**3.63**	**3.64**	**3.63**	**3.74**	**3.85**	**3.89**	**4.02**	**3.97**	**3.97**
	12.51	**12.83**	**13.00**	**12.80**	**12.97**	**13.25**	**13.13**	**13.72**	**14.16**	**14.26**
Number of public health nurses	**110**	**118**	**120**	**118**	**119**	**125**	**121**	**122**	**119**	**128**
% of national PHN total	**8.1%**	**8.6%**	**8.8%**	**8.5%**	**8.6%**	**8.9%**	**8.5%**	**8.4%**	**8.1%**	**8.8%**
Per 10000 of population	**3.55**	**3.80**	**3.84**	**3.76**	**3.78**	**3.96**	**3.82**	**3.81**	**3.67**	**3.91**
Expenditure per 10,000 of population	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
General Hospitals	1139	1291	1362	1500	1555	1715	1808	2066	2217	2634
Special Hospitals	823	911	982	965	976	1027	1063	1168	1244	1415
Community Care	716	832	911	1067	1230	1262	1162	1334	2205	2696

5. South Eastern Health Board

Activity and Funding:

Based on 1997 to 1999, we estimate the South Eastern Health Board accounted for 9% of national non capital expenditure (including the voluntary sector and GMS Expenditure in the region). It accounted for 6.2% of non capital expenditure within the Acute Hospital Programme in 1990, and 7.8% in 1999. This compares with a share of the population of approximately 11% during the period. It also accounted for between 9% and 10% of total acute hospital beds during the period.

The number of inpatient beds per thousand of population in the region has been c.2.8 in the period, below the national average of 3.4 in 1990 and 3.1 in 1999. The rate of inpatient admission per 1,000 in the region of population increased from 134 in 1990 to 150 in 1999, compared to a national average of 147 in 1990 and 142 in 1999. Day cases increased from 16% of total cases in 1990 to 27% in 1999, (compared to the national average of 20% and 36% at 1990 and 1999 respectively).

Casualty attendances per one thousand of population increased from 208 to 290 per annum in the period, compared to a national position of 319 in 1990 and 327 in 1999. Between 1998, casualty attendances increased from 113,087 to 123,626 in the region.

Personnel:

The South Eastern Health Board Region consistently accounted for c.9% of healthcare professionals nationally and approximately 9% of all personnel engaged in health boards and voluntary hospitals (excluding mental handicap homes).

The region enjoyed an increase in the number of medical/dental personnel per thousand of population over the ten years, increasing from 0.8 to 1.1 in the period. The corresponding change in nursing personnel was 5.7 to 6.3 and in paramedics 0.6 to 1.2. In overall terms the numbers engaged in the health board and voluntary hospitals in the region increased from 12.2 to 15.2 per thousand population in the period. This compares with a national average of 15.4 to 17.6.

The number of public health nurses per ten thousand of population in the region increased from 3.8 to 4.6 over the ten years. This compares with a national average of 3.87 and 4.1 in 1990 and 1999 respectively.

The relative change in the region compared to the national position is shown below under a range of indicators.

Change in Period 1990-1999	**South Eastern Region %**	**National %**
Growth in net non capital expenditure	162	159
Growth in net current expenditure to acute Hospital sector	203	142
Growth in inpatient beds available	9	-1
Growth in inpatient admissions	18	3
Change in average length of stay	-10	-3
Increase in numbers of day beds	70	148
Increase in number of day cases treated	129	140
Increase in total number of patients	36	30
Increase in Casualty attendances	48	9
Increase in staffing levels:		
Medical/dental personnel	53	35
Nursing	17	9
Paramedical	117	69
Management in Admin	73	60
All staff	32	24

South Eastern Health Board	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Total Net Current Expenditure										
General Hospital Programme	37.7	41.8	49.6	56.1	64.8	70.0	73.0	85.5	89.6	116.8
Special Hospital Programme	27.3	29.7	32.0	36.2	36.6	37.6	39.1	45.8	62.0	62.0
Community Care Programme	28.5	32.2	35.4	39.7	45.6	48.1	44.5	51.4	62.5	91.0
Central Services	12.3	14.0	19.5	20.5	16.6	17.4	16.3	18.5	6.6	6.9
Total Net Current Expenditure	**105.7**	**117.7**	**136.5**	**151.6**	**163.6**	**173.1**	**172.9**	**200.4**	**221.5**	**276.7**
Acute Hospital Programme	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Expenditure Data	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	30.8	35.4	40.6	46.6	51.8	56.5	60.0	70.5	84.7	97.3
Non Pay	11.7	12.8	15.7	17.8	21.5	22.8	23.5	27.6	30.2	36.1
Gross Expenditure	42.5	48.2	56.3	64.4	73.3	79.3	83.5	98.1	114.9	133.4
Income	4.8	6.4	6.7	8.3	8.6	9.4	10.5	12.6	15.3	16.6
Net Expenditure	37.7	41.8	49.6	56.1	64.8	70.0	73.0	85.5	99.6	116.8
Voluntary Acute Hospitals	0.9	1.1	1.3	1.4	1.6	1.6	1.1	0.0	0.0	0.0
	38.6	**42.9**	**50.9**	**57.5**	**66.4**	**71.6**	**74.1**	**85.5**	**99.6**	**116.8**
Non capital expenditure as % of national expenditure	**6.2%**	**6.1%**	**6.5%**	**6.8%**	**7.4%**	**7.3%**	**7.0%**	**7.2%**	**7.6%**	**7.8%**
Acute Hospital Data	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Total Beds Available	1,031	1,010	1,059	1,046	1,078	1,129	1,109	1,114	1,102	1,128
In-Patient Admissions	51,170	50,907	49,327	52,147	52,936	56,690	58,544	58,994	59,979	60,430
% Occupancy	83.1	82.2	80.8	80.5	79.4	78.1	77.1	79.1	80.8	78.4
Average Length of Stay	5.9	6.0	6.13	5.9	5.8	5.4	5.3	5.4	5.4	5.3
Day Beds Available	33	33	36	37	37	37	51	53	55	56
Day Cases	9,779	12,440	8,805	9,282	9,508	11,671	13,352	15,637	18,029	22,394
Total Cases	60,949	63,356	58,132	61,429	62,443	68,361	71,896	74,631	78,008	82,824
Casualty Attendances	79,203	89,038	95,965	93,801	100,709	106,229	107,604	110,134	113,087	116,977
Dialysis Treatments	1,826	1,780	1,758	3,784	2,470	2,601	2,847	4,838	6,072	6,042
% of national acute beds	8.7%	8.4%	8.7%	8.8%	9.1%	9.4%	9.3%	9.4%	9.3%	9.6%
% of national acute admissions	9.9%	10.0%	9.6%	10.0%	10.1%	10.7%	10.9%	11.0%	11.1%	11.4%
Day cases as a % of total cases	16%	20%	15%	15%	15%	17%	19%	21%	23%	27%
per 1000 of population										
Number of inpatient beds	2.7	2.6	2.7	2.7	2.8	2.9	2.8	2.8	2.8	2.8
Rate of inpatient admission	134	133	130	136	136	146	150	149	150	150
Number of day beds	0.09	0.09	0.10	0.10	0.10	0.10	0.13	0.13	0.14	0.14
Casualty attendances	208	232	249	243	259	273	275	279	283	290
Personnel data	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Medical/Dental personnel	292	296	314	327	354	367	378	393	428	446
Nursing	2,186	2,223	2,279	2,320	2,438	2,507	2,462	2,459	2,480	2,559
Paramedics	214	224	246	274	320	355	352	402	427	465
Healthcare professionals	**2,692**	**2,743**	**2,839**	**2,921**	**3,112**	**3,229**	**3,192**	**3,254**	**3,335**	**3,470**
Management/admin	478	499	519	557	624	641	609	687	726	826
Other	1,464	1,504	1,540	1,581	1,633	1,713	1,630	1,704	1,714	1,840
	4,634	**4,746**	**4,898**	**5,059**	**5,369**	**5,583**	**5,431**	**5,645**	**5,775**	**6,136**
% of national healthcare professionals	**8.8%**	**8.7%**	**8.8%**	**8.9%**	**9.2%**	**9.3%**	**9.1%**	**9.0%**	**9.3%**	**9.4%**
% of national personnel	**8.6%**	**8.7%**	**8.8%**	**8.9%**	**9.2%**	**9.4%**	**9.1%**	**9.2%**	**9.1%**	**9.3%**
% of national population	**10.9%**	**10.9%**	**10.9%**	**10.8%**	**10.8%**	**10.8%**	**10.8%**	**10.8%**	**10.8%**	**10.8%**
per 1000 of population										
Medical/Dental personnel	**0.77**	**0.77**	**0.81**	**0.84**	**0.91**	**0.94**	**0.97**	**0.99**	**1.07**	**1.10**
Nursing	**5.74**	**5.80**	**5.91**	**5.99**	**6.28**	**6.44**	**6.29**	**6.22**	**6.28**	**6.34**
Paramedics	**0.56**	**0.58**	**0.64**	**0.71**	**0.82**	**0.91**	**0.90**	**1.02**	**1.07**	**1.15**
Healthcare professionals	**7.06**	**7.16**	**7.36**	**7.54**	**8.02**	**8.29**	**8.15**	**8.24**	**8.34**	**8.59**
Management/admin	**1.25**	**1.30**	**1.35**	**1.44**	**1.61**	**1.65**	**1.56**	**1.74**	**1.82**	**2.05**
Other	**3.84**	**3.92**	**3.99**	**4.08**	**4.21**	**4.40**	**4.16**	**4.31**	**4.29**	**4.56**
	12.16	**12.39**	**12.70**	**13.06**	**13.83**	**14.34**	**13.87**	**14.29**	**14.45**	**15.20**
Number of public health nurses	**145**	**142**	**146**	**148**	**157**	**157**	**157**	**166**	**163**	**187**
% of national PHN total	**10.7%**	**10.4%**	**10.7%**	**10.7%**	**11.3%**	**11.1%**	**11.1%**	**11.5%**	**11.1%**	**12.2%**
Per 10000 of population	**3.80**	**3.71**	**3.78**	**3.82**	**4.04**	**4.03**	**4.01**	**4.20**	**4.08**	**4.63**
Expenditure per 10,000 of population	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
General Hospitals	1012	1121	1320	1485	1710	1838	1893	2164	2482	2893
Special Hospitals	717	775	829	909	942	986	999	1138	1321	1535
Community Care	746	840	916	1026	1175	1237	1136	1301	1564	2254

6. North Western Health Board

Activity and Funding:

Based on 1997 to 1999, we estimate the North Western Health Board accounted for c.6% of national non capital expenditure (including the voluntary sector and GMS Expenditure in the region). It accounted for 5% of non capital expenditure within the Acute Hospital Programme during the decade. This compares with a share of the population of approximately 6% during the period. It also accounted for c.5% of total acute hospital beds during the period.

The number of inpatient beds per thousand of population in the region increased from 2.8 to 3.2 between 1990 and 1999, compared to the national average of 3.4 in 1990 and 3.1 in 1999. The rate of inpatient admission per 1,000 in the region of population increased from 134 in 1990 to 160 in 1999, compared to a national average of 147 in 1990 and 142 in 1999. Day cases increased from 21% of total cases in 1990 to 36% in 1999, (compared to the national average of 20% and 36% at 1990 and 1999 respectively).

Casualty attendances per one thousand of population increased from 215 to 245 per annum in the period, compared to a national position of 319 in 1990 and 327 in 1999. Between 1998, casualty attendances increased from 49,703 to 57,243 in the region.

Personnel:

The North Western Health Board region consistently accounted for c.6% of healthcare professionals nationally and approximately 7% of all personnel engaged in health boards and voluntary hospitals (excluding mental handicap homes).

The region enjoyed an increase in the number of medical/dental personnel per thousand of population over the ten years, increasing from 0.9 to 1.2 in the period. The corresponding change in nursing personnel was 7.2 to 7.7 and in paramedics 1.2 to 1.6. In overall terms the numbers engaged in the health board and voluntary hospitals in the region increased from 18.5 to 21 per thousand population in the period. This compares with a national average of 15.4 to 17.6.

The number of public health nurses per ten thousand of population in the region increased from 5.1 to 5.4 over the ten years. This compares with a national average of 3.87 and 4.1 in 1990 and 1999 respectively.

The relative change in the region compared to the national position is shown below under a range of indicators.

Change in Period 1990-1999	**North Western Region %**	**National %**
Growth in net non capital expenditure	143	159
Growth in net current expenditure to acute Hospital sector	89	142
Growth in inpatient beds available	20	-1
Growth in inpatient admissions	25	3
Change in average length of stay	-2	-3
Increase in numbers of day beds	233	148
Increase in number of day cases treated	166	140
Increase in total number of patients	55	30
Increase in Casualty attendances	19	9
Increase in staffing levels:		
Medical/dental personnel	38	35
Nursing	12	9
Paramedical	38	69
Management in Admin	39	60
All staff	19	24

North Western Health Board	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Total Net Current Expenditure										
General Hospital Programme	37.4	43.7	48.6	38.7	41.4	44.2	45.9	54.6	60.5	70.7
Special Hospital Programme	14.4	15.5	16.5	12.4	12.6	13.4	13.9	16.6	17.4	21.0
Community Care Programme	20.6	22.9	25.4	47.9	52.7	53.6	52.4	60.0	67.3	86.2
Central Services	4.4	5.2	8.2	10.0	8.2	8.4	5.5	5.8	7.2	9.1
Total Net Current Expenditure	**76.8**	**87.3**	**98.7**	**108.9**	**112.9**	**119.5**	**117.2**	**137.0**	**152.4**	**187.0**
Acute Hospital Programme	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Expenditure Data	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	31.5	36.6	41.0	31.5	35.0	36.7	38.1	45.2	51.0	58.0
Non Pay	12.3	14.0	15.6	12.9	12.2	13.1	13.6	15.9	17.1	21.2
Gross Expenditure	43.8	50.6	56.6	44.4	47.2	49.8	51.7	61.1	68.1	79.2
Income	6.4	6.9	8.0	5.7	5.8	5.6	5.8	6.5	7.6	8.5
Net Expenditure	37.4	43.7	48.6	38.7	41.4	44.2	45.9	54.6	60.5	70.7
Voluntary Acute Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	37.4	**43.7**	**48.6**	**38.7**	**41.4**	**44.2**	**45.9**	**54.6**	**60.5**	**70.7**
Non capital expenditure as % of national expenditure	**6.8%**	**6.2%**	**6.2%**	**4.6%**	**4.6%**	**4.5%**	**4.3%**	**4.6%**	**4.6%**	**4.7%**
Note : Certain expenditure was recategorised from General Hospital Programme to Community Care Programme from 1993.										
Acute Hospital Data	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Total Beds Available	572	598	689	658	665	688	668	682	672	686
In-Patient Admissions	27,849	28,788	32,729	33,319	34,395	34,686	33,998	34,129	35,373	34,753
% Occupancy	82.0	82.9	79.1	81.1	82.4	80.9	80.8	77.4	81.2	80.0
Average Length of Stay	5.9	6.0	5.7	5.8	5.9	5.7	5.8	5.4	5.6	5.8
Day Beds Available	6	6	6	15	15	15	21	22	20	20
Day Cases	7,468	6,003	8,902	12,698	12,414	15,076	16,308	16,302	17,674	19,852
Total Cases	35,317	34,791	41,631	46,017	46,809	49,761	50,306	50,431	53,047	54,605
Casualty Attendences	44,720	45,078	44,993	44,943	47,369	47,975	45,837	47,923	49,703	53,260
Dialysis Treatments	3,157	3,464	3,878	3,580	4,101	4,209	4,242	4,583	4,828	5,189
% of national acute beds	4.8%	4.9%	5.4%	5.6%	5.6%	5.6%	5.6%	5.6%	5.7%	5.8%
% of national acute admissions	5.4%	5.6%	6.4%	6.4%	6.6%	6.6%	6.3%	6.4%	6.6%	6.5%
Day cases as a % of total cases	21%	17%	21%	28%	27%	30%	32%	32%	33%	36%
per 1000 of population										
Number of inpatient beds	2.8	2.8	3.2	3.1	3.2	3.2	3.2	3.1	3.1	3.2
Rate of inpatient admission	134	138	156	159	164	165	161	160	164	160
Number of day beds	0.03	0.03	0.03	0.07	0.07	0.07	0.10	0.10	0.09	0.09
Casualty attendances	215	220	215	214	226	228	217	225	231	245
Personnel data	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Medical/Dental personnel	190	226	219	223	227	233	246	253	260	262
Nursing	1,492	1,536	1,569	1,570	1,562	1,580	1,545	1,541	1,539	1,667
Paramedics	255	268	269	291	327	314	301	334	338	351
Healthcare professionals	**1,937**	**2,030**	**2,047**	**2,084**	**2,106**	**2,127**	**2,092**	**2,128**	**2,137**	**2,280**
Management/admin	511	515	521	526	528	563	585	622	650	710
Other	1,402	1,415	1,444	1,417	1,489	1,342	1,384	1,447	1,493	1,576
	3,850	**3,960**	**4,012**	**4,027**	**4,123**	**4,032**	**4,061**	**4,197**	**4,280**	**4,566**
% of national healthcare professionals	**6.3%**	**6.5%**	**6.4%**	**6.3%**	**6.2%**	**6.1%**	**6.0%**	**5.9%**	**6.0%**	**6.2%**
% of national personnel	**7.1%**	**7.3%**	**7.2%**	**7.1%**	**7.1%**	**6.8%**	**6.8%**	**6.8%**	**6.8%**	**6.9%**
% of national population	**5.9%**	**5.9%**	**5.9%**	**5.8%**	**5.9%**	**5.8%**	**5.8%**	**5.8%**	**5.8%**	**5.8%**
per 1000 of population										
Medical/Dental personnel	**0.91**	**1.09**	**1.05**	**1.06**	**1.08**	**1.11**	**1.17**	**1.19**	**1.21**	**1.21**
Nursing	**7.18**	**7.38**	**7.45**	**7.49**	**7.40**	**7.52**	**7.33**	**7.24**	**7.15**	**7.67**
Paramedics	**1.23**	**1.29**	**1.28**	**1.39**	**1.56**	**1.49**	**1.43**	**1.57**	**1.57**	**1.62**
Healthcare professionals	**9.32**	**9.75**	**9.78**	**9.94**	**10.04**	**10.12**	**9.92**	**10.00**	**9.93**	**10.49**
Management/admin	**2.46**	**2.47**	**2.49**	**2.51**	**2.52**	**2.68**	**2.77**	**2.92**	**3.02**	**3.27**
Other	**6.75**	**6.81**	**6.95**	**6.82**	**7.16**	**6.46**	**6.66**	**6.96**	**7.10**	**7.58**
	18.52	**19.02**	**19.18**	**19.20**	**19.65**	**19.19**	**19.26**	**19.73**	**19.89**	**21.01**
Number of public health nurses	**105**	**104**	**107**	**111**	**107**	**106**	**105**	**106**	**110**	**117**
% of national PHN total	**7.7%**	**7.7%**	**7.9%**	**8.2%**	**7.9%**	**7.8%**	**7.7%**	**7.8%**	**8.1%**	**8.6%**
Per 10000 of population	**5.05**	**5.00**	**5.11**	**5.29**	**5.10**	**5.05**	**4.98**	**4.98**	**5.11**	**5.38**
Expenditure per 10,000 of population	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
General Hospitals	1252	1454	1609	1277	1363	1451	1499	1756	1937	2242
Special Hospitals	482	515	546	408	413	438	454	537	557	666
Community Care	690	764	841	1579	1735	1760	1712	1944	2155	2733

7. North Eastern Health Board

Activity and Funding:

Based on 1997 to 1999, we estimate the North Eastern Health Board accounted for 7% of national non capital expenditure (including the voluntary sector and GMS Expenditure in the region). It accounted for 6% of non capital expenditure within the Acute Hospital Programme during the decade. This compares with a share of the population of approximately 8.5% during the period. It also accounted for c.8% of total acute hospital beds during the period.

The number of inpatient beds per thousand of population in the region has reduced from 3.3 to 2.8 in the period, below with the national average of 3.4 in 1990 and 3.1 in 1999. The rate of inpatient admission per 1,000 in the region of population increased from 134 in 1990 to 136 in 1999, compared to a national average of 147 in 1990 and 142 in 1999. Day cases increased from 9% of total cases in 1990 to 25% in 1999, (compared to the national average of 20% and 36% at 1990 and 1999 respectively).

Casualty attendances per one thousand of population increased from 302 to 322 per annum in the period, compared to a national position of 319 in 1990 and 327 in 1999. Between 1998, casualty attendances reduced from 102,697 to 97,474 in the region.

Personnel:

The North Eastern Health Board region consistently accounted for c.7% of healthcare professionals nationally and approximately 7% of all personnel engaged in health boards and voluntary hospitals (excluding mental handicap homes).

The region enjoyed an increase in the number of medical/dental personnel per thousand of population over the ten years, increasing from 0.8 to 1.0 in the period. The corresponding change in nursing personnel was 5.3 to 6.0 and in paramedics 0.7 to 1.2. In overall terms the numbers engaged in the health board and voluntary hospitals in the region increased from 12.7 to 15.1 per thousand population in the period. This compares with a national average of 15.4 to 17.6.

The number of public health nurses per ten thousand of population in the region increased from 4.0 to 4.3 over the ten years. This compares with a national average of 3.87 and 4.1 in 1990 and 1999 respectively.

The relative change in the region compared to the national position is shown below under a range of indicators.

Change in Period 1990-1999	**North Eastern Region %**	**National %**
Growth in net non capital expenditure	217	159
Growth in net current expenditure to acute Hospital sector	127	142
Growth in inpatient beds available	-11	-1
Growth in inpatient admissions	7	3
Change in average length of stay	-12	-3
Increase in numbers of day beds	N/a	148
Increase in number of day cases treated	254	140
Increase in total number of patients	30	30
Increase in Casualty attendances	13	9
Increase in staffing levels:		
Medical/dental personnel	39	35
Nursing	20	9
Paramedical	94	69
Management in Admin	97	60
All staff	25	24

North Eastern Health Board	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Total Net Current Expenditure										
General Hospital Programme	30.9	34.7	37.7	30.9	31.5	35.4	39.7	61.0	76.4	92
Special Hospital Programme	8.4	10.3	11.4	11.1	11.2	11.7	13.4	16.0	16.2	18.1
Community Care Programme	19.0	20.9	23.5	38.3	44.2	47.2	48.2	56.7	65.2	88.1
Central Services	5.6	7.3	7.7	8.3	7.9	8.8	3.8	4.5	6.1	7.5
Total Net Current Expenditure	**64.5**	**73.1**	**80.2**	**88.6**	**94.8**	**103.1**	**105.1**	**138.2**	**163.9**	**205.7**
Acute Hospital Programme	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Expenditure Data	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	26.3	29.9	32.9	24.4	25.5	27.3	32.0	50.6	64.6	74.7
Non Pay	9.8	10.4	11.0	10.2	10.1	12.5	12.1	17.7	22.2	29.5
Gross Expenditure	36.1	40.3	43.9	34.6	35.6	39.8	44.1	68.3	86.9	104.2
Income	5.2	5.6	6.2	3.7	4.1	4.4	4.4	7.3	10.5	12.2
Net Expenditure	30.9	34.7	37.7	30.9	31.5	35.4	39.7	61.0	76.4	92.0
Voluntary Acute Hospitals	9.6	11.1	12.4	13.8	14.6	16.6	17.1	19.0	8.3	0.0
	40.5	**45.8**	**50.1**	**44.7**	**46.1**	**51.6**	**56.8**	**80.0**	**84.7**	**92.0**
Non capital expenditure as % of national expenditure	**6.5%**	**6.5%**	**6.4%**	**5.3%**	**5.1%**	**5.2%**	**5.3%**	**6.7%**	**6.8%**	**6.9%**
Note : Certain expenditure was recategorised from General Hospital Programme to Community Care Programme from 1993.										
Acute Hospital Data	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Total Beds Available	994	1,013	1,008	964	946	890	911	911	895	885
In-Patient Admissions	40,131	39,900	39,248	39,858	38,367	38,862	40,857	41,358	41,597	42,911
% Occupancy	77.2	73.1	75.8	74.7	72.9	76.2	73.9	75.9	78.8	76.6
Average Length of Stay	6.6	6.8	7.0	6.6	6.5	6.4	6.0	6.1	6.2	5.8
Day Beds Available	0	0	0	12	24	31	32	27	31	32
Day Cases	4,119	3,810	4,448	5,994	6,086	7,491	10,061	11,715	12,380	14,581
Total Cases	44,250	43,710	43,696	45,852	44,453	46,353	50,918	53,073	53,977	57,492
Casualty Attendences	90,168	89,454	91,450	86,864	86,760	94,149	92,686	98,969	102,697	101,532
Dialysis Treatments	0	0	0	0	37	2,119	2,212	2,490	2,838	3,280
% of national acute beds	8.4%	8.5%	8.3%	8.2%	8.0%	7.5%	7.6%	7.7%	7.6%	7.5%
% of national acute admissions	7.8%	7.8%	7.7%	7.6%	7.3%	7.3%	7.6%	7.7%	7.7%	8.1%
Day cases as a % of total cases	9%	9%	10%	13%	14%	16%	20%	22%	23%	25%
per 1000 of population										
Number of inpatient beds	3.3	3.4	3.3	3.2	3.1	2.9	3.0	2.9	2.9	2.8
Rate of inpatient admission	134	133	130	131	126	128	133	134	133	136
Number of day beds	0.00	0.00	0.00	0.04	0.08	0.10	0.10	0.09	0.10	0.10
Casualty attendances	302	298	303	288	282	309	303	320	329	322
Personnel data	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Medical/Dental personnel	228	237	239	244	260	286	277	423	300	318
Nursing	1,593	1,649	1,652	1,662	1,682	1,819	1,824	2,282	1,818	1,916
Paramedics	193	188	196	208	235	283	288	373	330	374
Healthcare professionals	**2,014**	**2,074**	**2,087**	**2,114**	**2,177**	**2,388**	**2,389**	**3,078**	**2,448**	**2,608**
Management/admin	378	390	396	430	485	526	515	674	680	744
Other	1,418	1,382	1,348	1,365	1,401	1,381	1,233	1,533	1,388	1,412
	3,810	**3,846**	**3,831**	**3,909**	**4,063**	**4,295**	**4,137**	**5,285**	**4,516**	**4,764**
% of national healthcare professionals	**6.6%**	**6.6%**	**6.5%**	**6.4%**	**6.4%**	**6.9%**	**6.8%**	**8.5%**	**6.8%**	**7.1%**
% of national personnel	**7.1%**	**7.0%**	**6.9%**	**6.9%**	**7.0%**	**7.2%**	**6.9%**	**8.6%**	**7.1%**	**7.2%**
% of national population	**8.5%**	**8.5%**	**8.5%**	**8.5%**	**8.5%**	**8.5%**	**8.4%**	**8.4%**	**8.4%**	**8.4%**
per 1000 of population										
Medical/Dental personnel	**0.76**	**0.79**	**0.79**	**0.80**	**0.86**	**0.94**	**0.90**	**1.37**	**0.96**	**1.01**
Nursing	**5.33**	**5.49**	**5.47**	**5.48**	**5.54**	**5.97**	**5.96**	**7.39**	**5.82**	**6.08**
Paramedics	**0.65**	**0.63**	**0.65**	**0.69**	**0.77**	**0.93**	**0.94**	**1.21**	**1.06**	**1.19**
Healthcare professionals	**6.74**	**6.91**	**6.91**	**6.97**	**7.17**	**7.84**	**7.80**	**9.97**	**7.84**	**8.27**
Management/admin	**1.27**	**1.30**	**1.31**	**1.42**	**1.60**	**1.73**	**1.68**	**2.18**	**2.18**	**2.36**
Other	**4.75**	**4.63**	**4.51**	**4.57**	**4.69**	**4.62**	**4.13**	**5.13**	**4.65**	**4.73**
	12.76	**12.81**	**12.68**	**12.89**	**13.37**	**14.10**	**13.51**	**17.11**	**14.46**	**15.11**
Number of public health nurses	**119**	**118**	**123**	**126**	**126**	**130**	**118**	**118**	**122**	**137**
% of national PHN total	**8.8%**	**8.6%**	**9.0%**	**9.1%**	**9.1%**	**9.2%**	**8.3%**	**8.1%**	**8.3%**	**9.0%**
Per 10000 of population	**3.98**	**3.93**	**4.07**	**4.15**	**4.15**	**4.27**	**3.85**	**3.82**	**3.91**	**4.34**
Expenditure per 10,000 of population	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
General Hospitals	1356	1526	1658	1474	1517	1674	1864	2691	2712	2917
Special Hospitals	315	343	377	367	368	384	439	516	520	574
Community Care	637	695	777	1261	1456	1550	1574	1835	2088	2793

8. Midland Health Board

Activity and Funding:

Based on 1997 to 1999, we estimate the Midland Health Board accounted for 5% of national non capital expenditure (including the voluntary sector and GMS Expenditure in the region). It accounted for between 3% and 4% of non capital expenditure within the Acute Hospital Programme during the decade. This compares with a share of the population of approximately 6% during the period. It also accounted for c.4% of total acute hospital beds during the period.

The number of inpatient beds per thousand of population in the region has reduced from 2.5 to 2.2 in the period, compared to the national average of 3.4 in 1990 and 3.1 in 1999. The rate of inpatient admission per 1,000 in the region of population increased from 118 in 1990 to 128 in 1999, compared to a national average of 147 in 1990 and 142 in 1999. Day cases increased from 20% of total cases in 1990 to 24% in 1999, (compared to the national average of 20% and 36% at 1990 and 1999 respectively).

Casualty attendances per one thousand of population increased from 155 to 270 per annum in the period, compared to a national position of 319 in 1990 and 327 in 1999. Between 1998, casualty attendances increased from 57,086 to 63,040 in the region.

Personnel:

The Midland Health Board region consistently accounted for c.5% of healthcare professionals nationally and approximately 5% of all personnel engaged in health boards and voluntary hospitals (excluding mental handicap homes).

The region enjoyed an increase in the number of medical/dental personnel per thousand of population over the ten years, increasing from 0.8 to 1.1 in the period. The corresponding change in nursing personnel was 5.6 to 6.6 and in paramedics 0.9 to 1.4. In overall terms the numbers engaged in the health board and voluntary hospitals in the region increased from 14.0 to 16.6 per thousand population in the period. This compares with a national average of 15.4 to 17.6.

The number of public health nurses per ten thousand of population in the region increased from 4.6 to (4.8) over the ten years. This compares with a national average of 3.87 and 4.1 in 1990 and 1999 respectively. The region would therefore appear relatively well provided in terms of public health nurses.

The relative change in the region compared to the national position is shown below under a range of indicators.

Change in Period 1990-1999	**Midland Region %**	**National %**
Growth in net non capital expenditure	149	159
Growth in net current expenditure to acute Hospital sector	97	142
Growth in inpatient beds available	-10	-1
Growth in inpatient admissions	13	3
Change in average length of stay	-6	-3
Increase in numbers of day beds	50	148
Increase in number of day cases treated	47	140
Increase in total number of patients	20	30
Increase in Casualty attendances	82	9
Increase in staffing levels:		
Medical/dental personnel	48	35
Nursing	23	9
Paramedical	72	69
Management in Admin	54	60
All staff	24	24

Midland Health Board	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Total Net Current Expenditure										
General Hospital Programme	26.3	30.2	32.8	39.8	27.1	30.7	33	38.8	44	51.7
Special Hospital Programme	11.1	12.4	13.4	16.4	14.4	16.2	15.6	18	18.6	20.3
Community Care Programme	18.0	20.4	22.4	24.0	42.8	45.2	45.0	50.4	57.2	72.7
Central Services	6.6	6.5	7.7	2.8	3.3	3.4	3.7	4.7	5.8	9.7
Total Net Current Expenditure	**62.1**	**69.5**	**76.3**	**83.0**	**87.6**	**94.5**	**97.3**	**111.9**	**125.6**	**154.4**
Acute Hospital Programme	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Expenditure Data	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	22.7	25.9	28.6	33.6	23.0	25.3	27.0	31.9	36.7	41.8
Non Pay	8.4	9.2	9.6	13.2	9.0	10.3	11.0	12.3	13.7	15.6
Gross Expenditure	31.1	35.1	38.2	46.8	32.0	35.6	38.0	44.2	50.4	57.3
Income	4.8	4.9	5.4	7.0	4.9	4.9	5.0	5.4	6.4	5.6
Net Expenditure	26.3	30.2	32.8	39.8	27.1	30.7	33.0	38.8	44.0	51.7
Voluntary Acute Hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	26.3	**30.2**	**32.8**	**39.8**	**27.1**	**30.7**	**33.0**	**38.8**	**44.0**	**51.7**
Non capital expenditure as % of national expenditure	**4.2%**	**4.3%**	**4.2%**	**4.7%**	**3.0%**	**3.1%**	**3.1%**	**3.3%**	**3.3%**	**3.4%**
Note : Certain expenditure was recategorised from General Hospital Programme to Community Care Programme from 1994.										
Acute Hospital Data	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Total Beds Available	516	521	479	485	479	474	460	473	475	485
In-Patient Admissions	23,993	24,176	23,923	25,491	25,307	26,732	27,248	28,136	28,692	27,121
% Occupancy	78.7	77.8	75.5	78.2	82.9	84.6	85.3	90.7	82.5	86.2
Average Length of Stay	5.8	6.3	5.5	5.6	5.7	5.5	5.4	5.6	5.6	5.5
Day Beds Available	24	24	24	24	24	24	27	29	32	36
Day Cases	5,887	4,535	4,388	4,804	5,542	5,889	6,726	6,896	7,459	8,674
Total Cases	29,880	28,711	28,311	30,295	30,849	32,621	33,974	35,031	36,151	35,795
Casualty Attendances	31,386	37,541	41,804	44,498	45,684	50,907	51,952	54,472	57,086	57,173
Dialysis Treatments	0	0	0	0	0	0	0	0	0	0
% of national acute beds	4.3%	4.3%	3.9%	4.1%	4.0%	4.0%	3.9%	4.0%	4.0%	3.9%
% of national acute admissions	4.7%	4.7%	4.7%	4.9%	4.8%	5.0%	5.1%	5.2%	5.3%	5.1%
Day cases as a % of total cases	20%	16%	15%	16%	18%	18%	20%	20%	21%	24%
per 1000 of population										
Number of inpatient beds	2.5	2.6	2.3	2.4	2.3	2.3	2.3	2.3	2.3	2.2
Rate of inpatient admission	118	119	117	125	124	131	133	136	137	128
Number of day beds	0.12	0.12	0.12	0.12	0.12	0.12	0.13	0.14	0.15	0.17
Casualty attendances	155	185	205	218	223	249	253	263	272	270
Personnel data	**1990**	**1991**	**1992**	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**
Medical/Dental personnel	**157**	**171**	**169**	**172**	**186**	**196**	**206**	**211**	**223**	**232**
Nursing	**1,140**	**1,164**	**1,194**	**1,232**	**1,248**	**1,270**	**1,305**	**1,335**	**1,420**	**1,399**
Paramedics	**177**	**180**	**181**	**191**	**216**	**239**	**254**	**267**	**289**	**304**
Healthcare professionals	**1,474**	**1,515**	**1,544**	**1,595**	**1,650**	**1,705**	**1,765**	**1,813**	**1,932**	**1,935**
Management/admin	**281**	**285**	**295**	**298**	**313**	**327**	**348**	**376**	**403**	**432**
Other	**1,075**	**1,117**	**1,060**	**1,118**	**1,108**	**1,040**	**1,086**	**1,136**	**1,151**	**1,141**
	2,830	**2,917**	**2,899**	**3,011**	**3,071**	**3,072**	**3,199**	**3,325**	**3,486**	**3,508**
% of national healthcare professionals	**4.8%**	**4.8%**	**4.8%**	**4.8%**	**4.9%**	**4.9%**	**5.0%**	**5.0%**	**5.4%**	**5.2%**
% of national personnel	**5.3%**	**5.3%**	**5.2%**	**5.3%**	**5.3%**	**5.2%**	**5.4%**	**5.4%**	**5.5%**	**5.3%**
% of national population	**5.8%**	**5.8%**	**5.7%**	**5.7%**	**5.7%**	**5.7%**	**5.7%**	**5.7%**	**5.7%**	**5.7%**
per 1000 of population										
Medical/Dental personnel	**0.77**	**0.84**	**0.83**	**0.84**	**0.91**	**0.96**	**1.00**	**1.02**	**1.06**	**1.10**
Nursing	**5.62**	**5.73**	**5.85**	**6.03**	**6.10**	**6.20**	**6.35**	**6.44**	**6.77**	**6.61**
Paramedics	**0.87**	**0.89**	**0.89**	**0.93**	**1.06**	**1.17**	**1.24**	**1.29**	**1.38**	**1.44**
Healthcare professionals	**7.27**	**7.46**	**7.57**	**7.80**	**8.07**	**8.33**	**8.59**	**8.74**	**9.22**	**9.14**
Management/admin	**1.39**	**1.40**	**1.45**	**1.46**	**1.53**	**1.60**	**1.69**	**1.81**	**1.92**	**2.04**
Other	**5.30**	**5.50**	**5.20**	**5.47**	**5.42**	**5.08**	**5.28**	**5.48**	**5.49**	**5.39**
	13.96	**14.37**	**14.21**	**14.73**	**15.02**	**15.00**	**15.56**	**16.04**	**16.63**	**16.58**
Number of public health nurses	**94**	**102**	**104**	**100**	**101**	**105**	**105**	**105**	**108**	**102**
% of national PHN total	**6.9%**	**7.5%**	**7.6%**	**7.2%**	**7.3%**	**7.5%**	**7.4%**	**7.2%**	**7.3%**	**6.7%**
Per 10000 of population	**4.64**	**5.03**	**5.10**	**4.89**	**4.94**	**5.13**	**5.11**	**5.06**	**5.15**	**4.82**
Expenditure per 10,000 of population	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
General Hospitals	1297	1488	1608	1946	1325	1499	1606	1873	2099	2443
Special Hospitals	550	611	657	802	704	742	759	868	887	959
Community Care	889	1005	1098	1174	2091	2207	2189	2431	2729	3436