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Committee on the Future of Healthcare

Sláintecare Report

May 2017



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Chair's Foreword



The formation of the Oireachtas Committee on the Future of Healthcare provided a unique and historic opportunity for TDs from across the political spectrum to come together to develop consensus on a long-term policy direction for Ireland's healthcare system. Our task has been to consider how best to ensure that, in future, everyone has access to an affordable, universal, single-tier healthcare system, in which patients are treated promptly on the basis of need, rather than ability to pay.

The Dáil's unanimous decision to establish an all-party Committee for this purpose was highly commended by international health systems expert Dr Josep Figueras, who emphasised the positive role that political consensus can play in reform, saying that: *"One of the things we have learnt elsewhere is the need to have some stability in the reform process. The idea of putting a multi-party committee together to create consensus is a very wise decision..."*

Since June 2016, the Committee has worked tirelessly in its consideration of the national and international evidence, through public hearings, facilitated workshops and in-depth consideration of the evidence. The many stakeholder submissions we received provided us with a unique insight into the experiences of those who use our system, those who work in it and of the many organisations and bodies that are involved in it. The Committee wishes to thank most sincerely all those who took the time to respond to our call for submissions, which are available to view online [here](#). The Committee also thanks all those who made themselves available to provide evidence to the Committee at its public hearings, sometimes at short notice, and to engage with the Committee on the often complex and complicated issues facing our health system.

During its work programme, the Committee worked closely with an expert team from the Trinity Centre for Health Policy and Management, who provided significant and invaluable support in health policy and health economics. Their expertise, knowledge and sheer commitment have been crucially important as we examined and debated a wide range of issues.

It is also important to mention the role played by the Oireachtas Library and Information Service, which provided several valuable papers for the Committee on key topics.

As Chair, I want to take this opportunity to acknowledge the hard work and dedication of my fellow Committee Members. All Members have worked respectfully and collegially over many months to deliver this report. Inevitably, Members hold different political views. However, we have reached a consensus on how to achieve the shared goal of a universal single-tier health system.

This report represents a new vision for the future of healthcare in Ireland. The Committee considers it imperative that its recommendations are implemented without delay. Therefore, on behalf of the Committee, I wish to formally request that this report be debated in the Dáil at the earliest possible opportunity.



Róisín Shortall, T.D.

Chair

Committee On The Future Of Healthcare

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Acknowledgements

The Committee wishes to acknowledge the invaluable contribution of everyone who assisted us in our work over the last 12 months.

In preparing this report, the Committee worked closely with a team of health policy specialists from the Trinity Centre for Health Policy and Management, led by Dr Steve Thomas.

We wish to sincerely thank Dr Thomas, Dr Sarah Barry, Dr Sara Burke, Dr Bridget Johnson and Ms Rikke Siersbaek for their specialist advice and for their commitment to the project. We also wish to recognise the contribution of Dr Eddie Molloy, Management Consultant, for his assistance and generosity in giving time to brief the Committee.

During its deliberations, the Committee placed great importance on considering national and international evidence. We would like to thank Dr Charles Normand, Dr Catherine Darker, Prof. Ian Graham (Trinity College, Dublin), Dr Anne Nolan and Dr Maev-Ann Wren (ESRI), Dr Stephen Kinsella (University of Limerick) for briefing the Committee, and for responding to requests for information.

The Committee also wishes to thank Dr Josep Figueras (Director of the European Observatory on Health Systems and Policies) and Professor Allyson Pollock (Newcastle University) for providing the Committee with an international perspective on health systems and universal health.

The Committee wishes to acknowledge Mr Jim Breslin and officials from the Department of Health including Mr Tony Flynn and Mr Derek McCormack; and Mr Tony O’ Brien and officials from the HSE including Mr Ray Mitchell for their co-operation and assistance during the Committee’s work.

The Committee also wishes to acknowledge the work of the Oireachtas Library and Research Service in preparing briefing papers, and the Secretariat team for its ongoing support.

The Committee would like to especially thank the Royal College of Physicians of Ireland (RCPI) for briefing the Committee on its work, and especially to Ms Siobhan Creaton, for assisting the Committee with facilities for a number of Committee meetings.

Finally, the Committee wishes to thank each of the witnesses and stakeholder groups who gave evidence to the Committee, and generously gave of their time to provide the Committee with submissions as part of the public consultation process.

Key Recommendations

1. Expand Health and Wellbeing

- Increase Health and Wellbeing Budget – €233m over ten years
- Resource and develop a universal child health and wellbeing service – €41m over first five years

2. Reduce and Remove Charges

- Removal of inpatient charges for public hospital care – €25m in Year 1
- Reduce prescription charge for medical card holders from €2.50 to €1.50 in Year 1 and to 50c in Year 3 – €66.7m in Year 1, a further 66.7m in Year 3 (€133.6m in total)
- Reduce the Drug Payments Scheme threshold from €144 per month to €120 and €100 at a cost of €75m in Year 3 and €184.9m in Year 6 (€259.9m in total)
- Halve the Drugs Payment Scheme threshold for single-headed households in Year 1 to €72 per month
- Removal of Emergency Department charge in Year 8

3. Primary Care Expansion

- Expansion of community diagnostics and shifting treatment from the acute sector to the community
- Counselling in primary care: extend counselling provided by private providers through GP/primary care referral at a cost of the order of €6.6 million over three years
- Develop public psychology services in primary care at a cost of the order of €5m over two years to get this service up and running. This would fund 114 assistant psychologists, 20 child psychologists and allow for the development of a CBT online resource
- Universal GP care – €455 million over five years
- Universal primary care – €265.6 million over first five years of the plan

4. Social Care Expansion

- Universal palliative care – €49.8 million over the first five years of the plan
- Increasing homecare provision – €120 million in the first five years of the plan
- Additional services for people with disabilities – €290 million over ten years

5. Mental Healthcare

- Child and Adolescent Mental Health Teams – €45.7 million, delivered by Year 5
- Adult Community Mental Health Teams – €44.5 million, delivered by Year 5
- Old Age Psychiatry – €18.8 million, delivered by Year 5
- Child and Adolescent Liaison – €4 million, delivered by Year 5
- Intellectual Disability Mental Health Services: 120 additional staff – €8.5 million, delivered by Year 5

6. Dentistry Expansion

- Reinstate pre-economic crisis budget to Dental Treatment Services Scheme – €17 million in Year 1

7. Expanding Public Hospital Activity

- Expanding public activity in public hospitals – €649 million from Years 2 to 6 of the plan
- Increase numbers of public hospital consultants – €119 million between Years 4 and 10

8. Legislation

- There are several important areas for legislation associated with the programme of reform. These relate to key values and principles to embed into the Irish health system, new governance structures, funding mechanisms, and organisational realignment and enhancement
- Legislate for a new HSE Board
- Legislate for the National Health Fund and new funding mechanisms for the transitional funding, legacy funding and package expansion components, as required
- Enact the Irish (Sláinte) Health Act which will provide the legislative basis for a universal entitlement to a broad package of health and social care for everyone living in Ireland with maximum waiting times and a Cárta Sláinte through:
 - *Introducing Heads of Bill by 2017 for phased entitlement expansion to include all Irish residents by 2023, as described in Section 2 of the report*
 - *Introducing legislation by Spring 2018 for the following waiting time policies, to be implemented on a phased basis by 2023*
 - *No-one should wait more than 12 weeks for an inpatient procedure, 10 weeks for an outpatient appointment and 10 days for a diagnostic test*

- *Individual waiting lists are published by facility, by specialty*
- *Introduce a maximum wait time in EDs, working towards a four hour target*
- *Hospitals that breach guarantees are held accountable through a range of measures including sanctions on senior staff, but not to the detriment of healthcare delivery*
- Legislate for accountability – that the Minister for Health is ultimately responsible for delivering health system change and for the delivery of care to the population. Staff at all levels within the health systems are also accountable for their delivery of relevant aspects of the health service to the population through specific, known performance measure and support for the development of needed skills to promote improvement
- Legislate for national standards in clinical governance, national and local accountability structures right down to community and hospital levels, so that clinical governance covers all clinical staff including consultants

9. Implementation

- Progress on the report's implementation should begin immediately and be adequately resourced to ensure effective delivery
- The Dáil should be briefed, with a debate on the progress of the report, by the Minister of Health every four months in the first year, to gain momentum, and every six months thereafter. This will help maintain progress, continue high-level political involvement and further consolidate sustained action and support
- Set up a Programme Implementation Office under the auspices of An Taoiseach by July 2017, with the remit to oversee and enable the implementation of this report and develop a detailed implementation plan for the reform programme
- The Implementation Office should work closely with the HSE and will have representation on the management teams at both national and regional level, and will report directly to the Minister for Health
- As one of its first actions, the Implementation Office should devise a detailed implementation programme project plan for each year of the plan, identifying key milestones by December 2017 which can be monitored across sectors
- A first draft of the detailed implementation project plan should be published by the end of 2017. It will be based on the deliverables detailed in this report and will operationalise the phased implementation of the reform
- Supply the Implementation Office with appropriate financial resources (up to €10 million for its lifecycle) and relevant human resources with proven capacity in leadership, programme management, project management, content expertise and communication

- Establish the Implementation Office, with all necessary infrastructure
- Identify and recruit a senior level (equivalent to Secretary General), highly independent Lead Executive with specific experience in change management, by July 2017
- Recruit all staff by October 2017, with the majority being external recruits

10. Funding

- Establish the National Health Fund
- Funding flows into the NHF should include a mixture of general taxation and specific earmarked funds, to be decided by the Government of the day
- Guaranteed expansion of health funding by between €380-465 million per year, for expanded entitlements and capacity to delivery universal healthcare
- Implement transitional and legacy funding arrangements to a total of €3 billion over six years, to boost reinvestment into one-off system changing measures, training capacity and capital expenditure
- Earmark/ringfence funds to health care priorities, such as expanded primary and social care, palliative care, and mental health
- Ringfence savings that will arise from reduced tax-relief costs as people move from PHI to avail of improved public health provision and allocate these to expansion of entitlement and transitional funding
- Disentangle public and private health care financing in acute hospitals and remove ability of private insurance to fund private care in public hospitals

Table 1: Transitional and Legacy Funding (Years 1-6)

COMPONENT	COST (€M)
ehealth	875
Primary Centres and OOH	120
Community Diagnostics	60
Training Expansion	
– GPs	235
– Consultants	178
– Other Primary Care	252
System change	50
Renovation and Hospital Bed Capacity	1,230
	€3,000

Sources: HSE (2016, 2017)

Executive Summary

In June 2016, the Dáil established the Committee on the Future of Healthcare with the goal of achieving cross-party, political agreement on the future direction of the health service, and devising a ten year plan for reform. The agreement among all political groupings in the Oireachtas on the extent of challenges facing the health service, and on the need to set out a vision for long-term change, was reflected in the Committee's Terms of Reference. These are set out in full at Appendix 5, but key elements included the recognition of:

- *The severe pressures on the Irish health service, the unacceptable waiting times that arise for public patients, and the poor outcomes relative to cost*
- *The need for consensus at political level on the health service funding model based on population health needs*
- *The need to establish a universal single tier service where patients are treated on the basis of health need rather than on ability to pay*
- *That to maintain health and wellbeing and build a better health service, we need to examine some of the operating assumptions on which health policy and health services are based*
- *That the best health outcomes and value for money can be achieved by re-orientating the model of care towards primary and community care where the majority of people's health needs can be met locally and*
- *The Oireachtas intention to develop and adopt a 10 year plan for our health services, based on political consensus, that can deliver these changes*

This report sets out the Committee's agreed vision and strategic plan, and is the culmination of many months of evidence-based deliberation informed by a wide range of stakeholder perspectives. In it, the Committee outlines an agreed vision and strategic plan to transform the Irish health service. This report recognises that the Irish health service as it stands at the moment is not providing the population with fair or equitable medical care. Our health services do not have the bed capacity to provide timely urgent and planned care.

Recruitment and retention of staff is critical if we are to address the challenges facing our struggling health service. Governance and accountability in our health structures needs to be strengthened, enabling integrated care to develop which will create an efficient and cost effective health services which meet patients' needs in a timely manner.

Primary care and general practice is also facing a manpower crisis. As we reorient our health services towards primary and social care in our community the recruitment and retention of existing general practice and primary care professionals will be essential if our new reformed health service is to have a solid foundation.

The report emphasises the need to move decisively towards equitable access to a high quality, universal single-tier system. In preparing the report, the Committee worked closely with a team from the Trinity Centre for Health Policy and Management, led by Dr Steve Thomas, who provided expert health policy and health economics advice and guidance to support the Committee’s work.

Through its months-long public consultative process, the Committee examined evidence from hundreds of stakeholders which indicated broad support for its approach. It reviewed a considerable amount of evidence on health service reform, and held a number of workshops, facilitated by the Trinity team, to form a full picture of the critical factors needed to deliver meaningful improvements in the health service.

Eight Fundamental Principles of the Report

As one of the most important outputs of these workshops, the Committee reached early agreement on the following eight fundamental principles to frame its discussions and underpin its recommendations:

Engagement

- *Create a modern, responsive, integrated public health system, comparable to other European countries, through building long-term public and political confidence in the delivery and implementation of this plan on the basis of:*

Nature of Integrated Care

- *All care planned and provided so that the patient is paramount (ensuring appropriate care pathways and seamless transition backed-up by full patient record and information)*
- *Timely access to all health and social care according to medical need*
- *Care provided free at point of delivery, based entirely on clinical need*
- *Patients accessing care at most appropriate, cost effective service level with a strong emphasis on prevention and public health*

Enabling Environment

- *The health service workforce is appropriate, accountable, flexible, well-resourced, supported and valued*
- *Public money is only spent in the public interest, for the public good (ensuring value for money, integration, oversight, accountability and correct incentives)*
- *Accountability, effective organisational alignment and good governance are central to the organisation and functioning of the health system*

Overview of the Report

The report comprises five sections: Population Health Profile; Entitlements and Access; Integrated Care; Funding; Implementation. The Executive Summary sets out the key elements of each of these chapters and the main recommendations in each.

The Committee concluded that our healthcare system must be re-orientated to ensure equitable access to a universal single tier system, and that the vast majority of care takes place in the primary and social care settings. This shift away from the current hospital-centric model will enable our system to better respond to the challenge of chronic disease management, to provide care closer to home for patients, to deliver better value-for-money and to maintain a strong focus on health promotion and public health.

Significant and ongoing investment, in the region of €2.8bn over a ten year period, will be required in order to build up the necessary capacity, provide all residents with entitlements to primary and social care, and reduce the relatively high out-of-pocket costs experienced by Irish people. The Committee recognises the need to “Brexite-proof” any measures that relate to cross-border initiatives or services.

While this shift towards primary and community based care is an essential element in addressing the challenge of access to our hospital system, additional measures will also be needed. These will include waiting time guarantees for hospital care, expanded hospital capacity and the phased elimination of private care in public hospitals. A transitional fund of €3bn will support investment across the health system in areas such as infrastructure, e-health and expansion of training capacity.

Under the Committee’s recommendations, the HSE in future will act as a more strategic “national centre” carrying out national level functions, with regional bodies designed on the basis of optimum organisation and regional health resource allocation. The Committee also recommends that the system should continue to be funded primarily by general taxation, with some ear-marked funding, all flowing into a National Health Fund.

Population Health Profile

Demographics and Chronic Disease

The health of the Irish population has improved in recent decades. Life expectancy is high at 83.5 years for women and 79.3 years for men and is comparable to the rest of Europe. However, significant variations exist in health outcomes between social, economic, regional and age groups.

The Irish population is growing and it is also getting older. Inevitably, a larger older population creates increased demand for health and social care, especially with regard to managing chronic diseases. Managing chronic disease accounts for a growing share of finite health resources, and demands new approaches. To meet this challenge, health services must be delivered in an efficient, integrated manner at the lowest level

of complexity. Population health approaches can prevent chronic illness from developing in the first place, so prevention must be a strong focus of our health system.

Social Determinants of Health

Health inequalities can result from economic and social inequalities. The impacts of social determinants of health are evident in health outcomes in Ireland. Research shows that a number of chronic illnesses and markers of ill-health are more common among deprived sections of the population. The Inverse Care Law applies where those who need care most have least access to that care. There is clear evidence of the negative impact of low family income on the health of children, and health outcomes among older persons also vary according to social class.

The Committee supports the key aims of the *Healthy Ireland* strategy, which is targeting the broader social determinants of health, recognising that investment in population level interventions that improve health outcomes is not only fair, but also a good investment. The Committee echoes the cross-departmental approach outlined in *Healthy Ireland*, which takes population health and wellness into account in all areas of Government. However, it notes that *Healthy Ireland's* promised implementation plan and Outcomes Framework are yet to be published.

Recommendations from This Section:

- *The urgent publication of specific timelines and measurable goals and Outcomes Framework for Healthy Ireland and the adequate resourcing of the work needed to carry it out*
- *That the role of Minister of State for Health Promotion should be retained in future Governments*

Entitlement and Access

Primary Care and Hospital Care

In Ireland, there are virtually no universal entitlements to healthcare, and the 1970 Health Act only sets out eligibility for some services. The Committee is recommending that clear entitlements to universal healthcare be provided to all, underpinned by legislation. People with full eligibility (medical cards) gain access to a range of health and social care services without charge. Those with limited eligibility (the rest of the population) receive public hospital care free of charge, or subject to statutory charges. People with a GP visit card may also be eligible for free GP care, in particular children under the age of six years.

Inclusion in other schemes, such as the Long Term Illness Scheme, the Drugs Payment Scheme and the High Tech Drugs Scheme also affect whether one has to pay for services and, if so, how much. The Maternity and Infant Scheme provides maternity and infant care for the first six weeks of life, and is one of the few truly universal aspects of the current health system.

Social Care Services

The HSE funds a range of services for people with intellectual, physical and sensory disabilities. However, based on the evidence, people with disabilities face difficulties in accessing services. In regard to mental health, the Committee is of the view that community mental health services remain under-resourced, and overly reliant on medication rather than psychological and counselling services. Homecare services in the form of home help hours and home care packages are also provided through the HSE. However, in the absence of an entitlement to such services, many people also pay out of pocket for private homecare services.

Access to Health and Social Care

In Ireland, access to health and social care is not just determined by eligibility. It is also dependent on the type, volume and geographic location of services. Guaranteeing eligibility or even an entitlement to care does not ensure access, unless treatment can be provided within a reasonable timeframe.

Ireland is extremely unusual in a European context in terms of the difficulties in accessing care for many people, the full price and high cost paid by many people, and the absence of legal entitlements to care. Ireland is also unusual in that those with supplementary private health insurance or who can pay out of pocket are able to access hospital services quicker than those in the public system who do not have private health insurance.

Access to universal healthcare brings significant outcomes in terms of improving access to care, better health status and life expectancy, lowering financial hardship and improved equality; and experience from the last 10 to 15 years from several low and middle income countries shows that implementation of universal healthcare is possible.

Future Model of Care

The Committee's preferred design is a model where the vast majority of healthcare is provided in the community.

This will involve the expansion of entitlements to primary and social care services, as well as expansion of capacity within the system to deliver better access to primary care and general practice, and to public hospital care. It will also involve the phasing out of private care in public hospitals, alongside the removal or reduction of out-of-pocket payments from households.

In regard to expansion of capacity, the Committee recommends:

- *Expansion of health and wellbeing and other measures central to providing integrated care*
- *Adequate resourcing of child health and wellbeing services*
- *Reduction and removal of charges*
- *Expansion of primary care, social care, mental healthcare, dentistry, and public hospital activity*
- *Expansion of public hospital activity, including through removal of private care from public hospitals*

Cárta Sláinte

The Committee proposes the introduction of a health card scheme, the Cárta Sláinte, which will entitle all residents to access a comprehensive range of services based on need. This will be legislated for, and implemented over a five year period. The range of services covered is detailed in Section 2.

Timely Access to Public Hospital Care and Elimination of Private Care from Public Hospitals

Providing timely access to public hospital care will be achieved by a series of measures including:

- *The expansion of public hospital care, and specific waiting time guarantees re-orientating the system so that the vast majority of care is delivered and accessible in primary and social care settings, and addressing under-staffing across the health system*

The Committee also proposes the phased elimination of private care from public hospitals, leading to an expansion of the public system's ability to provide public care. Holders of private health insurance will still be able to purchase care from private healthcare providers.

The Committee acknowledges that removing private care from public hospitals will be complex. It therefore proposes an independent impact analysis of the separation of private practice from the public system with a view to identifying any adverse and unintended consequences that may arise for the public system in the separation. Given the acknowledged need to increase capacity in the public system, it is important that any change should not have an adverse impact on the recruitment and retention of consultants and other health professionals in public hospitals.

Costs and Phasing

The estimated costs associated with the expansion of entitlements, and associated capacity, are in the region of an additional €2.8bn over a ten year period, over and above other likely cost increases such as demographic pressures and medical inflation. The Committee proposes a phased approach, expanding entitlements over a ten year period.

However, it is important to note that expanding entitlement, without the capacity to respond on the supply-side, will most likely mean rationing and continued waiting lists. This also applies to extending eligibility to universal GP care where existing capacity is exhausted. The Committee strongly believes that capacity must be addressed, while progressing the re-orientation of the system towards primary and social care.

Main Recommendations from This Section:

- *Design care pathways in such a way as to guarantee timely access to quality of care*
- *Expand health and wellbeing and other measures central to providing integrated care, and double the health and wellbeing budget*
- *Adequately resource child health and wellbeing services, including implementation of the National Maternity Strategy*
- *Reduce and remove hospital inpatient charges, reduce prescription charges and drugs payment scheme threshold*
- *Primary care expansion, including investment in community diagnostics, free GP care and fully staffed primary care teams to include counselling and other community based services*
- *Social care expansion, including investment in palliative care services, homecare services and community services for persons with disabilities*
- *Mental health care expansion and investment in primary care counselling and staffing of mental health teams*
- *Dentistry expansion including reinstatement of previous public dental schemes*
- *Public hospital activity expansion, undoing two tier access to public hospital care, including increased access to diagnostics in the community, reduced waiting lists for first outpatient department (OPD) appointment and hospital treatment, and expanding public hospital capacity by removing private care from public hospitals*
- *Legislate for an entitlement to care, and resource and implement the Cárta Sláinte*

Integrated Care

Towards a New Model of Integrated Care

The Committee believes that its proposed new model of coordinated health and social care is needed to meet the needs of our older population, with its more complex set of clinical and social care needs, and to address the growing prevalence of chronic disease. A national health service for the 21st century needs to deliver the ‘triple aim’ of health systems by improving care, improving health and reducing costs. An integrated care system puts the person at the centre of system design and delivery, and is well-organised and coordinated to manage costs.

The Committee uses the WHO health building blocks framework to set out the core elements of the integrated and well-functioning health system that this plan will deliver. Based on the international body of research, the Committee defines Integrated Care as the following:

‘Healthcare delivered at the lowest appropriate level of complexity through a health service that is well organised and managed to enable comprehensive care pathways that patients can easily access and service providers can easily deliver. This is a service in which communication and information support positive decision-making, governance and accountability; where patients’ needs come first in driving safety, quality and the coordination of care.’

The Committee’s preferred model of care is for everyone in Ireland to access public health, health promotion, diagnostics, treatment and care when needed in the appropriate setting, as close to home as possible, with a reasonable period of time, with little if any charge at the point of access.

Six Critical Changes

In order to promote the delivery of efficient, effective and integrated care, there are some critical changes that need to happen. These are:

- *A strong, government wide commitment to promoting health, reducing health status inequalities and supporting good health throughout the life course*
- *Care should be delivered at the lowest level of complexity as is safe, efficient and good for patients*
- *The significant expansion of diagnostic services outside of hospitals. This is to enable timely access for GPs and other referring clinicians to diagnostic tests which do not necessarily need to be provided in hospitals*
- *The disentanglement of public and private care and the phased elimination of private care from public hospitals. This will require a range of measures including, addressing the replacement of private income currently received by public hospitals, and careful workforce planning and strategies to recruit and retain staff. As noted above, the Committee recommends an independent impact analysis of the separation of private practice from the public system with a view to identifying any adverse and unintended consequences that may arise for the public system in the separation*
- *Addressing long waiting times, poor conditions and delayed access to essential diagnosis and treatment as common features of the Irish public’s experience of Emergency Departments (EDs). This requires a system-wide response, including investment in non-hospital services as well as hospitals*
- *Addressing long waiting list for access to elective care. The Committee believes that these are one of the major deficiencies of the current Irish healthcare system. An integrated and system-wide approach is needed to tackle this. Investment in capacity should be informed by the Capacity Review currently ongoing. However, supply-side policies alone will not be enough. International experience is definitive that without enforced waiting time guarantees, waiting lists and waiting times will not come down*

Modelling Integrated Care Using the WHO System Building Blocks

Health Workforce

In order to provide an expanded package of entitlements, and develop a single tier system, the right workforce needs to be in place with appropriate management and support. Integrated workforce planning capacity must be developed. However, this on its own is not sufficient; the health workforce is an international market with professionals migrating in search of better terms and conditions and prospects and the Irish health service must become an employer of choice. The Committee received extensive evidence from demotivated staff, many of whom are considering migration or have already migrated. As the economy recovers and prospects for renewed pay deals emerge, the issue of pay should be addressed. However, it is also essential that issues that were the cause of demotivation are understood and dealt with.

The current GP contract negotiations can facilitate new ways of working so that GPs are incentivised to carry out health promotion/public health work, disease prevention, delivery of integrated care and management of chronic diseases including mental health and multi-morbidities.

Leadership and Governance Structures

Good leadership and governance are critical functions of any health system. The Committee strongly believes there is a requirement for clearer clinical and managerial accountability and governance throughout the system. This includes clarity at all levels, from the Minister for Health, the Department of Health, the HSE and healthcare providers. The Committee proposes that the HSE be reformed into a more strategic national centre, with an independent board and fewer directorates.

Recognising international evidence on the negative impact of system re-organisation or merger, the Committee believes structural change should be as simple as possible, and only what is needed to meet the requirements of integrated care. The HSE strategic national centre will be supported by regional care delivery through regional bodies, recognising the value of geographical alignment for population-based resource allocation and governance to enable integrated care.

Patient Safety and Clinical Governance

Patient safety is fundamental to the delivery of quality healthcare. The public must have confidence in the safety of our health services. Strong governance structures, clarity on reporting relationships and senior clinical leadership are among the key factors required to ensure this happens. Clinical governance is a component of the total governance of health systems but, in Ireland, it lacks legislative underpinning. The Committee recommends that clinical governance frameworks be developed further and that appropriate legislation be developed.

Integrated Care Funding Mechanisms

There is a strong case for pooled budgets across primary and social care to support integrated care. A resource allocation model is required that allows for equity of access to health services across different geographic areas, taking into account population need, demographics, deprivation and other measures. Ideally, it should relate funding to all aspects of care within a specific area.

Medicines and Medical Technologies

Major challenges will arise in future years in relation to high-tech drugs, orphan drugs and novel treatment regimes. Examination of international strategies and models in medicines management, utilisation of opportunities for joint negotiation, including through our membership of the single market, and appropriate oversight and audit of prescribing and dispensing patterns are all key elements of addressing this challenge. Beyond medicines, appropriate application of HTA can be used to rectify inconsistencies in the current system, where some new, expensive and only modestly effective treatments are funded while some existing services that offer good value for money are subject to long waiting lists.

eHealth

eHealth has the potential to support safer, more efficient, high quality integrated healthcare systems. The HSE and Department of Health have launched an eHealth strategy with plans to roll out a unique health identifier system by 2018. The Committee recommends continued strong support of this strategy, particularly ensuring the necessary funding for timely roll-out of the EHR system.

Information and Research

The Committee recognises that the health system has a wealth of data within individual organisations and branches of the system. A common unit of geography for data collection and integration will increase capacity for cross-organisational research. The Committee also recommends the continued funding and development of integrated management systems for financial control and workforce planning.

Main Recommendations from This Section:

Population Health

- *Strengthen mechanisms for the full implementation of Healthy Ireland including leadership from the Taoiseach, government wide and health system implementation, taking population health and wellness into account in all workings of the government, possibly through Health Impact Assessment, and the prompt development and publication of an Outcomes Framework for Healthy Ireland*

Primary and Social Care

- *Use all available mechanisms and processes to ensure healthcare is delivered at the lowest level of complexity as is safe, efficient and good for the patients. This includes priority resourcing of primary and social care*
- *Ensure significant expansion of diagnostic services outside of hospitals to enable timely access for GPs to diagnostic tests. Primary care centres should be the hub of community diagnostic services so that all patients can access diagnostics in these centres*

Acute Hospital Care, and Public-Private Disentanglement

- *Provide public funding to replace the approximately €649 million income expected from private care in public hospitals, the funding to be phased in as private care is phased out over five years*
- *The provision of private care by consultants in public hospitals will be eliminated over five years. This will mean that all patients will be treated on the same public basis in public hospitals, ensuring equity of access for all based on need rather than ability to pay*
- *An independent impact analysis should be carried out of the separation of private practice from the public hospital system, with a view to identifying any adverse and unintended consequences that may arise for the public system in the separation*
- *Careful workforce planning to meet current and future staffing needs, and measures to ensure that public hospitals (as well as all service provision units and centres) are/become an attractive place to work for experienced, high quality staff*
- *Sufficient numbers of consultants and other health professionals to meet population need*
- *Current unacceptable waiting times for public hospital care in emergency departments, outpatient clinics (OPD) and planned daycase and inpatient treatment must be reduced so that timely access is provided, based on need and not ability to pay*
- *Enable a system wide response to ED wait times so that integrated, patient-centred care is provided by enhanced primary and social care services*
- *Investment in hospital infrastructure and staffing in order to enhance capacity. The outcome of the Capacity Review currently underway should inform the detailed planning for the infrastructural investment provided for in the proposed Transitional Fund, as well as for the staffing required*
- *No-one should wait more than 12 weeks for an inpatient procedure, 10 weeks for an outpatient appointment and ten days for a diagnostic test. Hospitals that breach guarantees are held accountable, through a range of effective measures including, ultimately, sanctions on senior staff, but not to the detriment of healthcare delivery*

Health Workforce

- *That the HSE and the Department of Health must develop their integrated workforce planning capacity so as to guarantee sufficient numbers of well-trained and well motivated staff deployed in a targeted way to deliver care in the most appropriate care setting and that the Irish health system becomes a place where people feel valued and want to work. This will mean re-training of existing staff in many cases to ensure capabilities for integrated care*
- *That staff recruitment should take place at regional level, or at a more local level if practicable, and in conjunction with local clinical manager*
- *That recruitment of hospital consultants and NCHDs should be to Hospital Groups rather than to individual hospitals, as part of meeting the medical staffing needs of smaller hospitals*

Leadership and Governance Structures

- *That the Minister for Health is held responsible and accountable on a legislative basis for the delivery of healthcare, the health system and health reform*
- *The HSE Directorate should become a more strategic ‘national centre’ with a reduced number of national directors reporting to the Director General*
- *The National Directors will be relocated into other roles strengthening the functions required for the new mode of integrated care, for example relating to building strengthened leadership capacity in the community for primary and social care*
- *Greater alignment of service provision for integrated care across care domains should be implemented at Community Healthcare Networks (CHN) level. This will include further mapping analysis and use of funding, information sharing and eHealth mechanisms*
- *The geographic alignment of Hospital Groups and Community Health Organisations will help to support population-based health planning and delivery. Further analysis and consultation should be undertaken to identify how alignment can best be achieved with minimal disruption to key structures including at Community Healthcare Networks (CHN) level*
- *A move towards a form of regional health resource allocation with accompanying governance structures to formally connect Hospital Groups and Community Health Organisations for the provision of integrated care, using CHOs and CHNs as the core unit of health service coordination and provision*
- *The establishment of regional bodies that will be accountable for implementing integrated care at sub-national level by strengthening the local care provision system, ensuring service coordination between the different care domains, community network building and resource allocation for integrated or shared services*
- *Integrated care, such as the Carlow-Kilkenny Integration Model (CKIM) which established the Local Integrated Care Committee (LICC) structures in the Ireland East Hospital Group, should be supported and developed*

- *An independent board and Chair should be appointed to the HSE at the earliest opportunity, by the Minister, following a selection process through the Public Appointments Service. Board membership should reflect the skills required to provide oversight and governance to the largest public services in the State. The Chair of the Health Service Board will be accountable to the Minister. The Health Service Director General will be accountable to the Board*
- *A blueprint for clinical governance across the health system should be put in place in a timely and optimal manner. This should be underpinned by legislation which specifies the structures, processes and responsibilities of boards, management and clinicians for the operationalisation of clinical governance within all organisations*

Funding Mechanisms

- *Development and utilisation of a Geographic Resource Allocation Formula to ensure the equitable allocation of resources based on both population characteristics and activity level*

Medicines and Medical Technology

- *Examination of strategies and models in use internationally to identify best practice in medicines management, including evaluation, procurement and usage*
- *International collaboration and active cooperation with other EU member states, to share information and utilise all opportunities for joint negotiation in particular through our membership of the European single market*
- *A population health approach to Health Technology Assessment (HTA) to aid evidence-based decision making for funding medical technology use in the public system*

eHealth

- *Continued strong support of the e-health strategy – particularly ensuring the necessary funding for timely roll-out of the EHR system*

New Funding Model

A key cause of Ireland's relatively high spending may well be its emphasis on an expensive model of healthcare delivery. Currently, the Irish healthcare system is funded primarily through general taxation (69%), although private health insurance (12.7%) and out of pocket payments (15.4%) are also significant sources of funding. Ireland spends a higher percentage of GDP and GNP on healthcare than the OECD average. Moving to a better model of service delivery should prove more efficient and eventually cheaper, although investment is needed to implement reform.

Appraisal of Funding Models

The Committee has appraised various funding model options for moving to a universal single-tier system, and considered a number of options when looking at what the position of private health insurance would be in a universal, single tier system. It recommends a model where private insurance will no longer confer faster access to healthcare in the public sector, but is limited to covering private care in private hospitals.

Expansion of Funding

Any expansion in entitlements will have to be matched by increased funding. At the same time, funding must increase to match already growing health needs. Expansion of the general government health budget in the last two years has been at a rate of 7% per year. The Committee recommends that this expansion should continue at a minimum over the next five years, to support the necessary investment of in the region of €2.8bn over 10 years. In addition, in order to implement system change, there is a need for once-off transitional funding estimated at €3bn. The funding will be for capital projects, new structures, new equipment, additional staff training capacity and new services. It also includes the necessary funding for implementation of the eHealth strategy. The Committee has worked closely with the Centre for Health Policy in Trinity College Dublin, which provided indicative costings for the Committee’s consideration. Further work will be carried out in relation to costing as part of the implementation process. The Committee believes that the additional investment in our health system is needed now to ensure that it is sustainable in the long-term. Better value for money will be achieved by:

- *Ensuring that care is delivered at the lowest level of complexity that is clinically appropriate*
- *That most care is delivered in primary and community settings*
- *That the necessary priority is given to health promotion and preventive care and that there is a strong focus on medicines management*
- *The proposed resource allocation funding model, implementation of the e-health strategy, continued development of integrated management systems and more effective use of data, which will all support improved efficiency*

Protection of Health Funding

Healthcare funding is vulnerable to cuts during tighter fiscal times. Developing multi-annual budget cycles will help preserve funding stability and increase predictability for managers and providers. A second critical step is to consider some form of protection or earmarking of health budgets either in their entirety or for certain priority activities.

The Committee Proposes That:

- *The single-tier system will be funded through a combination of general taxation revenues and earmarking of some taxes, levies or charges into a single National Health Fund. This will help build more transparency, sustainability and independence into health funding*
- *A single fund, rather than many purchasing mechanisms, will better incentivise integration of services and accountability as outlined in the Integrated Care section. As the system moves towards the single-tier model, it will become less reliant on out of pocket payments and private health insurance*

Main Recommendations from This Section:

- *Establishment of the National Health Fund (NHF)*
- *Guaranteed expansion of health funding by €380-465 million per year, in years one to six, and at lower levels thereafter, for expanded entitlements and funding of additional capacity to deliver universal healthcare*
- *Implement transitional and legacy funding arrangements to a total of €3 billion over 6 years, to boost reinvestment into one-off system changing measures, training capacity and capital expenditure*
- *Earmark/ringfence funds to health care priorities, such as expanded primary and social care, palliative care, and mental health*
- *Ringfence savings that will arise from reduced tax-relief costs as people move from private health insurance to avail of improved public health provision and allocate these to expansion of entitlement and transitional funding*
- *Disentangle public and private health care financing in acute hospitals. Remove ability of private insurance to fund private care in public hospitals*

Implementation

One of the strongest concerns of the Oireachtas Committee on the Future of Healthcare is to ensure that this is not just another report on the health sector which is not implemented. This Report is the product of extensive cross-party collaboration and dialogue. This high level of political support for the reform programme must be carried over into implementation of these recommendations so that the momentum built to solve the chronic problems of the Irish health system can be sustained. The Committee recommends the establishment of an Implementation Office under the auspices of An Taoiseach, reporting directly to the Minister for Health, to oversee and enable the implementation of these recommendations, and to develop a detailed implementation plan for the reform programme. It is important that the Implementation Office be established as soon as possible, with the required staff and resources.

Ongoing and effective monitoring and evaluation is a prerequisite for ensuring successful reform. A Cabinet Sub-Committee should be established with a remit to oversee the programme and review implementation of the plan. Several important areas of legislation are associated with the programme, including the swift introduction of legislation for phased entitlements expansion and for waiting time guarantees.

Main Recommendations from This Section:

- *That progress on the report's implementation begins immediately and is adequately resourced to ensure effective delivery*
- *That the Dáil is briefed, and there is a debate on the progress of the report, by the Minister of Health every four months in the first year, to gain momentum, and every six months thereafter. This will help maintain progress, continue high-level political involvement and further consolidate sustained action and support*
- *Setting up of a Programme Implementation Office under the auspices of An Taoiseach by July 2017, with the remit to oversee and enable the implementation of this plan and develop a detailed implementation plan for the reform programme*
- *The Implementation Office will work closely with the HSE and will have representation on the management teams at both national and regional level, and will report directly to the Minister for Health*
- *As one of its first actions, the Implementation Office is to devise a detailed implementation programme project plan for each year of the plan, identifying key milestones by December 2017 which can be monitored across sectors*
- *That a first draft of the detailed implementation project plan is published by the end of 2017. It will be based on the deliverables detailed in this report and will operationalise the phased implementation of the reform*
- *The Implementation Office should be supplied with appropriate financial resources (up to €10 million for its lifecycle) and relevant human resources with proven capacity in leadership, programme management, project management, content expertise and communication*
- *Establishment of the Implementation Office, with all necessary infrastructure*
- *Identification and recruitment of a senior level (equivalent to Secretary General), highly independent Lead Executive with specific experience in change management by July 2017*
- *Recruitment of all staff by October 2017, with the majority being external recruits*

Section One: Population Health Profile

In this report, the Oireachtas Committee on the Future of Healthcare outlines a vision and a plan for re-orienting the health service towards a high quality integrated system providing care on the basis of need and not ability to pay. Through its months-long consultative process, the Committee has heard from hundreds of stakeholders and health policy researchers, forming a full picture of the diverse, complex factors that influence the health of individuals and groups.

A number of these factors are directly related to the health service and the provision of healthcare, but many are not. While the following sections explore the specific health system reform policies that the Committee recommends, this section examines those factors which underpin population health and set the stage for good and ill health. A clear understanding of the determinants of health must inform all health system planning and reform.

This section is based on international evidence, submissions made to the Committee, and past and current Irish policy and research. It begins by examining the current demographics and health status of the Irish population. It then explores the social determinants of health and the ways in which they affect health outcomes. Finally it discusses the various interventions that can be made in response, both at public health and health service levels.

It is important to note this is not a detailed needs assessment of the Irish population now or in the future. Such work is currently commissioned by the Department of Health. These findings are expected later in 2017 and combined with Census 2016 analyses should inform the detailed Implementation Plan to follow this report.

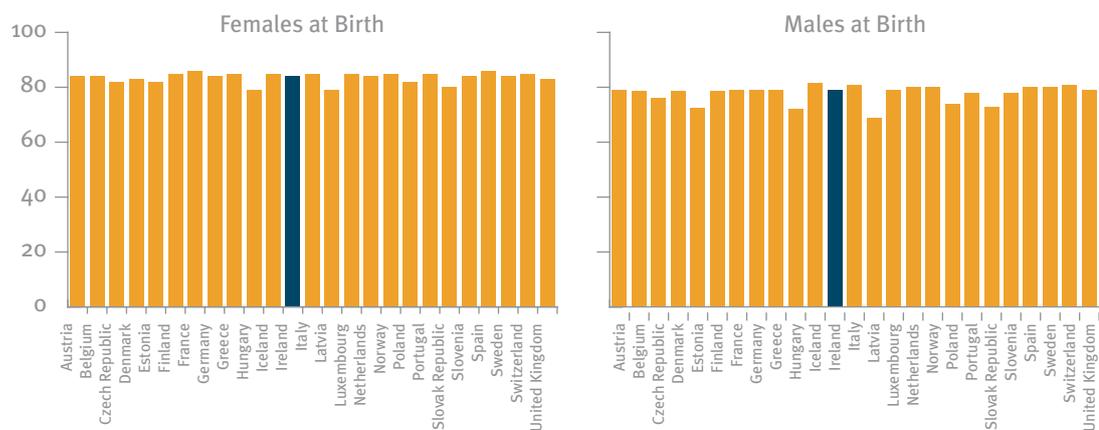
The Committee's Terms of Reference specify that it shall:

- *Recognise the need for consensus at political level on the health service funding model based on population health needs*
- *Examine existing and forecast demand on health services, including the changing demographics in the Irish population*

1.1 The Health of the Irish Population

In the last few decades, the health of the Irish population has improved. Life expectancy at birth in Ireland is high at 83.5 years for women and 79.3 years for men. Between 2004 and 2014, life expectancy for women in Ireland increased from 81.1 years to 83.5 and for men from 76.1 years to 79.3. As Chart 1 shows, Ireland's current life expectancy is comparable to the rest of Europe.

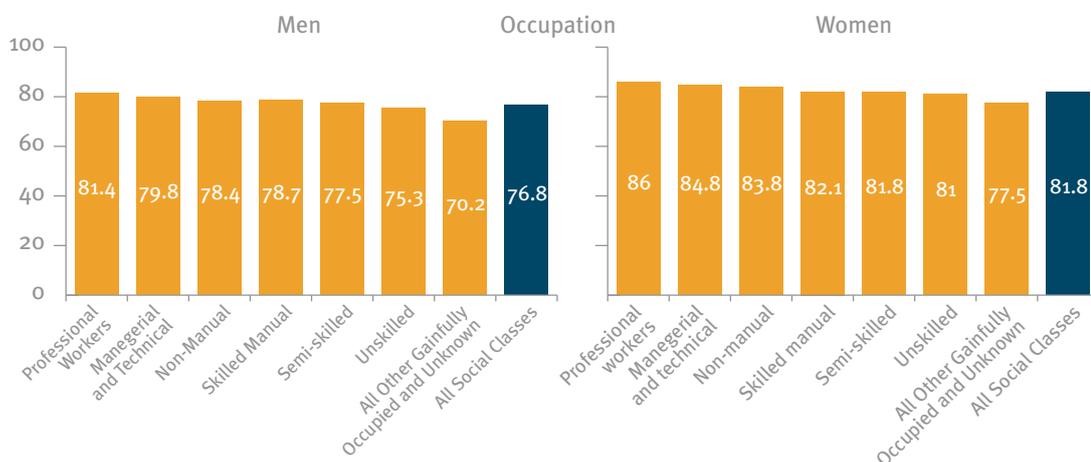
Figure 1: Life Expectancy at Birth in European Countries 2014



Source: OECD

Similarly, circulatory system disease mortality rates decreased by 28% between 2006 and 2015 while, over the same period, cancer death rates fell by 13% and infant mortality rates fell by 19%. Irish residents also record consistently high rates of self-evaluated good health. However, while these figures reflect the general trends in the population as a whole, significant variations exist in health outcomes between social, economic, regional and age groups.¹ For example, as is evident in Chart 2, life expectancy in Ireland is lower for people with low income.

¹ Health in Ireland – Key Trends 2016

Figure 2: Life expectancy at Birth in Ireland by Gender and Social Class, 2006/2007

Source: CSO

1.2 Demographics

The Irish population is continuing to grow. As of the last census in 2016, the size of the population is 4.76 million people. This represents an increase of 176,613 people since 2011 at a growth rate of 3.8%. For the previous decade, the population growth rate had been just over 8%.²

Within the total population growth, there has been an even larger growth among persons over the age of 60. This population group made up 15.3% of the total population in 2006 and that percentage went up to 18.4% in 2016. In absolute terms, that represents a growth of 210,000 additional people aged 60+ between 2006 and 2016. The 60+ population in Ireland now stands at 860,000 and is projected to keep growing by 28,500 people per year to 1.15 million, or 23% of the total population, by 2026. Additionally, the group of individuals over the age of 80 has increased by more than 20,000 between 2006 and 2016 and is projected to grow by another 36,000 by 2026, to a total of 104,000.³

The majority (75%) of older persons in Ireland rate their health as good or very good or excellent, and are active participants in the lives of their families and communities⁴. However, inevitably, a larger older population creates increased demand on the health service, particularly in respect of the health and social care needs of the frail elderly and with regard to managing chronic illnesses⁵. Chronic illnesses are more prevalent as people age. Sixty-five percent of those over 65 and four out of five of those over 85 have two or more chronic conditions. Estimates predict that the

² CSO, 2017. *Survey on Income and Living Conditions 2015*

³ HSE, *Planning for Health. Trends and Priorities to inform Health Service Planning 2017*

⁴ Department of Health, *Positive Aging 2016; TILDA, 2017*

⁵ *Better Health, Improving Health Care, Department of Health*

prevalence of chronic illness will grow by 29% by 2020. Chronic disease management has an increasingly challenging impact on the health system and on healthcare spending.⁶ The treatment and management of chronic illnesses account for a large share of health resources, including:

- 80% of all GP visits
- 40% of hospital admissions
- 75% of hospital bed days

The growing population with chronic illness demands new approaches. Managing complex health needs has consequences not only on the health and wellbeing of individual patients but also on the health system as a whole – health services must be delivered in an efficient, integrated manner at the lowest level of complexity to meet this challenge.

Research shows that addressing a subset of chronic illnesses, including congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension, through clinical leadership in primary care settings, results in better outcomes and more appropriate care than if provided in hospital.

When these conditions are effectively managed by primary care teams and patients themselves are empowered, exacerbations or hospitalisations can be minimised. The impact for patients is better health when chronic conditions do not deteriorate and for health systems the cost savings are significant.⁷ Additionally, population health approaches can prevent chronic illness from developing in the first place – prevention must therefore be a strong focus of the health system.

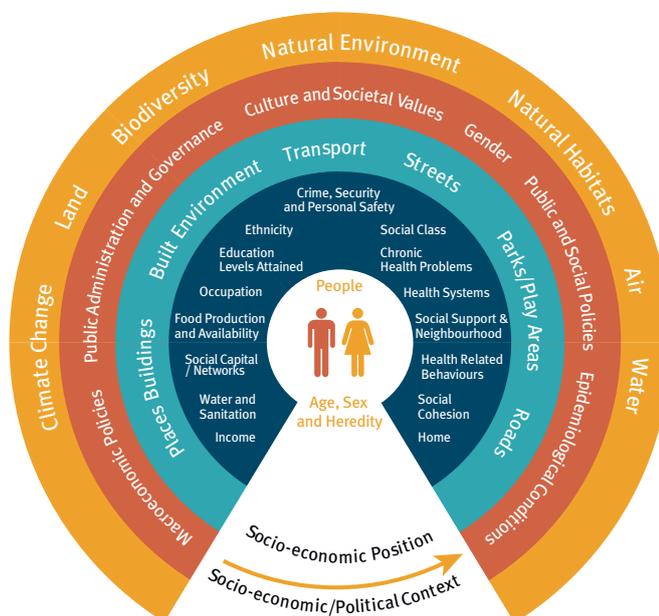
1.3 Social Determinants of Health

A healthy and long life is the result of many complex factors which affect different people to different extents. Some, like our biology and genetic material, are relatively fixed while others might change quite a lot over the course of a life. These factors, often referred to as the social determinants of health, include inequality, income, education, social position and inclusion/exclusion, employment, stress, built environment, housing, transportation, public policies, health behaviours and more. International and global factors, like climate change, refugee and immigrant movements, also impact on the conditions for healthy living. Viewing health at a population level, these factors can set the stage for either good or ill health.⁸ Chart 3 below, shows a graphic representation of the determinants of health and their complex interplay.

6 Planning for Health. Trends and Priorities to inform Health Service Planning 2017; HSE, *Primary Care Reimbursement Service (PCRS) Statistical Analysis of Claims and Payments 2015* Health Service Executive National Service Plan 2016

7 *King's Fund*, 2015

8 Farrell, C., McAvoy, H., Wilde, J. and Combat Poverty Agency (2008) *Tackling Health Inequalities – An All-Ireland Approach to Social Determinants*. Dublin: Combat Poverty Agency/Institute of Public Health in Ireland

Figure 3: Determinants of Health Source: Health Ireland Framework (Department of Health (2013))

Source: Adapted from Dalghren and Whitehead, 1991 and Grant and Barton, 2006)

Some important facts about social determinants of health include⁹:

- They often contribute to health inequalities between different social groups, because they are not distributed evenly across society (the poor face more health inequalities)
- They influence health both directly and indirectly. For example, a lack of education can limit access to adequate employment or damp housing can contribute to respiratory illnesses
- They are interconnected – poverty is linked to poor diet, housing, access to health services and much more
- They operate on different levels – some are expressed in the direct conditions of everyday life such as smoking and alcohol habits while structural issues, such as government policies operate on a wider scale.¹⁰

Health inequalities can result from economic and social inequalities. In this context it is important to note that poverty is a growing problem in Ireland, and the austerity period only exacerbated it. The percentage of Irish residents at risk of falling into poverty went from 14.4% in 2008 to 16.9% in 2015 while the consistent poverty rate went from 4.2% in 2008 to 8.7% in 2015. Despite a target set in 2014 to halve child poverty by 2020 to 70,000, in 2016, the number of children living in consistent poverty in Ireland was 132,000.¹¹

9 Healthy Ireland

10 Farrell, C., McAvoy, H., Wilde, J. and Combat Poverty Agency (2008) *Tackling Health Inequalities – An All-Ireland Approach to Social Determinants*. Dublin: Combat Poverty Agency/Institute of Public Health in Ireland

11 CSO, 2017; p. 17; Barnardos, 2016

The out-of-pocket cost barriers for many health services in Ireland also likely suppress some of the health need that actually exists, especially in primary care. Individuals who cannot afford to pay to see the GP may forego care and may either endure illness without treatment or seek care at a higher level of complexity such as the Emergency Department at a later, more serious stage of illness. Therefore, the current volume of care is not an adequate gauge for the true demand. The rise in demand for GP services after the introduction of the under-6s GP visit card in 2015 bear this out. The phased extension of entitlement to free GP care to the entire population will lead to higher visitation rates. There will need to be a corresponding phased increase in capacity of general practice to deliver this care. A new GP contract and salaried GPs will facilitate this.

Also, it is clear that, from both a societal and individual perspective, the fragmented Irish healthcare system has many direct and indirect costs, both human and financial.

There is a cost to individuals who lose the ability to participate in specific activities, might lose income or might even lose years of life due to untreated or inadequately treated illness.

For society, these factors matter too – when residents of a country are healthy, they are more productive and are able to participate in employment and in the economy. On aggregate, low income individuals utilise higher quantities and higher cost healthcare services, contributing disproportionately to a societal budget that must be dedicated to healthcare. Social inequality cost the NHS in England £4.8 billion during 2011-2012 as a result of excess hospital admissions. Up-front investment in health promotion and primary care is a wise investment which promotes better outcomes and higher quality of life but also will result in lower total healthcare spending.¹²

In response, a key recommendation of this report is that every Irish resident gets access to the healthcare they need regardless of ability to pay and gets protection from impoverishment resulting from health needs. Additionally, the Committee suggests that further work be carried out to ensure that government policies work to address the social determinants of health.

These include the use of Health Impact Assessments and preventative care and health promotion, and better integration of and coordination between every aspect of the health service and all other relevant sectors, including finance, social protection, education, transportation, housing, agriculture, urban planning and more.

¹² Asaria, M, Foran, T, Cookson, R, 2016

Across Europe and the world, there is a growing recognition of the effects of health inequality. Both the EU and the WHO have consistently found persistent and significant inequities in avoidable health risks and premature deaths between and within European countries. A recent WHO report notes the need for joint action and governance structures to guide the work of the complex set of stakeholders and sectors that all play a role in counter-balancing the social determinants of health.¹³

1.4 The Impact of the Social Determinants of Health

The impacts of social determinants of health are evident in health outcomes in Ireland. As Chart 3 above clearly showed, social class has a direct bearing on life expectancy. A number of chronic illnesses and markers of ill-health are more common among deprived sections of the population, including:

- *Diabetes*
- *Coronary heart disease*
- *High cholesterol*
- *High blood pressure*
- *Depression*
- *Admissions to psychiatric hospital (Department of Health, 2013)*

While most chronic illnesses carry some degree of burden on their own, research has shown that in individuals with multiple chronic illnesses, the burden of each is amplified by the other. This interaction and amplification adds to the complexity of the experience as well as the treatment.¹⁴ People with chronic illnesses also have much higher rates of anxiety and depression than the rest of the population. Such mental illness increases the burden of physical illness, its impairment and its costs.¹⁵

Looking at health using a life cycle approach is helpful in order to identify sensitive points when biological and social factors have the most impact on the health trajectory. Critical periods of development, including gestation, childhood, and adolescence, are key stages when social and cognitive skills, attitudes, coping strategies, habits, and values are more easily attained than at other times. The degree to which an individual successfully attains these skills influences their health later in life.¹⁶

¹³ http://ec.europa.eu/health/sites/health/files/socialdeterminants/docs/healthinequalitiesineu_2013_en.pdf WHO, 2014

¹⁴ Tsai, A, Mendenhall, E, Trostle, J, Kawachi, I, 2017

¹⁵ WHO, 2010

¹⁶ WHO, 2000

For example, there is clear evidence of the negative impact of living in a low income family on the health of Irish children. The Growing Up in Ireland survey has found that based on social class, differences in health emerge early and widen over the life-span. Differences in health between social groups are not evident at birth or nine months of age, but do emerge by three years of age. The survey found that three-year-olds from the least advantaged social class backgrounds are more likely to have behavioural problems, have a chronic illness, to experience limitations in daily activities, and to have worse respiratory health.¹⁷

For older children, ages 11-17, being from a more affluent family is correlated with rating one's own health as good, having higher life satisfaction and self-confidence, being more engaged with hobbies, doing more sports and belonging to clubs, having higher fruit and vegetable consumption, eating breakfast regularly and being less likely to be the victim of bullying.¹⁸

Similarly, health outcomes and health behaviours among older persons vary according to social class. Older persons from deprived areas are less likely to be physically active, and more likely to have a higher body mass index and to be a smoker than those from the least deprived areas.¹⁹

1.5 Responding to the Social Determinants of Health

In Section 2, the Committee outlines the entitlement expansion which will, in line with its Terms of Reference, “*establish a universal single tier service where patients are treated on the basis of health need rather than on ability to pay.*” Such a development will provide a positive impact on the effects of the social determinants of health. However, addressing the determinants of poor health must also place a special focus on factors beyond the health service. Research shows that “the most effective actions to achieve greater health equity at a societal level are actions that create or reassert societal cohesion and mutual responsibility”.²⁰

In 2008, an Institute of Public Health in Ireland report outlined the need for intervention beyond the individual level: “*Individuals can make choices in everyday life that improve and protect their health. But their health is also influenced by external factors beyond their control. In order to address these external factors and create social conditions conducive to health, Governments need to champion public health and health equity. They need to collaborate right across departments and public bodies. They also need to work with other sectors such as the community and voluntary sector, service users, commercial interests, employers and trade unions.*”²¹

17 Growing Up in Ireland, 2013

18 [http://www.nuigalway.ie/media/healthpromotionresearchcentre/hbscdocs/nationalreports/HBSC2014-edit-\(LW\).pdf](http://www.nuigalway.ie/media/healthpromotionresearchcentre/hbscdocs/nationalreports/HBSC2014-edit-(LW).pdf)

19 <http://www.cardi.ie/sites/default/files/Inequalities%20health%20behaviours%20FINAL%20web.pdf>

20 Marmot et al, 2012

21 Farrell, C., McAvoy, H., Wilde, J. and Combat Poverty Agency (2008) <http://www.publichealth.ie/files/file/Tackling%20health%20inequalities.pdf>, p. 19

Similarly, the WHO, in their 2014 Health in All Policies statement, called on governments to carry out all public policy work with population health and health equity in mind: *“The health of the people is not only a health sector responsibility. Tackling this requires political will to engage the whole of government in health.”*²²

An understanding of the diverse factors that influence health is evident in Ireland’s public health strategy, Healthy Ireland. A core goal is to reduce health inequalities based on the recognition that health and wellbeing are not evenly distributed across socioeconomic groups. Healthy Ireland recognises that risk factors for chronic diseases are more common among groups living in deprived areas or those who belong to lower socioeconomic groups. Inequalities also exist across the rural/urban divide, and between people of different genders, ethnic groups, ages and abilities.²³

“The AHCE strongly believe that through focused investment greater efficiencies can be gained within the healthcare sector. Investing in effective public health measures and awareness campaigns will improve the general health of the population and place less demands on services into the future.” (Association of Hospital Chief Executives)

The Healthy Ireland strategy therefore is targeting wider social determinants of Health. Healthy Ireland acknowledges that “all Government Departments and all sectors of society must be working together to influence and improve the various determinants of health”. It also suggests that “effective health and wellbeing improvement calls for new ways of working and requires a mandate and formal commitment from central Government.”²⁴

According to Healthy Ireland, investing in population level interventions that enable health is not only a fair action but also a good investment. The aim of a fair distribution of health and wellbeing resonates with sustainable development, tackling poverty, building strong communities, and raising education levels. The international evidence around the social determinants of health (SDH) is well documented and includes a review undertaken to provide updated evidence for Health 2020.

The review argues the moral case for action and points out that while prevention is a ‘good buy’, it also leads to other benefits for society, which might, in turn, have more immediate economic benefits.²⁵ The RCPI also emphasises the need to promote self-management and health prevention: *“A sustainable healthcare system will not be possible unless prevention and self-management is prioritised, resourced and rewarded.”* (Royal College of Physicians of Ireland (RCPI submission to Committee)

22 WHO, 2014 http://apps.who.int/iris/bitstream/10665/112636/1/9789241506908_eng.pdf, p. 1

23 Healthy Ireland A Framework for improved Health and Wellbeing 2013 – 2025

24 *ibid*

25 *ibid*

The Committee echoes the approach outlined in Healthy Ireland, with leadership from the Taoiseach and across cabinet, taking population health and wellness into account in all workings of the government. However, Healthy Ireland has yet to realise its full potential. For example, upon publication it committed to ‘a high level implementation plan and an Outcomes Framework... later in 2013’. These remain unpublished, but are needed to progress Healthy Ireland’s key aims. Furthermore, the Committee is of the view that the role of Minister of State for Health Promotion within the Department of Health is an essential one to maintain a priority focus on this issue.

The Committee Recommends:

- The urgent publication of specific timelines and measurable goals and outcomes framework for Healthy Ireland and the adequate resourcing of the work needed to carry it out
- That the role of Minister of State for Health Promotion should be retained in future Governments

1.6 Implications for the Health Service

Social and income equality should also be guiding principles in the design of healthcare systems. According to the WHO, “Health-care systems contribute most to improving health and health equity where the institutions and services are organised around the principle of universal coverage ...and where the system as a whole is organized around Primary Health Care. These include both the PHC model of locally organised action across the social determinants of health, and the primary level of entry to care with upward referral.”²⁶

Taking a whole systems approach, then, has important implications for our approach to public health. Up-front investments and a powerful prevention strategy will prevent chronic disease from overwhelming the health service in the future. In Section 2, the Committee outlines the strategy to adequately resource population health and wellbeing.

²⁶ Closing the gap in a generation: Final Report of the Commission on Social Determinants of Health, WHO, 2008, p. 95

Section Two: Entitlements and Access to Healthcare

The Committee on the Future of Healthcare has specific Terms of Reference relevant to entitlement and access. The Terms of Reference state that there is a: *...need to establish a universal single tier service where patients are treated on the basis of health need rather than on ability to pay.*

In August 2016, the Committee produced its first interim report²⁷, which specified the following goal for the Committee: *To establish what healthcare entitlements should be covered under an agreed definition of ‘universal’ healthcare.*

During the Committee’s workshops held in late 2016 and early 2017, related principles were agreed, including three which are most relevant to entitlement:

- *Timely access to all health and social care according to medical need*
- *Care provided free at point of delivery based entirely on clinical need*
- *Patients accessing care at most appropriate, cost effective service level with a strong emphasis on prevention and public health*

This section outlines the complexity of entitlements and access to services as experienced by the Irish population. ‘Entitlement’ means ‘the fact of having a right to something’. Eligibility is defined as having the necessary qualities or satisfying the necessary conditions to qualify for a public scheme.

In Ireland, there are virtually no universal entitlements to healthcare, only ‘eligibility’ for some services as specified in the 1970 Health Act. The 1970 Health Act divides all residents into two categories:

Category 1 – people with full eligibility (with medical cards) (36%)

Category 2 – people with limited eligibility (without medical cards) (64%).²⁸

²⁷ *Interim Report on the Future of Healthcare*

²⁸ *Health Service Performance Report August/September 2016*

2.1 People with Medical Cards

Those with medical cards, Category 1, gain access to a range of health and social care services without charge, including GP care, and inpatient and outpatient hospital care. However, due to long waits for some services, such as outpatient appointments, planned hospital care, primary and social care, and allied healthcare professionals, while there is a theoretical entitlement to care, no practical entitlement exists as people are unable to access care within a reasonable period of time. People in Category 1 get access to all prescription drugs at €2.50 per item, capped at €25 per family per month.

Medical cards are means tested and mostly determined by having an income below a certain threshold (€184 for a single person under 66 living alone, €266.50 for a married couple). A small number of medical cards are provided on the basis of discretion.²⁹

There is clear concern among patient advocacy groups that the medical card system does not adequately address the financial barriers to healthcare that are experienced by many, in particular those with chronic diseases.

“The financial burden associated with living with a chronic illness or disability needs to be properly assessed and reflected within the medical card system. The current system does not appropriately reflect the cost of living with a chronic illness/disability.” (Neurological Alliance of Ireland)

“A key recommendation was the extension of the discretionary medical card scheme to those with epilepsy who are income ineligible...It is a huge concern to us that so many experienced cost barriers to essential services...” (Epilepsy Ireland submission)

Even for those with medical cards, the prescription charge was raised by stakeholders as posing a difficulty for those needing to access essential medicines.

“The medical card doesn’t offer everything free. Prescription charges are an uneasy burden for some families and individuals.” (Mr Paddy Kevane, Social Carer, Kerry)

The impact of charges from the wider health system perspective was also referenced.

“Many patients, particularly those with fixed incomes, just cannot afford to pay [the prescription charge]. Instead they gamble with their health every day, either by reducing their medication or stopping it entirely...The ultimate outcome is sicker patients, with more complex medical needs.” (Irish Pharmacy Union)

29 Keane, 2014 <http://www.lenus.ie/hse/handle/10147/336322>

2.2 People without Medical Cards

Those without medical cards (category 2) either access public hospital care free of charge (public outpatient appointment) or subject to a statutory charge (inpatient hospital care at €80 per day, capped at €800 per year). Non-medical card holders who present to the Emergency Department without a GP referral are charged €100 and they have to pay the full cost of visiting a GP (€52 on average per GP visit). Under the Drugs Payment Scheme (DPS), a person (or family) without a medical card pays up to €144 per month for prescription medication.

Patient advocacy groups highlighted the challenges which out-of-pocket costs present to those with chronic diseases in particular.

“Currently, people with asthma have to pay regular out of pocket payments for healthcare. The personal expenditure on asthma goes far beyond just medication and GP visits. People with asthma face other direct costs such as emergency visits, inpatient care, ambulance use, bloods and diagnostic tests.” (Asthma Society)

“A single GP visit in Ireland costs on average €50...family carers may allow their own health to worsen due to the cost of accessing healthcare, and instead prioritise the costs of care provision. Whilst many family carers may hold a medical card or GP visit card, there are many who do not.” (Care Alliance Ireland)

2.3 The Maternity and Infant Care Scheme

The Maternity and Infant Care Scheme was introduced in sections 62 and 63 of the 1970 Health Act making maternity care and infant care for the first six weeks of life free for all mothers and babies. This scheme is one of the only truly universal aspects of the current system. The HSE recently approved the National Healthy Childhood Programme which seeks to standardise supports to parents throughout childhood based on best international evidence.

2.4 Access to Primary and Social Care Services

In the 1970 Health Act (which still determines eligibility), there is an absence of clarity on access to care which is not GP or hospital provided. This means that for the whole population, there is a huge variety in access to primary and social care services depending on geographic location and existing supply in that area. Generally access to aids and appliances, public allied health professionals and Public Health Nurses (PHNs) are not available to those without medical cards, as noted by the Irish Heart Foundation:

“A medical card gives access to many services which are unavailable to patients without a medical card, such as public health nurses.” (Irish Heart Foundation)

However, recent analysis of the Irish Longitudinal Study on Ageing (TILDA) data found that 72% of older, frail people living in the community do not have access to public health nursing. Those who did not get PHNs included those with medical cards.³⁰ Clearly, issues of access are related to available supply and models of care prevalent in different parts of the country. For instance the SIREN study highlights the limited provision of primary care in the North-East.³¹ Submissions to the Committee indicated the impact of gaps on service users.

“The key components [of care for older people] include support to live well for those with stable long-term conditions, but also for those with complex co-morbidity, dementia and frailty; rapid support close to home in crisis; good acute care; access to community rehabilitation and enablement after acute illness or injury to maintain independence.” (Age Action Ireland)

“Under the current health and social care system, people with dementia and their carers face serious barriers in equity of access and outcomes from the point of diagnosis to end of life.” (Alzheimer Society of Ireland)

Spinal Injuries Ireland referred to the “shortage and postcode lottery of community services such as PA hours, physiotherapy, occupational therapy and counselling”. Their submission noted that 54% of those with a spinal cord injury do not feel they receive adequate counselling in the community, while 48% do not feel they receive adequate physiotherapy.

The 2001 Health Strategy, ‘Quality and Fairness, A Health System for You’ highlighted the absence of a ‘statutory framework underpinning access to services within a stated time frame’ and proposed legislation to remedy this.³² Such legislation was never progressed. Instead, the Committee is of the view that any extension or withdrawal of eligibility has been made on a piecemeal basis: for example, the extension of medical cards to over 70 year olds in 2001, the introduction of GP Visit Cards in 2005, the withdrawal of universal medical cards for over 70 year olds in 2009, and the introduction of the Nursing Home Support Scheme in 2009.

³⁰ Roe, L., O’Halloran, A, Normand, C, Murphy, C. (2016). *The Impact of Frailty on Public Health Nurse Service Utilisation Dublin, TILDA, Trinity College Dublin*

³¹ Thomas, S, Foley, C, Kane, B, Lynch, B, Smith, S, Healy, O, Browne, J. (2016) *Equity of Resource Allocation in Urgent and Emergency Care Systems in Ireland. Research Paper. SIREN Project*

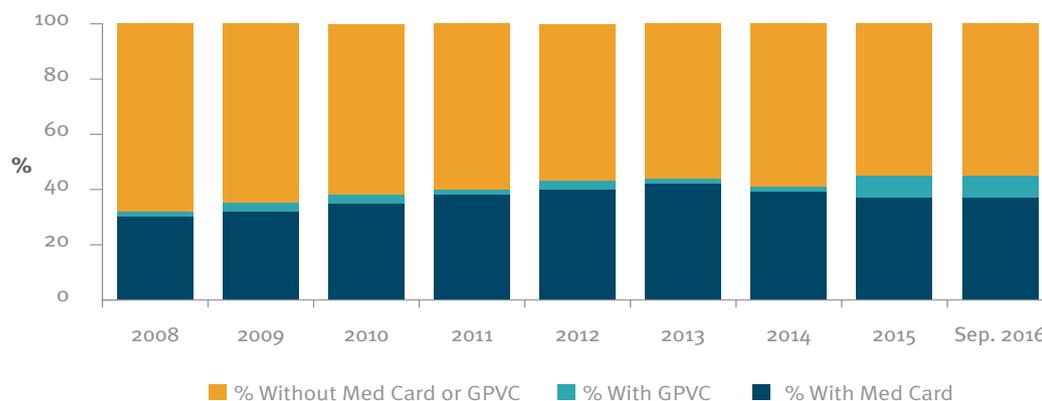
³² Department of Health and Children (2001), *Quality and Fairness. A Health System for You*

2.5 Gp Visit Cards (GPVC)

In 2005, a GP visit card was introduced which enables access to GP care without charge for those whose income is below a certain amount, but above the medical card threshold. In 2015, GP visit cards were introduced to all under six year olds and over 70 year olds. These allow GP visits without charge but critically do not provide access to essential medication, aids and appliances or the whole range of public primary and social care services to which a medical card facilitates access.

Chart 4 below highlights population coverage by medical cards and GP visit cards (GPVC). On average a medical card entails a direct payment of €900 per year per person (from the State to GP practices and pharmacies), whereas a GP visit card only incurs a direct payment of €230 per person per year.³³ Other benefits and access are not costed in this sum. For example, hospital care for people with medical cards is not included.

Figure 4: Population Coverage of Medical Cards and GP Visit Cards



However access to health and social care in Ireland is not just determined by eligibility. It is also dependent on the type, volume and geographic location of the services. Some of these elements are outlined later and in Chart 5 on page 22 which portrays an overview of access to health and social care in Ireland.

2.6 Long Term Illness Scheme

Inclusion in other government schemes such as the Long Term Illness Scheme (LTI) also affects whether one has to pay for services or not. The LTI Scheme covers medicines and medical appliances directly related to certain illnesses free of charge. In December 2015, 138,415 people were covered by the LTI scheme at an average cost to the State of €1,234 per person.³⁴

However, many chronic diseases are not covered by the LTI causing significant out of pocket payments for people without medical cards. For example, diabetes is covered but asthma, hypertension and cancer are not. Submissions to the Committee indicated dissatisfaction with this scheme.

“The NAI is calling for a ten year strategy for healthcare to implement the recommendations of the Expert Group on medical card eligibility and to review the LTI scheme... widening entitlement to this scheme across the range of disabling neurological conditions.” (Neurological Alliance of Ireland)

“The LTI scheme excludes many disabling genetic and rare disorders and must be reformed and expanded.” (Genetic and Rare Disorders Association)

High Tech Drug Schemes

The High Tech Drug Scheme (HTDS) covers the cost of high cost medicines, usually prescribed in hospitals and dispensed to people through community pharmacists. They include items such as anti-rejection drugs for transplant patients or medicines used in conjunction with chemotherapy or hormonal therapy. People with medical cards get these drugs without charge, the rest of the population pay €144 per month for these drugs as the rest of the cost is covered by the HSE. In 2015, 70,321 people were registered under the HTDS at a cost of €662 million.³⁵

Dental Schemes

Under the Dental Treatment Service Scheme (DTSS), people with medical cards are entitled to some dental care without charge. Access to dental care for those on lower incomes was significantly curtailed as part of a range of austerity measures introduced in 2010. The Irish Dental Association submission highlighted this issue. Even though the number of people with medical cards seeking dental care under the DTSS increased by 35%, the numbers of scale and polishes fell by 97% and fillings fell by 33% between December 2009 and December 2015. Over the same period surgical extractions and routine extractions increased by 53% and by over 14% respectively, as dentists are only funded to provide emergency care and carry out extractions.

³⁴ *ibid*

³⁵ *ibid*

In December 2015, the average cost of the DTSS per person to the State was €160 (€69m for 436,000 people).³⁶ In 2009, before budget reduction measures, the average cost of DTSS per person was €252 per person (€86m for 343,067 people).³⁷ The public allocation to the Dental Treatment Benefit Scheme which enabled people who pay PRSI to get dental services at reduced cost was cut from €62m to €10m between 2010 and 2015, severely limiting access to dental care for non-medical card holders.

“Currently, oral healthcare in Ireland is provided through a mix of publicly funded schemes, fully private provision, a public dental service and specialist/hospital services...there are a number of problems with the current model of care including lack of funding and resources, savage cuts to funding and the scope of treatments covered that were implemented during the crisis...” (Irish Dental Association)

Community Eye Care Services

Under the Community Ophthalmic Services Scheme, medical card holders and their dependants are entitled, free of charge, to eye examinations and necessary glasses/appliances. The budget allocation to this scheme in 2015 was €31 million.³⁸ In 2008, the budget was €22 million.³⁹ At present, there are just 22 HSE community ophthalmic physicians.

This results in long waiting lists for publicly provided care, high levels of unmet need and people paying out of pocket for ophthalmic services.

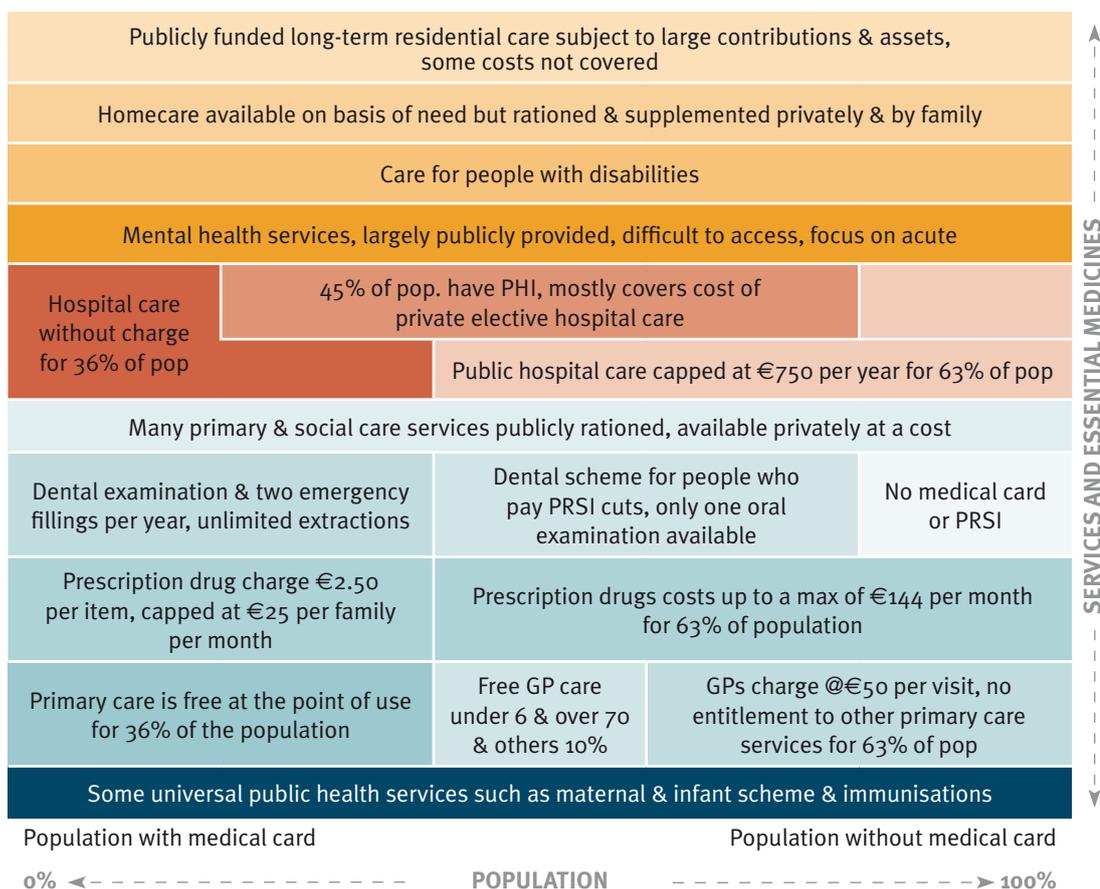
³⁶ Primary Care Reimbursement Service (PCRS) Statistical Analysis of Claims and Payments 2015

³⁷ Primary Care Reimbursement Service (PCRS) Statistical Analysis of Claims and Payments 2009

³⁸ Primary Care Reimbursement Service (PCRS) Statistical Analysis of Claims and Payments 2015

³⁹ Primary Care Reimbursement Service (PCRS) Statistical Analysis of Claims and Payments 2009

Figure 5: Overview of Access to Health and Social Care in Ireland



2.7 Special Care Services

The HSE funds a range of services for people with intellectual, physical and sensory disabilities. Some of these services are provided directly by the HSE, others are provided by voluntary organisations contracted by the HSE. People with disabilities are entitled to general health services on the same basis as everyone else depending on their medical card status.

Disability Services

Disability policy actively promotes living in the community and person-centred services for people with disabilities. In theory, people with disabilities should have priority access to a range of community care services, such as public health nurses, home helps, personal assistance, psychological services, speech and language therapy, occupational therapy, social work services, physiotherapy, day care and respite care. In practice, based on the evidence, people with disabilities often wait a long time to access rationed services without choice of service provider. They also end up paying out of pocket for such services. There are significant geographic differences in access to such care.

While many people with disabilities live at home, some remain in residential care due to the absence of appropriate accommodation and supports in the community. This has a negative impact on the wellbeing of people with disability and militates against independent living. The Committee is of the view that it is also an inefficient use of public money. €1.5 billion was allocated to disability services in 2016.⁴⁰

“People with a disability are one of the groups in Ireland at highest risk of poverty with an ‘at risk of poverty’ rate of 22.8%, a deprivation rate of 51.3% and a consistent poverty rate of 13.2%. As a group they are one of the heaviest users of health services... However, the health system as it is currently constituted lacks a clear understanding of the range of care required by disability and does not take cognisance of its often episodic nature which necessitates different levels of service at different stages of a person’s condition.” (Disability Federation of Ireland)

Mental Health Services

Community mental health services in Ireland are provided by the HSE Adult and Child and Adolescent Mental Health Teams. The Committee notes the significant shift in services from institutions to the community. Nevertheless, the Committee believes that teams remain under-resourced and overly reliant on medication services instead of having access to a range of allied health professionals including counsellors, speech and language therapists and occupational therapists. Evidence from Mental Health Reform suggests that mental health services are understaffed by approximately 20%. The absence of talk therapies results in an over-dependence on medication and an over-reliance on acute services.⁴¹

Mr Tom Maher of St Patrick’s Mental Health Services spoke to the Committee about access to mental health services. *“...With mental health care, there are sociological barriers to accessing mental health care in the first place arising from stigma...Where services are not available it is an additional barrier. If people do not access services, over a long period...it will only disimprove a person’s mental health”.*

Many submissions received by the Committee highlighted the need for significant improvement and investment in mental health services, as part of an integrated approach to health and social care.

There are significant disparities in how services are provided across the country, with long and closed waiting lists for care outside of hospital, with most inpatient services provided privately. In August 2016, 2,080 children and adolescents were waiting to be seen by the Child and

⁴⁰ Health Service Executive National Service Plan 2016

⁴¹ Mental Health Reform Submission

Adolescent Mental Health Services, with 170 waiting for over 12 months.⁴² This results in people often paying out of pocket to access counselling and support services in the absence of comprehensive, early intervention community services. The ISPCC highlighted this issue in its submission to the Committee: *“In April 2016, it was reported that 214 young people were waiting more than 12 months for a Child and Adolescent Mental Health Services (CAMHS) appointment while 1,075 were waiting longer than three months. For young people without appropriate support their difficulties may worsen as they wait; this can be extremely distressing for both the young person in question and their parents/carers.”* (ISPCC)

The availability of private acute psychiatric care covered by private health insurance can result in hospitalisations which may not be required if services were publicly provided in the community. The Committee believes that a significant proportion of mental healthcare can, and should be provided as part of primary care.⁴³ Currently, GPs can refer medical card holders to counselling without charge but this service is not available to non-medical card holders. The Committee considers that greater integration is needed between primary and acute care for people with acute mental health needs and publicly provided counselling services as part of primary care.

In 2016, Ireland spent 6.4% of the overall health budget on mental health. A Vision for Change recommended this should be over 8% (Department of Health, 2006). In the UK and Canada, 13% of the health budget is allocated to mental health, in New Zealand, it's 11%. (Mental Health Reform)

A Vision for Change recommended well-trained, fully-staffed, community-based multi-disciplinary Community Mental Health Team. It set out additional staffing requirements for these teams. Indicative funding needed to deliver on this amounts to just over €120m, adjusted for population growth, which the Committee believes must be phased in over the next five years. This includes funding for Child and Adolescent Mental Health Teams, Child and Adolescent Liaison, Old Age Psychiatry, and mental health services for people with intellectual disability. The Committee notes the current policy review process being undertaken by the Department of Health since *A Vision for Change* came to the end of its 10 year term in 2016, which may further inform investment in this area.

The Committee is also proposing that an additional €6.5m be made available to extend counselling in primary care. This service was introduced initially for those with medical cards. The new funding will represent a doubling of expenditure on this service, to be phased in over the next three years.

⁴² Health Service Performance Report August/September 2016

⁴³ Mental Health Reform Submission

Homecare Services

Homecare services in the form of home help hours and home care packages are provided through the HSE. Between 2005 and 2007, there was an increase in the numbers of hours provided to an increasing number of older people who required support to live at home. However these services were reduced as part of the package of austerity measures. In December 2015, 47,891 people were in receipt of home help services with 10,456,801 home help hours provided.⁴⁴ In 2007, 54,736 people were in receipt of over 12.3m home help hours.⁴⁵

“The majority of people with dementia would like to stay in their own homes for as long as possible, however our current system is failing to provide adequate home-based supports to enable this.” (Alzheimer Society of Ireland)

In December 2015, 15,274 people were in receipt of a home care package while 195 people received intensive home care packages, facilitating patients with very high level of dependency/ complex needs to return home after acute episodes of care. Home care services in Ireland are unregulated. The budget allocation to homecare in 2016 was €324 million.⁴⁶ In the absence of an entitlement to homecare services, many people pay out of pocket for private homecare services.

“It is very difficult to access home care and support. A statutory entitlement to home care is essential if the service is to attract ring-fenced funding and to meet the needs and preferences of older people. Without certainty in the allocation of homecare, an increasing number of people with low to moderate level of dependency will have no choice but to go into long-term residential care, with a substantial cost to the State...” (Age Action Ireland)

Dr Michael Browne, in his evidence to the Committee, referred to a lack of support and services for those needing care in the community.

“Obviously, it is evident that this dearth of services creates problems, but I wish to refer to simple things such as easier access to physiotherapy, occupational therapy and house adaptations.... At that level there is great potential for more interventions at relatively low cost.”

Long Term Nursing Home Care

Long term nursing home care is funded under the Nursing Home Support Scheme (NHSS) which was introduced in 2009. Under the NHSS, applicants are assessed clinically and financially. The clinical assessment determines whether a person requires nursing home care and financial assessment determines the extent of their financial contribution. Under the scheme, nursing home

⁴⁴ HSE, Health Service Executive National Service Plan 2016

⁴⁵ HSE, National Service Plan 2008

⁴⁶ HSE, Health Service Executive National Service Plan 2016

residents will pay up to 80% of their disposable income towards the cost of their care during their lifetime, and up to 22.5% of the value of their home, if their assets are over a certain limit, for the first three years of their care.

Once deemed clinically in need of nursing home care, applicants can choose from a private or public nursing home. All nursing homes are regulated by HIQA. A review of the NHSS in 2015 found that increased funding would be required based on demographic change. It also recommended administrative changes to make the scheme less burdensome on applicants and their families. In 2017, €940 million was allocated to the NHSS. In August 2016, 23,054 people were living in residential care funded under the NHSS.⁴⁷

Palliative Care

The goal of the integrated model for palliative care as delivered in Ireland is to improve quality of life for both the patient and family, providing patients with relief from the symptoms, pain and stress of a serious illness, whatever the diagnosis. It is currently provided by 23 community palliative care teams which offer universal access to specialist palliative care services in the patient’s home. Specialist palliative care beds are available in eight of the nine Community Health Organisations.⁴⁸ There are geographic variations in the provision of both community and hospital palliative care services. Palliative care is considered by the WHO to be an essential component of universal health coverage.

“... coordinated, seamless care of people at end of life remains a largely elusive goal with many pockets of progressive good practice and development isolated by location and not mainstreamed, or hampered by deficits in infrastructure, staffing or training. One of the main challenges is to “join the dots” – to coordinate, replicate, progress and embed innovative, evidence-based solutions to issues which arise in care of the dying and the bereaved.” (Irish Hospice Foundation)

2.8 Complexities of Accessing Care in Ireland

According to the WHO, Ireland is ‘unique among EU countries in not providing universal coverage of primary care... its system of entitlement to publicly financed healthcare is complex... Gaps in coverage in Ireland create significant financial barriers to access particularly for those without medical cards or private health insurance (PHI). This results in not only unmet need but also in inequitable and inefficient patterns of use... these barriers are substantial relative to most EU countries especially for primary care’.⁴⁹ The issue of equity was also highlighted by Dr Josep

⁴⁷ *ibid*

⁴⁸ *HSE Palliative Care Submission*

⁴⁹ *WHO, 2012, 95*

Figueras, who presented international evidence to the Committee that *“In countries like Ireland, which have supplementary insurance enabling people to bypass the queues, there is a negative impact on equity.”*

People’s access to healthcare in Ireland is further complicated by the fact that 45% of the population have PHI. Having PHI and/or the ability to pay privately for some services (such as private outpatient appointment, diagnostics, allied healthcare professionals, aids and appliances, home care) assists those who can afford them by giving them faster access to care and in covering the cost of care, even if only partially.

“An ICGP survey highlighted the public private divide in stark terms. 88.5% of GPs surveyed said a patient’s ability to pay affected their ability to access diagnostic tests used to detect cancer.” (Irish Cancer Society) and... “Taxes paid for 77% of health expenditure in 2013. Yet in our primarily tax-funded health system, people with PHI have quicker access to healthcare compared to fellow taxpayers without insurance.” (Health Reform Alliance)

Paying for such services out of pocket causes impoverishing and, in some instances, catastrophic health spending.⁵⁰ Without clear entitlements, a complex system of eligibility has developed, resulting in a very small range of universal services in Ireland such as the maternity and infant care scheme, vaccinations and screening services. However, even being eligible for care does not mean that people get it. This is most evident in the length of waiting lists for public hospital outpatient, daycase and inpatient care.

“Excessively long waits for procedures...such as minor eye surgery and orthopaedic surgery... have consequences for older people’s independence.” (Age Action Ireland)

Therefore, guaranteeing eligibility or even an entitlement to care does not ensure access, unless treatment can be provided within a reasonable timeframe. These issues are considered with in greater detail in Section 5. However, it is important to note that entitlement without the capacity to respond on the supply-side will mean rationing and most likely by continued waiting lists. This also applies to extending eligibility to universal GP care where existing capacity is exhausted.

Health Service Capacity

Entitlement to health services, and adequate health service capacity are both fundamental requirements if we are to deliver timely access to health and social care according to medical need. The Committee notes that there is widespread agreement that capacity is a significant part of the problem. The system is struggling with what Professor Garry Courtney referred to in his

⁵⁰ Johnston 2015, *Irish Findings on Financial Protection, Mapping the Pathways to Universal Healthcare Seminar, The Hub, Trinity College Dublin Centre for Health Policy and Management*

testimony to the Committee as the “misalignment between demand and capacity”. As set out in Section 3, demographic pressures, along with the increasing prevalence of chronic disease, are driving significant growth in demand. In recent years, however, healthcare budgets have not kept pace. There are significant capacity constraints, as primary care, acute care and social care services all fight to keep up with current demand. The effect on access to high-quality care for patients, and on the working environment for staff, was emphasised to the Committee by witnesses and stakeholders.

“Over the last eight years, the Irish health service has been subject to radical contraction, in an unmanaged and unplanned way... This has negatively impacted upon the ability of frontline staff to deliver the highest quality of care underpinned by internationally proven best, evidence based, practice and has had a negative effect on the health of the population through delayed access to services.” (Irish Nurses and Midwives Organisation)

“Waiting lists for timely access to outpatient appointments, elective surgeries, access to hospital beds, tests, specialist consultants, GPs, community services etc. ultimately cost lives and cause injury to patients.” (Irish Patients’ Association)

“In the case of Home Care Packages it is clear that at the most basic level, investment in the scheme is not sufficient to meet current needs... People are finding it increasingly difficult to access appropriate Home Care Packages for their loved ones, and there is wide disparity in relation to availability at local level.” (Care Alliance Ireland)

“While revised estimates and supplementary budgets have been allocated in recent years to address shortfalls in funding for day to day spending, these have not been sufficient to address the significant infrastructure and capacity deficits as demonstrated by growing waiting lists, ED overcrowding and unmet demand.” (Irish Hospital Consultants’ Association)

The Committee is of the view that focusing solely on capacity will not solve the problems of our health system. However, the Committee strongly believes that capacity must be addressed while progressing the re-orientation of our system towards primary and social care, as set out in its Terms of Reference. For this to happen, people must be able to access primary and social care services, in a timely manner, without financial barriers. That means we must on the one hand expand the entitlement to services in primary and social care, and on the other expand the capacity to meet the additional demand.

Accordingly, there is a clear need for additional funding to address capacity constraints and expand entitlements, over and above funding for expected demographic and inflationary pressures. This section includes specific proposals for investment, in particular additional staffing across the system. This investment is targeted in a way that supports the realisation of the Committee’s preferred design – the delivery of the vast majority of care in the community setting.

Indicative costs for this additional investment amount to an estimated health budget increase in the order of €2.8bn over a proposed ten year period, between €380-€465m per annum proposed for the early years of this plan, tapering to reduced increases in the later years as capacity is built up and entitlements expanded. This additional investment for implementation of the Sláinte plan is essential if we are to deliver timely access to safe, quality care, improve value for money and contain increases in the longer term. It will also create the conditions whereby we can solve the ongoing access pressures in our acute hospital system. Unless the majority of care is provided in the primary and social care setting, our hospital system will continue to struggle.

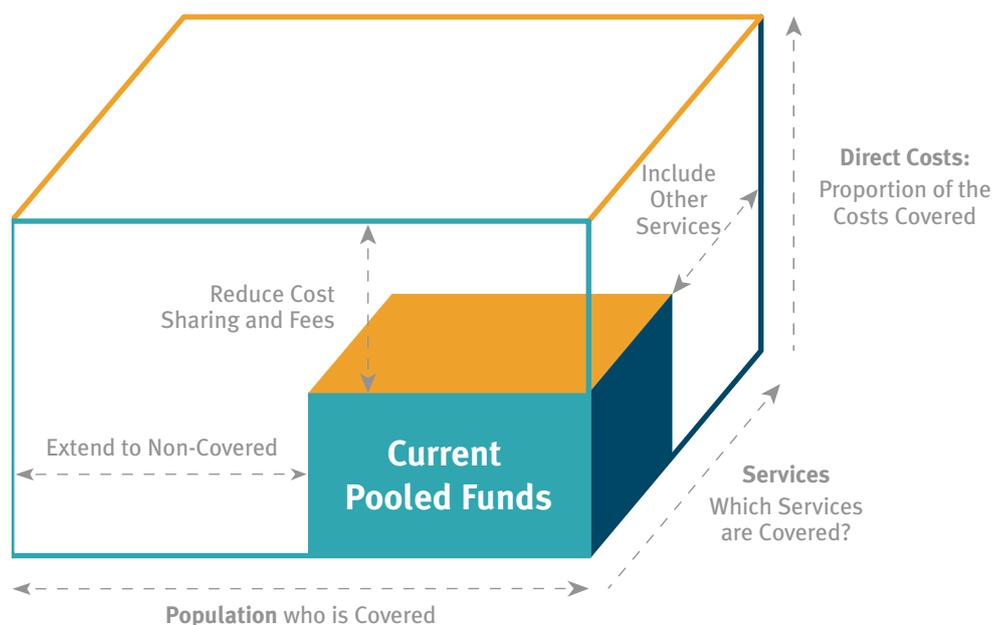
The issue of capacity is also addressed as part of the proposals in Sections 3 and 4 of the report. Section 3 addresses the need for a better resourced primary care and social care network as a core element of integrated care in Ireland, and the critical service delivery challenges we face. Section 4 addresses the funding model required for our system, including in particular the need for significant additional once-off investment as part of a transitional fund, and to address legacy underfunding issues. This once-off investment is estimated at a further €3bn spread over a number of years. It focuses on key areas including full implementation of the e-health strategy, improvements in access to diagnostics in the community, and hospital infrastructure. It also includes significant funding to support expansion of training for necessary staff.

2.9 International Evidence And Experience

The WHO conceptualises universal health coverage in the following way, seeing it as three dimensional, comprising of;

- *The population – who is covered (breadth of coverage)*
- *The services (or basket of care) – what is covered (depth of coverage)*
- *Financial protection (what do people pay out of pocket and how to protect people from financial hardship or catastrophic payments for accessing health and social care)*

Figure 6: WHO Cube on Universal Health Coverage



Three Dimensions to Consider When Moving Towards Universal Coverage

The World Health Organisation Assembly Resolution in 2005 urged countries to develop health financing systems to ensure all people have access to needed services without financial risks caused by paying for care or loss of income due to sickness. This was confirmed in the World Health Assembly 2011 emphasising the importance of good quality services and viewing UHC as a destination.⁵¹ The WHO used the term ‘universal health coverage’ to mean:

That all people and communities can use the promotive, preventative, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship

⁵¹ WHO, *Universal Health Coverage: Concepts and Principles*

Elsewhere, the World Health Organisation definition of universal health coverage embodies three related objectives:

- *Equity in access to health services – everyone who needs services should get them, not only those who can pay for them*
- *The quality of health services should be good enough to improve the health of those receiving services; and*
- *People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm⁵²*

Such objectives tie in very closely with the principles and Terms of Reference of the Committee. The European Union promotes the concept of universality. The European Council Conclusions on Common Values and Principles in EU Health Systems in 2006 stated:

*The overarching **values** of universality, access to good quality care, equity, and solidarity have been widely accepted in the work of the different EU institutions... Universality means that no-one is barred access to health care; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay. EU health systems also aim to reduce the gap in health inequalities, which is a concern of EU Member States.⁵³*

As stated above, Ireland is extremely unusual in a European context in terms of the difficulties in accessing care for many people, the full price and high cost paid by many for access to GPs and other essential care as well as the absence of legal entitlements to care. A recent analysis of eight countries, Belgium, England, France, Germany, Holland, Scotland, Sweden, Switzerland, found a consistent and wide range of services were available to all adults aged 19 to 60 years of age, regardless of income or health status.⁵⁴

This work found that ‘the scope of services is comparable and comprehensive across the eight countries with only marginal differences’.⁵⁵ It also found no direct relationship between the range of services covered and the level of public spending on healthcare. Instead, differences in spending could be explained by variations in the volume and price of healthcare services between the eight countries. There were significant differences in cost-sharing (how much people paid for the services at the point of delivery) between the countries with different thresholds for access for different health services in each country.

52 Source: http://www.who.int/health_financing/universal_coverage_definition/en/

53 <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:146:0001:0003:EN:PDF>

54 van der Wees et al, 2015

55 *ibid*

Experience from the last 10 to 15 years from several low and middle income countries show that implementation of universal healthcare is possible and brings significant outcomes in terms of improved access to care, better health status and life expectancy, lowered financial hardship and improved equality. In the example of Thailand, after substantial reform initiated in 2001, health coverage is now virtually universal. As a result, unmet need is close to non-existent, and a number of key health outcomes including overall life expectancy and infant and child mortality have improved significantly. While government health expenditures have grown, spending has been kept in check using a variety of tools including capitation, global budgets, primary care gatekeeping and preventative care.⁵⁶ Internationally, the Committee also noted that there is a trend towards having a very specific definition of the ‘basket of care’, for example, what citizens are entitled to by the publicly financed system. This is especially the case in countries where new healthcare legislation was introduced.⁵⁷

2.10 Evaluating Options

The Committee’s work plan included a commitment, *‘to establish what healthcare entitlements should be covered under an agreed definition of ‘universal’ healthcare*

Given the WHO concept of UHC, the following definition of universal healthcare is being adopted by the Committee: *A universal healthcare system will provide population, promotive, preventative, primary, curative, rehabilitative and palliative health and social care services to the entire population of Ireland, ensuring timely access to quality, effective, integrated services on the basis of clinical need.*

The Committee has agreed the following services should come under the remit of universal healthcare:

- *Public health/preventative care, including health promotion activities, screening and family planning supports for self-management of health*
- *Community diagnostics*
- *Primary care, general practice and chronic disease management*
- *Outpatient care (general & specialised) – shifting emphasis to the community*
- *Hospital day case, ambulatory urgent day care treatment and assessment, inpatient, pre-emergency and emergency care*
- *Rehabilitation*

⁵⁶ Limwattananona, S., Sven Neelsen, B, O'Donnell, O, Prakongsai, P, Tangcharoensathien, V, van Doorslaer, E, Vongmongkola V (2015). “Universal coverage with supply-side reform: The impact on medical expenditure risk and utilization in Thailand.” *Journal of Public Economics* 121: 79-94

⁵⁷ Schreyögg, J., Stargardt, T, Velasco-Garrido, M, Busse, R. (2005). “Defining the “Health Benefit Basket” in nine European countries. Evidence from the European Union Health BASKET Project.” *European Journal of Health Economics* 6(Supp 1): 2-10

- *Drugs*
- *Access to medical devices and appliances*
- *Allied professional care*
- *Dental, ophthalmic and aural care*
- *Mental healthcare, counselling and drug addiction services*
- *Maternity care, including IVF*
- *Long-term care, including home care supports*
- *Social care*
- *Palliative care*

Where appropriate, all of the above must have an emphasis on enhancing public health and prevention, enabling self-care and the shift from hospital delivered care to primary and social care delivered in the community, especially in relation to the management of chronic diseases and delivering integrated care.

This will ensure value for money and ease of access. The care pathway also has to be designed in such a way as to guarantee timely access to quality of care.

The Committee Recommends:

- That the care pathway has to be designed in such a way as to guarantee timely access to quality of care

2.11 Preferred Design

The Committee's preferred design is a model where the vast majority of all aspects of healthcare is provided for in the community through population health, primary or social care. This will involve the expansion of the health system to deliver better access to primary care and general practice and to public hospital care for all residents.

This includes the phasing out of private care in public hospitals, alongside the removal or reduction of significant proportion of out of pocket payments from households.

Phasing/Strategic Focus for Expansion for Delivering a Package of Care

The vision of the Committee is a universal health system accessible to all on the basis of need, free at the point of delivery (or at the lowest possible cost).

2.12 Committee Recommendations

- 1 Expand health and wellbeing & other measures central to provide integrated care
 - *Double the Health and Wellbeing Budget*

2. Adequately resource child health and wellbeing services
 - *Hire up to 900 more general nurses to work in the community with older people and people leaving the acute sector, to free up Public Health Nurses who have training in child health services to carry out child health work as part of the current Nurture-Infant Health and Wellbeing programme and the HSE's National Healthy Childhood Programme*
 - *Ensure that parents are supported to meet the emotional development needs of their children as well as their physical health needs through supporting the development of the parent-child relationship*
 - *Integrate an Infant Mental Health approach into the Primary Care Child Health and Wellbeing service*
 - *Child health and wellbeing services including parenting supports during pregnancy and in the early years of the child's life*

3. Reduce and remove charges
 - *Eliminate charges for access to public hospital care (€800 a year for each patient in public hospital care)*
 - *Decrease the prescription charge for medical card holders from €2.50 to €1.50 and then to 50c*
 - *Decrease the threshold for drug reimbursement for non-medical card holders from €144 to €120 and then to €100*
 - *Halve the drug threshold for single headed households without medical cards from €144 to €72*
 - *Remove the anomaly whereby a family which reaches the maximum DPS threshold in a given month may in fact have to pay more than the maximum if one family member also pays medical card prescription charges under a Discretionary Medical Card*
 - *Charges for Emergency Departments may be removed once services in primary care have been built up*

4. Primary care expansion

The focus here will be on building up the capacity of general practice, primary and social care services, and promoting the principle of providing quality, timely care at the lowest level of complexity. Capacity in hospitals will be freed up by shifting care, currently provided inappropriately by hospitals, into the community by integrating that care throughout primary, hospital and social care settings.

This will be achieved by delivering:

- *Universal access to diagnostics in the community*
- *Extension of counselling in primary care to the whole population*
- *Universal access to GP care without charge*
- *Universal access to primary care*

According to the Committee's plan, extending entitlements to universal services that require time and money to put sufficient staff in place will be phased, on the basis of means, as time will be needed to build up staffing of services so that they can meet demand. It is proposed to extend GP care and primary care services without charge to an additional 500,000 people each year on the basis of income. There will need to be a corresponding phased increase in capacity of general practice to deliver this. A new GP contract and salaried GPs will facilitate this.

5. Social care expansion

- *Universal Palliative Care*
- *Universal Home Care*

Social care expansion will start with delivering universal palliative and homecare services. These services can be delivered within the first five years of the programme. Other areas of social care require additional work to cost and examine staffing implications of reforms and the best way to provide services. These include, for example, the redesign of services for people with disabilities.

6. Mental health care expansion

- *Adequately staff child and adolescent mental health teams*
- *Adequately staff adult mental health teams*
- *Adequately staff old age psychiatry mental health teams*
- *Adequately staff liaison posts*
- *Adequately staff intellectual disability mental health services*

7. Dentistry expansion

- *Re-instate the pre-economic crisis budget to the Dental Treatment Services Scheme*
- *Develop a universal package of dental care*

8. Public hospital activity expansion

Introduce a range of measures to undo two tier access to public hospital care including:

- *Increased access to diagnostics in the community*
- *Reduced waiting lists for first outpatient department (OPD) appointment and hospital treatment, and*
- *Expand public hospital capacity*

The first two of these must be progressively realised in the early years of the plan. The removal of private care in public hospitals will require time to phase out. Increasing public hospital capacity will partially be achieved by freeing up existing capacity by, amongst other measures, transferring care from hospitals to the community, and phasing out private care in public hospitals.

This will require:

- *Increased public funding to replace current private income in public hospitals*
- *New governance structures to ensure quality care and accountability*
- *Changes to incentives and work contracts*
- *Alongside precise workforce planning to ensure the public system is an attractive place to work for staff who deliver high quality care*
- *The hospital sector will also need increased capacity in areas where it is currently under-resourced*

Legislate for an Entitlement to Care

The Committee proposes the introduction of a Cárta Sláinte (a Health Card) which all residents in Ireland will have within five years of the reform plan being initiated. The Cárta Sláinte will entitle all those ordinarily resident to access care based on need. This is consistent with current policy where entitlement to healthcare is based on ordinary residency rather than citizenship or other criteria. The Committee believes that it is important that the definition of ordinary residency for healthcare purposes acknowledges situations where people temporarily live abroad and then return to Ireland to take up residency once more.

A Cárta Sláinte will ensure access to all publicly funded health and social care services including;

- *GPs, public health nurses, primary care, addiction services, diagnostics, hospital care, home care, long term care and palliative care*
- *Public health/population health services, mental health services, maternity care, services for people with disabilities, access to medication, aids and appliances*
- *Dental, eye and ear services*

In order to guarantee access to care and not a place on a waiting list, those entitled to universal health and social care will be guaranteed access within a set period of time (see Section 3).

Over time, existing and new contracts and incentives will be used to shift care from hospitals to the community and/or the lowest level of complexity. People will be incentivised to access care in primary and social care settings as their Cárta Sláinte will ensure access in these settings either free of charge or at a low cost. In recognition that universal health and social care cannot be delivered over night, the Committee recommends delivering a full range of measures in a progressive way.

A Cárta Sláinte will be introduced to the whole population over a five year period through the following measures to expand entitlements which are detailed separately at the end of this section. Phasing is dependent on funding and having the staffing capacity to deliver universal care.

These costings are projected on the basis that an additional €380-465 million per year will be allocated to deliver universal healthcare annually for the first six years, after which additional costs will decline.

Further costing and staffing requirements

- *Numbers of additional Consultants and Hospital staff needed to provide timely access to Public Hospital care*
- *Additional chronic disease management costs in the community*
- *Universal Social Care (in particular services for people with disabilities)*

2.13 Rationale for Phasing Entitlement Expansion

Public Health and Wellbeing

Increase Health and Wellbeing Budget

Increasing the health and wellbeing budget is central to the sustainability of the health system. Given the increasing levels of chronic diseases and poor health indicators such as obesity, having a strong health and wellbeing function across government is crucial. The current budget in this area represents 1.6% of the overall budget. The Committee recommends a 7.2% increase on the 2016 budgeted figure, which would result in a doubling of the health and wellbeing budget over a ten year period. This would bring Ireland's health and wellbeing spend from the mid to a high end of the OECD average. A review of the international evidence suggests that it is difficult to benchmark similar comparator spending for primary care. Instead the focus should be on substantial targeted investment in this area, as recommended in this report.

Adequately Resource Child Health and Wellbeing Services

Investing in child health and wellbeing services is the best way to influence better health outcomes. Currently child health and screening services are provided by GPs, Community Health Doctors and Public Health Nurses. Public Health Nurses are under ever-increasing pressure to provide care for older people, people leaving hospital and palliative care, as a result of which child health work does not have sufficient priority.

The Committee is proposing that funding be provided for an additional 900 generalist nurses to work in the community. This will free up PHNs to do child health work as part of the current Nurture-Infant Health and Wellbeing programme and the HSE's National Healthy Childhood Programme. Given the known importance of *in utero* health, child health and wellbeing services need to start with the mothers and parents, providing antenatal support including mental health, better developed midwifery services, breastfeeding and parenting supports including peer supports. The Committee believes that the full implementation of the National Maternity Strategy will assist in delivering on some of these service developments.

Removing and Reducing Charges

Removal of Inpatient Charges for Public Hospital Care

People without medical cards and those who opt not to have their care covered by private health insurance are charged €80 per night for public hospital care, capped at €800 per year. In 2016,

this was expected to bring in an annual income of €25m for public hospitals. Removal of this charge is another step to achieve one tier access to care in Ireland and increases financial protection for those who currently have to pay these charges.

Reduce Prescription Charge for Medical Card Holders from €2.50 to €1.50, to 50 cent.

Budget 2010 introduced a prescription charge for medical card holders of 50 cent, capped at €10 per family per month. This was increased to €1.50 in January 2013 (capped at €20 per family per month) and €2.50 in December 2013 (capped at €25 per family per month). From 1 March 2017, the prescription charge for medical card holders over the age of 70 was reduced to €2 per item and the monthly maximum will be €20. These payments cause financial hardship to people on low income and can deter necessary use. The Committee recommends the reduction of this charge for all medical card holders under 70 from €2.50 (or €2 for those over 70) to €1.50 in Year 1 at the cost of €67m, and the further reduction to 50 cent in Year 2 at the cost of a further €66.7 (€133.5m in total). These reductions are necessary because people with medical cards by their nature are on a very low income and, for them, these charges can cause impoverishment and contribute to people stopping taking essential medication.

Reduce Drug Threshold to €120 and then to €100

People without medical cards (66% of the population) have to pay up to €144 per family per month for essential medication. This has increased from €85 in 2008. For people on low income (but not low enough to get a medical card), this can cause financial hardship, impoverishment and deter use of essential medication. In 2015, over 1.3m people were eligible and 269,930 (20.7%) availed of this scheme, at the cost of €67m to the State.⁵⁸ The Committee recommends bringing this back to €120 in Year 3 costing €75m and €100 in Year 5 costing a further €184m. Reducing this threshold will encourage adherence to medicines prescribed and decrease the impoverishment caused by these high charges.

Halving the Drug Threshold for Single Headed Households

Currently a one person household has to pay the same as a two or 10 person household. The Committee recommends reducing the threshold for one person households to €72 per month. This is an early delivery financial protection measure. This will impact most on single people and lone parent households with chronic diseases.

58 http://www.hse.ie/eng/staff/PCRS/PCRS_Publications/PCRS-statistical-analysis-of-claims-and-payments-2015.pdf

Primary Care

Diagnostics in Primary Care

One of the most significant obstacles to accessing timely diagnosis and care in Ireland is poor access to diagnostics for public patients. GPs need direct access to blood tests and radiology for all patients. There are capital, staffing and operational costs in delivering this. Generally, the Committee proposes that one primary care centre in each network becomes the diagnostics hub. These centres need to be available to all GP practices within that catchment area.

The Committee recognises that in some areas where there is currently no primary care centre, the diagnostic hub may be in the local hospital. More work is needed to cost the requirements of delivering timely access to diagnostics outside of the acute hospital setting. Figures referenced here are based on cost data from a recent HSE report submitted to the Committee, ‘Shifting the balance to high value care; A Planning for Health report, March 2017’.

Counselling in Primary Care

Currently people with medical cards can avail of counselling through referring clinicians. This is a new service, which 9,374 people utilised in 2016. For this service to be extended to the whole population, a budget increase is needed over time. The rationale is that if people get the right intervention at the right time, they may not need to access other more acute/crisis mental health services.

Given the limited availability of talk therapies in community mental health teams, extending counselling in primary care is a way of addressing mental health needs at a lower level of complexity, providing universal access to 6-8 counselling sessions for those whom their GP determines is in need of the service. The allocation for this service in 2016 was €6.5m. The Committee’s projections are based on doubling this spend over a three year period. A further allocation of €5m would allow additional psychologists to be hired as part of primary care services to work with people who do not need a referral to community mental health teams.

Free GP Care

Currently 46% of the population have access to GP care without charge at point of contact. Providing all Irish residents with access to GP care without cost is a critical enabler to providing high quality integrated care and protecting people from impoverishing payments to access essential care.

The Committee proposes extending access to GPs to the whole population by extending it to an additional 500,000 people each year for five years, on the basis of means. This is estimated to cost €91m per year additional cost.

Primary Care Staffing

Primary Care – A New Direction (2001) proposed primary care team composition for populations of 3-7,000 people as follows:

Table 2: Proposed membership of primary care team

Primary care team	Number envisaged
General practitioner	4.0
Health care assistant	3.0
Home helps	3.0
Nurse/midwife	5.0
Occupational therapist	0.5 – 1.0*
Physiotherapist	0.5 – 1.0*
Social worker	0.5 – 1.0*
Receptionist/clerical officer	4.0
Administrator	1.0

**to be assessed*

The nurse/midwife functions would include advanced nurse practitioner, clinical nurse specialist, public health nursing, midwifery, mental health, practice nurse and general nursing competencies. These staffing levels were used to project what staffing would be required.

Social Care

Palliative Care

The current specialist palliative care budget is €76m. Estimates submitted to the Department of Health indicate that with an additional €50m, universal palliative care can be provided. The Committee recommends that this be introduced in the first five years of the plan. This figure includes funding for LauraLynn Hospice, child respite and palliative care as well as specialist palliative care services for adults with a €10m allocation each year.

Home Care

In December 2016, 45,956 people were in receipt of HSE funded home help services, 16,351 people got Home Care Packages (HCPs) and 180 got intensive HCPs, the vast majority of whom also get a home help service. The average weekly hours for home help are 4.3 hours. The average weekly hours for HCPs are 6.5 hours and valued at €165 per week.

The number of people who apply and are assessed as needing a home help service or waiting for a HCP was 4,381 in December 2016, while it is estimated at any time an additional 800 people are awaiting more hours. These HSE figures show approximately 10% unmet need but this figure is bound to underestimate ‘need’ as lots of people do not apply for home care knowing they will not receive it. Wave 1 of TILDA indicates a figure of 26% unmet need. The 2017 budget allocation for home care is €403m, compared to €940m for the nursing home support scheme. Estimating a 30% increase in provision, it will cost €120m.

Services for People with Disabilities

Further work is needed to cost universal services for people with disabilities, which respect the autonomy of service users and their families as well as empowering them to be the key decision makers in how services are provided. There is a movement towards personalised budgets for people with disabilities. Further work is needed on costing and changing to such a model of care. In the meantime it is essential that services are developed to better meet the needs of people with disabilities and their families. The Committee recommends the earmarking of a €290m expansion over a ten year period, on top of the current allocation provided for disability services.

Mental Health

A Vision for Change set out the staffing requirement to shift the model of mental health care to a community based model of care. There is still significant under staffing of community mental health teams. For example, child and adolescent teams have less than half the staffing required and inadequate services to meet the needs of the population outside of specialist services. Therefore the Committee is recommending increased counselling in primary care and fully staffing child and adolescent mental health teams, as well as child and adolescent liaison and mental health services for people with intellectual disabilities. It is also proposing the current spend be examined to ensure it is providing value for money.

Dental Care

Dental health care, especially preventative dental care, is a crucial component of good health. Currently, out of pocket payments for dental care cause high levels of impoverishment and many people go without essential dental care due to cost. Reinstating previous publicly funded schemes is a short term measure to provide some dental care to some people. In the medium and long term, a more comprehensive package of dental care should be implemented as part of the Sláinte reform programme.

Reinstate Pre-Economic Crisis Budget to Dental Treatment Services Scheme

Under the DTSS, people with medical cards are entitled to some dental care without charge. This budget was cut by €17 million during the recent recession. Crucially, as the scheme now operates, virtually no treatments except extractions and emergencies are carried out and orthodontic services have been severely diminished. This scheme should be reinstated to pre-crisis levels in year one, until a more comprehensive package of care is put in place for the whole population.

The Department of Social Protection is in the process of re-instating aspects of the Dental Treatment Benefit Scheme. Currently the Department of Health is working on a new Oral Health Policy and it has commissioned costings on a minimal dental package. When this work is completed in 2017, a universal comprehensive package of care should be put in place.

Public Hospital Activity

Expanding Public Activity in Public Hospitals and Disentangling the Public Private mix in Public Hospitals

The Committee supports the principle of separating public and private care in public hospitals. Providing timely access to public hospital care will be achieved by the expansion of public hospital care, guaranteeing and delivering specific waiting time guarantees, and re-orientating the system so that the vast majority of care is delivered and accessible in primary and social care settings as is clinically appropriate, and by addressing under-staffing across the health system. In addition, the phased removal of private care from public hospitals alongside these measures will lead to an expansion of the public system's ability to provide care to public patients, thereby providing universal access to public hospital care in a reasonable period of time (The time guarantees for access to public hospital care are specified in Section 3, and, under this plan, will be underpinned by legislation.)

Current policy which removed the 20% limit of private work in public hospitals combined with the current practice of setting private patient income targets for public hospitals are perverse incentives. These should be removed by phasing out private work from public hospitals between Year 2 and 6 of this plan and replacing private patient income currently received by public hospitals over the same period. Based on current figures, this is costed at €649m.

Over this time, this income will be replaced by activity based funding for public patients, as more public patients will be treated as private patient numbers decrease. The Committee recognises and recommends that existing contracts may change through negotiation and the need for enhanced public only contracts for new recruits. Central to achieving this is ensuring the Irish public health system is a place where staff feel valued and in which they want to work.

The IMO, in its appearance before the Committee, cited its research which found that only 40% of Ireland’s medical graduates plan to practise here. On the reasons NCHDs are leaving, the IMO outlined the following:

“The top [reason] is under-staffing. If we look at the Hanly report in 2003, it shows that if we were to have a consultant-delivered health service in this country, based on our current population and the ratio set out in that report, we would need approximately 4,700 consultants. Currently we have 2,700...The second reason is that they are expected to carry out too many non-core tasks. They feel there are limited career progression opportunities. The fifth one is not having flexible training options...Pay is the fourth reason... The percentage of respondents that agreed with those statements is very similar. The top reason had 82% agreement and the fifth reason had 70% agreement.”

Such recruitment and retention issues apply across the staff categories. The Committee believes that we must create the conditions where we attract high-calibre applicants back to all health service positions, including consultant posts.

We must attract back professionals who have left the system, retain existing doctors and our newly-trained graduates, and recruit the additional consultants and other staff that are central to the delivery of a high quality public health system. This means new approaches to recruitment as well as new approaches to retaining staff, thereby creating a system where all professions are enabled to fully utilise their capacity and expertise in delivering safe, high quality care. In the meantime, in order to protect the interests of public patients, a system must be in place to ensure that consultants working in public hospitals are adhering to their current contractual commitments of 80%/70% public work.

In the first three/six months of this plan, an independent impact analysis of the separation of private practice from the public system should be carried out with a view to identifying any adverse and unintended consequences that may arise for the public system in the separation. The impact analysis should identify any challenges and propose solutions to ensure the disentangling of private care from public hospitals within the timeframe outlined above. Given the acknowledged need to increase capacity in the public system, it is important to ensure that any change should not have an adverse impact on the recruitment and retention of consultants and other health care professionals in public hospitals.

Additional Numbers of Consultants Required

Additional numbers of consultants are required to meet population need. Further work is needed to identify the specialties, numbers and locations of such new consultant posts. Some of this work is already done, for example in the National Maternity Strategy and in the proposal on palliative care submitted by the HSE. Overall, the Committee has allowed for an additional 20% (593) consultants to be put in place from Year 4, although some are included in area-specific costings, such as mental health and palliative care from year one. These will be additional posts; the filling of existing vacant posts is also an urgent requirement to ensure adequate staffing.

Replacement of Private Patient Income Stream for Public Hospitals

The revenue paid to public hospitals by private insurance companies amounted to €649m in 2016 and is estimated at €621m for 2017. The Committee recommends that this income stream be replaced by additional public funding over a five year period, starting in Year 2.

Section Three: Integrated Care

This section outlines the case and initial directions for the delivery of integrated care throughout the Irish health system. A single-tier universal healthcare system can only be delivered through integrated care. The Committee’s vision requires a system that is integrated in terms of all stages of an individual’s life, from cradle to the grave, and also in terms of a comprehensive continuum of care from health promotion and disease prevention to diagnosis, treatment, disease management, rehabilitation and palliative care. Further, such an integrated health system empowers people to play a pivotal role in managing their own health and ill-health.

This section also outlines the international evidence in favour of integrated care. It reviews the critical challenges involved in developing integrated care throughout the Irish health system. Using the WHO health system building blocks, it evaluates the required leadership and governance, funding mechanisms, ICT, workforce planning, and analysis required to deliver integrated care. Crucially, the analysis also addresses the enormous challenges posed by the current capacity constraints across our health system, including waiting lists and ED overcrowding.

The section concludes with a summary outline of the Committee’s preferred approach to service delivery and proposes critical enablers and phases for on-going implementation of integrated care.

“Integrated Care is a journey not a destination. We cannot fix the health system by strengthening the silos. More connections should be encouraged by the State to build trust, respect and agreed service change through integration of providers, care pathways and ICT systems. Innovation and change follows when this happens. This is the Carlow-Kilkenny story. This, we believe, is the best future for our health system.”
(Dr Ronan Fawsitt and Dr Garry Courtney, Carlow/Kilkenny Hospital/GP Group)

“[Integrated care] would promote seamlessness in the transition of people across services, providing multi-disciplinary care at the lowest level of complexity closer to where people live. The focus should be on improving access to primary and community care services. Examples of best practice include the integrated early intervention teams, age-related care units, stroke care clinical pathways, the new National Maternity Strategy, and numerous examples from other jurisdictions, including the dementia care model in Scotland. The experience from other countries has shown that integrated care is more efficient, reduces costs, enhances the quality of care and improves the overall health and wellbeing of the community.”
(Health Information and Quality Authority (HIQA))

3.1 Vision for Integrated Care

The Committee's Terms of Reference specify that it will:

“Examine and recommend how to progress a changed model of healthcare that advocates the principles of prevention and early intervention, self-management and primary care services as well as integrated care”.

This was reinforced by the Committee's First Interim Report in Goal 6, which committed *“to develop a model of integrated healthcare with an emphasis on primary and community care”.*

In its Second Interim Report⁵⁹, the Committee further defined the key elements of integrated care in an Irish context. This affirmed a critical focus on:

- *Health promotion and prevention of ill-health in the interest of improved public health and financial sustainability*
- *Recognising the fundamental role of general practice and primary care in managing the vast majority of care needs ... [meaning that] primary and community services must be in place and able to deliver in order to bring about a decisive shift away from our current hospital-centric system*
- *Ensuring patients' different care needs are met in an integrated way as they move from primary care to the hospital and perhaps on to community care*
- *An electronic health record as a critical enabler for integrated care*
- *The urgent requirement to address challenges in recruitment and retention of qualified staff as a fundamental aspect of capacity building in order to deliver on integrated care*
- *Over all of these factors, the need for clear clinical and managerial accountability and governance, and increased provision for frontline decision-making'*

Underpinning this vision, the Committee endorsed the following principles which drive a model where:

- *All care is planned and provided so that the patient is paramount (ensuring appropriate care pathways and seamless transition backed-up by full patient record and information) (Principle 2)*
- *There is timely access to all health and social care according to medical need (Principle 3)*
- *And patients access care at the most appropriate, cost effective service level with a strong emphasis on prevention and public health (Principle 5)*

3.2 International Evidence on Integrated Care

Integrated care is a response to the changing health profile of national populations, changes in health technology and organisation, and the inadequacy of current delivery models in responding to these shifts. A new model of coordinated health and social care is required to meet the needs of our older population, who are living longer with a complex set of clinical and social care needs. This new model is also needed to address the growing prevalence of chronic and disabling conditions such as diabetes, Chronic Obstructive Pulmonary Disease (COPD), heart-disease, dementia and stroke. This new model must respond to individual wishes and circumstances, be underpinned by strong public health and health promotion functions and be organisationally efficient and cost-effective.⁶⁰ These distinct requirements mean that we need a sophisticated health system that can respond in different ways to different circumstances – one size does not fit all.

Changing Health Need – The Example of Chronic Disease

Management of chronic diseases accounts for the majority of GP visits and hospital bed days in Ireland. The HSE projects that the prevalence of major chronic diseases will increase by 20% by 2020. Chronic diseases involve complex and multi-faceted health need which requires ongoing, co-ordinated care delivered in different settings at different times. However, the Irish health service was originally set up to provide intermittent care related to one discrete illness; therefore, it tends to care for patients with chronic diseases in a fragmented, episodic way. This leads to poorer outcomes because patients' needs are not met but it also leads to inefficient spending. To effectively serve a large and growing chronic disease patient population, the Irish health service requires a different approach.⁶¹

The prioritisation of primary care in response to Chronic Obstructive Pulmonary Disease (COPD) is a good example of this. Over recent years in Ireland the upward trend in COPD hospitalisation rates compares very poorly with other OECD countries. The hospitalisation rate for COPD is an indicator of the performance of a primary care system because 'the evidence base for effective treatment is well established and much of it can be delivered at a primary care level'.⁶²

⁶⁰ Kodner, D., & Spreeuwenberg, C. (2002). *Integrated care: meaning, logic, applications, and implications – a discussion paper. International Journal of Integrated Care*, 2, e12

⁶¹ Department of Health, 2016

⁶² OECD Health Statistics, 2017

A high-performing primary care system can reduce acute deterioration in people living with COPD and prevent their admission to hospital'.⁶³ Yet the Irish healthcare system continues to treat an increasing number of COPD patients through hospitalisation. To change this trend, the Committee wishes to create the conditions for a better resourced primary and social care network as a core element of integrated care in Ireland.

Delivering the 'Triple Aim' of Health Systems

A national health service for the 21st Century needs to deliver the 'triple aim' of health systems by improving care, improving health and reducing costs.⁶⁴ An integrated care system puts the person at the centre of system design and delivery, and is well-organised and coordinated to manage costs. It also ensures population health intelligence is a key determinant of design and decision-making.

Putting the person at the centre of the system also includes placing a priority on the wellbeing of the staff providing health services. Evidence shows that the promotion of a healthy workforce and working environment contributes to positive health outcomes for patients.⁶⁵ The changing nature of public expectations also strengthens the case for integrated care. A societal shift in favour of empowering the person as decision-maker, regular technological advances and the emphasis on greater transparency and accountability on the part of State agencies, are critical factors driving the demand for effective, streamlined and efficient services. Health budgets are limited, particularly given ongoing economic uncertainty; the provision of health services needs to be sustainable.

The World Health Organisation makes the case for integrated care on the basis of the: *'unequal progress in health status both between countries and within them, the changing health burden characterised by ageing populations, urbanisation and the globalisation of unhealthy lifestyles' and 'a belief that better organised health services can address common preventable causes of ill-health'*

The WHO further argues that: *'the current situation of fragmented health services is not fit for purpose; and that a system which does not address the social determinants of health and the need for people's participation in health decision-making will not be able to meet the challenges of today and tomorrow'*⁶⁶

63 OECD (2015) iLibrary, *Health at a Glance 2015 – Quality of Care – Avoidable hospital admissions*

64 Berwick DM, Nolan TW, Whittington J. *The Triple Aim: Care, health, and cost. Health Affairs, 2008 May/June;27(3):759-769*

65 Francis, R. QC (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, London, The Stationery Office

66 WHO global strategy on integrated people-centred health services 2016-2026 and Consultation *Placing people and communities at the centre of health services*. Geneva, Switzerland: World Health Organisation

In response to this mismatch between emerging health needs on the one hand, and an out-of-date system on the other, the Committee’s report presents a plan for integrated care that acknowledges:

- *The challenges of care delivery in the Irish system and the need to address current capacity constraints across the system to meet current and future demand for health services*
- *The on-going health system reform and service improvement work, and*
- *The need for transitional funding and robust arrangements to implement reform*

3.3 Defining and Delivering Integrated Care

Health systems are among society’s most complex and interdependent forms of organisation and increasingly require higher levels on integration given the factors noted above. It is paramount that a common understanding of ‘integrated care’ is developed⁶⁷ so that in managing the substantial associated political and technical challenges of implementing it, the goal of integrated care remains the focus over a sustained period.

Towards a Definition and Approach to ‘Integrated Care’ for Ireland

‘Integration’ is the ‘glue’ that binds the different elements of a system together enabling it to achieve common goals and optimal results.⁶⁸ Delivery of integrated care requires both ‘horizontal’ co-ordination, spanning professional and departmental boundaries, such as interdisciplinary team working, as well as ‘vertical’ coordination between primary, secondary and tertiary care domains, such as the design of optimal care pathways.⁶⁹ Integration is a means of improving access, quality, user satisfaction and efficiency of the health system.⁷⁰ The Committee defines integrated care as:

‘Healthcare delivered at the lowest appropriate level of complexity through a health service that is well organised and managed to enable comprehensive care pathways that patients can easily access and service providers can easily deliver. This is a service in which communication and information support positive decision-making, governance and accountability; where patients’ needs come first in driving safety, quality and the coordination of care.’

This definition of integrated care puts patients’ needs at its centre and values communication and information to support positive decision-making, good governance and accountability.

67 Department of Health (2012) *Future Health*

68 Kodner, D., & Spreeuwenberg, C. (2002). *Integrated care: meaning, logic, applications, and implications – a discussion paper. International Journal of Integrated Care, 2, e12*

69 National Institute of Medicine. (2001). *Crossing the quality chasm: a new health system for the 21st century. Washington: National Institute of Medicine*

70 Gröne and Garcia-Barbero, 2001, M., & W. H. O. European Office for Integrated Health Care Services. (2001). *Integrated care: a position paper of the WHO European Office for Integrated Health Care Services. International Journal of Integrated Care, 1, e21*

Recalibrating the system to build up primary and social care capacity is paramount to this approach. This enhanced capacity in primary and social care will in turn relieve some pressure on the acute hospital system, and free up capacity to deal with care that can only be provided there, although resourcing and co-ordination of the hospital sector is also critical. It is essential that the urgent capacity pressures facing all parts of the health system are considered as part of a whole-system response and drive towards integrated care.

International evidence on the characteristics of integrated care systems describes them as multidisciplinary in nature, well managed and coherent, and demonstrating empowering and collaborative cultural norms.⁷¹ Given these various parameters, the Committee recommends that integrated care in Ireland is implemented through three integration streams:

System Strengthening to include governance; funding mechanisms and financial management; workforce planning; eHealth and other knowledge-based technologies; quality and performance management; procurement.

Service Coordination that responds differently to different population and personal care needs, i.e. service integration

Network Building between care providers, advocacy groups and others, public, private and voluntary, throughout the health and social care domains, i.e. community integration.

The work of communicating and enabling a new culture of collaboration, empowerment, co-ordination and shared goals is pertinent to all three streams of work outlined above. Similar themes are emphasised in many stakeholder submissions. *“Moving from a focus on illness to a focus on wellness enables supports to be put in place at an earlier stage of the ageing or illness process, ensuring that small, short-term outlay translates to increased savings in the long term.”* – (Care Alliance Ireland). A key recommendation is to *“develop integrated pathways between the primary, secondary and social care systems to ensure care is coordinated around the person and resources are used to meet the needs of the individual.”* (Age Action)

“The Irish Healthcare Service must respond to very significant increases in demand driven by an ageing and changing population, a significant growth in the incidence of chronic illness, new health technologies as well as a training/education for medical professionals that is outcome driven.” (ASSERT Centre, College of Medicine and Health, UCC)

“The demographic profile of Ireland is changing rapidly and with this, the health needs of the Irish people are also shifting. However, it is clear that the current system of healthcare provision, developed for past conditions, is failing to cope with present realities.” (Association of

71 Valentijn, P. P., Vrijhoef, H. J. M., Ruwaard, D., Boesveld, I., Arends, R. Y., & Bruijnzeels, M. A. (2015). Towards an international taxonomy of integrated primary care: a Delphi consensus approach. *BMC Family Practice*, 16(1), 1-15. doi:10.1186/s12875-015-0278-x

Optometrists Ireland) And “...there is growing awareness and focus on preventative approaches to wellbeing and mental health. For instance... healthcare reforms place considerable emphasis on keeping people healthy and well. Similarly, in their pre-budget submission for 2016, Mental Health Reform recognised that early intervention approaches not only incorporate a focus on the infants’ physical needs but also their social and emotional health and wellbeing.” (Perinatal & Infant Mental Health)

3.4 Health System Reform in Ireland

Health Policy Context

At the heart of reform is the realisation of actual health system change. For a long period in Ireland services were delivered through health boards; voluntary, public and private hospitals; and a range of charitable and other organisations. This approach to health care delivery has resulted in fragmented and unsatisfactory care. In recognition of the need for a more integrated approach the 2004 Health Act organised health service delivery through a centralised body, the Health Service Executive (HSE). Since the HSE’s establishment in 2005 it has been in a continuous state of re-organisation and restructuring with little apparent benefit to users of services and persistent disruption for staff. Recent steps towards integration include the creation of Hospital Groups and Community Healthcare Organisations.⁷²

In recent years, the HSE has been developing five integrated care programmes in the areas of chronic diseases, older people, children, maternity and patient flow. Early results from the Integrated Care Programme for Older People show positive outcomes for older people as well as benefits to the health system. Other approaches to integrated care such as the Carlow/Kilkenny model demonstrate that collaboration between care professionals across primary, social care and hospital settings has positive benefits for patients, provides a better care pathway and facilitates more care outside of hospital. Such examples of good practice can help to prevent some of the traditional bottlenecks in the Irish health system. The 2016 Programme for Partnership Government identified seven priorities for health service delivery:

- *A decisive shift of the health service to primary care with the delivery of enhanced primary care in every community*
- *Guaranteeing the future sustainability of rural practice and in disadvantaged urban areas*
- *Creating a Healthy Ireland*
- *Building capacity for our emergency and acute services*

72. *The Establishment of Hospital Groups as a Transition to Independent Hospital Trusts, A Report to the Minister for Health, Dr James Reilly TD; and Community Health Organisations (HSE, 2014) – Report and Recommendations of the Integrated Service Area Review Group. Dublin*

- *Improving waiting times for hospital procedures*
- *Reforming the HSE into a more efficient, transparent health service for patients and staff*
- *Funding of the health service (which included a commitment to establish this Committee)*

Similar priorities were set by the Department of Health in 2016 which specified the need for:

- *Changing the mode of healthcare (enhancing health and wellbeing, not just providing services)*
- *Providing care at the lowest level of complexity*
- *Delivering the majority of care through primary care services Integrating care (usually led with active support from general practice and primary care)*
- *Ensuring continuous, reliable models of care to manage chronic diseases (at the lowest level of complexity)*
- *Ensuring patient safety and quality of care⁷³*

This Department of Health report also identifies important strategic enablers for reform. These are organisational structures, workforce planning, better ICT systems, improved financial models, and stronger leadership and management capacity.

3.5 Health Service Delivery

Public, primary, social, secondary and tertiary care have been consistently organised and funded separately, with hospital-centred care most powerful in terms of access to resources. To gain access to a range of public services without charge, such as diagnostics, specialist nurses, or physiotherapy, people often have to go to a hospital. Outside of hospital, GPs act as a gateway to care; once a patient is seen by a hospital specialist, it is the latter who usually acts as the access point.

This hospital-centric situation creates perverse incentives which mean people are cared for in hospitals instead of receiving as much care as they can at the lowest level of complexity in the community. In addition, the Committee believes that the current range of services is fragmented, episodic and difficult to negotiate as reflected in many of the submissions received.

The goal of the new model of service delivery proposed here is seamless integrated care, where the budget allocation, which directly impacts on numbers of staff and therefore services provided in various settings for 2017 was €4.4 billion (38%) for acute hospitals, €3.8 billion (33%) for primary care and €3.4 billion (29%) for social care.⁷⁴

⁷³ Department of Health (2016) "Better Health, Improving Health Care"

⁷⁴ HSE, Health Services People Strategy 2015-2018 – Leaders in People Services

The Committee's Terms of Reference state that: *The best health outcomes and value for money can be achieved by re-orientating the model of care towards primary and community care where the majority of people's health needs can be met locally.*

Distributed leadership in the context of a decisive shift to primary care requires clinical leadership to enable local service reform. The principle of a multi-disciplinary team-based approach to providing seamless care to patients should apply in hospital and community care settings. Community-based clinical leads are ideally placed to provide clinical leadership to a multi-disciplinary team that is tasked to provide seamless integrated care for patient. Community-based clinical leads are also ideally placed to collaborate and co-ordinate ambulatory care with hospitals through a shared governance model such as the Local Integrated Care Committee process.

The Committee's preferred model of care is for everyone in Ireland to access public health, health promotion, diagnostics, treatment and care when needed in the appropriate setting as close as possible to their home, within a reasonable period of time, with little if any charge at the point of access. This care should be of high quality, integrated and provided by qualified staff who feel valued.

Given the negative health outcomes for many people resulting from the fragmented nature of healthcare delivery in Ireland, and the challenges of access, several critical challenges need attention in the short-term. Addressing these issues will require among other things;

- *A strong whole of government commitment to implementing the public health goals of the Healthy Ireland initiative*
- *Ensuring access and resourcing health care at the lowest level of complexity possible, integrating mental health care within the primary care domain, expanding diagnostic services outside of hospitals. These changes are key to re-orientating the system towards primary and social care, and delivering on integrated care*
- *Disentangling public and private care in public hospitals over time, designating hospitals within or across Hospital Groups as elective, and taking concrete measures to improve access to Emergency Departments and manage waiting lists for elective care*
- *Ending the over-reliance on market mechanisms to deliver new health care services by the expansion of public nursing homes and homecare*
- *Addressing the capacity constraints evident across the health system, which result in difficulties in accessing care in various settings. Long waiting lists and ED overcrowding, as referenced above, are the most obvious manifestation of these pressures, but equally significant pressures exist in primary and social care, as evidenced by many of the stakeholder submissions received. In line with the Committee's vision of integrated care, capacity issues in any part of the health system cannot be considered in isolation*

3.6 Addressing Critical Service Delivery Challenges

There are some critical changes that need to happen to promote the delivery of efficient, effective and integrated care;

- *The first is a strong, government wide commitment to promoting health, reducing health status inequalities and supporting good health throughout the life course*

*Healthy Ireland*⁷⁵ sets out to do this. Examples of health promotion measures include exercise in school curricula, better play areas, walking and cycling lanes, healthy workplaces, and supporting activity in older people. Unless all public agencies are mandated to deliver aspects of the strategy that are within their remit, and unless there is a much stronger emphasis on population health, disease prevention and health promotion within the health services, the Committee firmly believes that the new health system model will not be sustainable.

- *The second critical change is that care should be delivered at the lowest level of complexity as is safe, efficient and good for the patients. This requires us to move down the care pyramid. For example, currently a significant amount of care is provided in acute settings, although it would be better provided in the primary and social care setting*

Similarly, even within the acute hospital system some aspects of care could be provided more effectively and efficiently in lower level hospitals leaving more complex cases for specialist hospitals. Integrated care may also mean, for example, locating specialist nurses in the community to work with GPs to manage chronic diseases.

There are also significant possibilities for extending the roles of paramedics, public health nurses, health care assistants, community based clinical leads and allied health professionals to provide services in the community. This will require the building up of staff capacity and facilities outside of hospitals or in lower level hospitals.

A further example of providing care at the lowest level of complexity is the integration of a significant proportion of mental healthcare with primary care. There is also need for greater integration between primary and acute care for people with more acute mental health needs. Even within the primary and social care settings, care could be better and more safely delivered within people's homes rather than in institutions, or by alternative cadres of healthcare providers or carers.

- *The third critical change supported by the Committee is the significant expansion of diagnostic services outside of hospitals. This is to enable timely access for GPs and referring specialists to diagnostic tests which do not necessarily need to be provided in hospitals. Currently many*

people end up in Emergency Departments or as outpatients in order to get a diagnostic test, which could be provided more efficiently and at a lower cost outside of the hospital

This in turn frees up hospitals to do the work they need to do. The Committee believes that primary care centres should be the hub of community diagnostic services so that any GP or relevant health professional within their catchment area can refer all patients for diagnostics in these centres. Primary Care Centres in some parts of the country are already fulfilling this role, for example the Living Health Clinic in Mitchelstown now provides direct local access to X-rays, ultrasounds and DEXA scans so that people from the Mitchelstown and Fermoy area no longer have to travel to Cork city or Mallow hospital for such services. There should be such access to diagnostics including blood tests in all areas, in HSE run primary care centres or as appropriate in some smaller hospitals. These services are currently free of charge when accessed on a hospital outpatient basis; the expansion of entitlement to community services, as set out in Section 2, will be an important aspect of encouraging utilisation of community diagnostics.

- *The fourth critical change is the disentanglement of public and private care. The current system relies on both public providers and a diverse range of private agents ranging from GPs, to hospitals, to Local Injury Units, to diagnostic centres. Some private agents, such as GPs, are at the heart of the public health system and have been central to the delivery of primary care. Others like private hospitals play a peripheral role supplying some care for private patients and for public patients who face long waits*

Conversely private patients are often treated in public hospital beds, absorbing capacity from public patients. The Committee believes that the public and private sectors should be disentangled over time. This will allow the private sector to operate more independently, and public sector resources to be channelled to public patients.

The continued delivery of private care in public hospitals works against the delivery of a single tiered universal system and hence the realisation of the Committee's Terms of Reference.

As noted in the key principles agreed by the Committee during workshop sessions:

- *Public money is only spent in the public interest/for the public good, ensuring value for money, integration, oversight, accountability and correct incentives*

In practice, this means that private beds will no longer be provided in public hospitals. Instead, the capacity of public hospitals will be built up over time while private care is removed from public hospitals.

This will require:

- *A fund to replace the €649m (2016 figure) private patient income in public hospitals between year two and six of the plan*
- *Consultants will only treat public patients in public hospitals, the proportion of private work in public hospitals will be eliminated over a phased period*
- *Careful workforce planning to meet current and future staffing needs, and measures to ensure that public hospitals are/become an attractive place to work for experienced, high quality staff*
- *Robust workforce planning which ensures that we maximise the utilisation of the skills of every worker that are currently available within the health service*
- *Sufficient numbers of consultants and other essential healthcare professionals to meet population need*
- *Current unacceptable waiting times for public hospital care in emergency departments, outpatient clinics (OPD) and planned daycase and inpatient treatment must be reduced so that timely access is provided, based on need and not ability to pay*
- *The successful re-orientation of care delivery to primary and social care settings so that most care is provided (publicly) outside of hospital*

Further, the design of hospitals needs to be re-thought. The Committee recommends an appropriate number of hospitals be designated as *elective only* within each Hospital Group. This is so that emergency and urgent care cannot crowd-out elective care which makes waiting lists and waiting times longer. It is important to note that the focus here is on providing protected capacity for elective care, rather than on any reduction of Emergency Department provision. The Committee notes that this policy innovation has been successfully introduced in Scotland. An integrated hospital waiting list management system is also an important component of reform.

The fifth critical challenge is to address long waiting times, poor conditions and delayed access to essential diagnosis and treatment as common features of the Irish public's experience of Emergency Departments (EDs). Despite successive ED Task Forces and Ministerial priorities, ED over-crowding persists and has a knock-on negative impact across the health system. For example in December 2016, there was a 6% increase in ED attendances and a 7.2% increase in ED admissions when compared to the same month in 2015. There were also a 7% increase in GP Out of Hours services and an 18% increase in ambulance calls.

Addressing ED overcrowding requires a system wide response as outlined in this report so that integrated, patient centred care is provided through enhanced primary and social care services. This requires investment in these non-hospital services so that the management of the vast majority of chronic diseases takes place outside of hospital.

It will also require investment in hospital infrastructure, additional consultants, nursing staff and other health professionals, the availability of direct access to diagnostics outside of hospitals for GPs and referring specialists as noted above and improved processes and efficiencies within hospitals. The Department of Health has announced a bed capacity review in 2017 as part of the long-term solution to ED overcrowding and waiting list management. The scope of this Review as outlined recognises that capacity in our hospitals cannot be considered in isolation from primary and community care capacity. The Committee recommends that the outcome of the Review should inform the detailed planning for the infrastructural investment provided for in the proposed Transitional Fund.

The sixth and essential critical challenge to address is the long waiting list for access to elective care. The Committee believes that this is one of the scourges of the current Irish healthcare system. It is not possible or desirable to deliver universal single-tier healthcare with the current high waiting times for diagnostics, outpatient appointments, in-patient, rehabilitative and allied health care. This has been an intractable problem within the Irish system for many years. The Committee believes that many of the solutions outlined are outlined in the approach described above. This is because in an integrated care system, solutions address several related problems at once.

The results from the international experience of measures to reduce waiting times is very positive. There are clear lessons which can be drawn from the experience of other countries that reduce waiting lists significantly over time. The critical innovation is to combine both demand and supply side interventions. It has long been understood that waiting lists are an indication that the health care system is not operating effectively. Where primary care systems are weak there will be a higher burden on acute care.

Further, where social and long-term care is in short supply, then acute care in hospitals will again be a costly and inefficient bottleneck. Hence an integrated and system-wide approach is needed – building up capacity in hospitals alone will not solve the problem, or provide a cost-effective and patient-centred approach. It is essential to invest in primary and social care so that the patient pathway to care only intersects with acute hospitals when needed and not as a default, as is currently the situation in Ireland. At the same time, the Committee recognises the need for enhanced capacity within our hospitals, informed by the Capacity Review as noted above.

This will help manage the reduction of waiting times in addition to decreasing the problems of hospital-acquired infections in those settings. A further Committee recommendation is to establish community diagnostic centres in key primary care centres in the country. This will make available diagnostic services free/at low cost without the delays currently experienced. This in turn will relieve the pressure on Emergency Departments and outpatient waiting lists.

Nevertheless, these supply side policies by themselves will not be enough to manage reducing waiting lists and times to acceptable levels. The additional strategy needed is to establish guarantees for maximum waiting times and make people accountable for these guarantees. International experience is definitive in that without such enforced guarantees waiting lists and waiting times will not come down. Guarantees are made effective by either penalising hospitals that do not meet them (England and Finland) or by offering patients choices for care outside of the public system if they remain on a waiting list beyond the guaranteed time (Portugal, the Netherlands, Denmark and more).⁷⁶

Early lessons from Sweden, one of the first OECD countries to introduce a waiting time guarantee, show that such guarantees “work best when they are comprehensive, covering all forms of specialist care as opposed to a selected set of procedures, have strong sanctions and economic incentives, and enable patients to exercise their right to use an alternative provider”.⁷⁷ All of these measures to strengthen the health system will accrue towards better management of the critical challenges outlined here. As an example of this, eHealth Ireland has outlined how eHealth could assist with tackling the waiting list problem with waiting list management solutions within 12 months, with a limited amount of investment.⁷⁸

These proposed solutions will be built in a compatible manner with the overall Electronic Health Record (EHR) and Individual Health Identifier (IHI) infrastructure in mind. The solutions should be considered as the first part of the EHR programme itself, whilst outside of the EHR Programme business case they would be proving technologies, cultural changes as well as capacity and capability within the system to adopt digital solutions (eHealth Submission).

In the sections above, the Committee has examined current patterns of service delivery in the Irish health system, including defining six critical challenges, so that integrated care can become a reality. The report now outlines a comprehensive model of integrated care.

3.7 Modelling Integrated Care

In this section, the WHO health system building blocks framework is used to set out the core elements of the integrated and well-functioning health system that this plan will deliver.⁷⁹

The Committee uses this approach to analyse particular health system elements which currently inhibit integrated care in Ireland and to make recommendations on these elements. Each building block concludes with a set of recommendations. They include:

⁷⁶ Siciliani, L., Moran, V., & Borowitz, M. (2014). *Measuring and Comparing Health Care Waiting Times in OECD Countries*. *Health Policy*, 118(3), 292-303

⁷⁷ OECD (2015) *iLibrary, Health at a Glance 2015 – Quality of Care – Avoidable Hospital Admissions*

⁷⁸ *eHealth Submission*

⁷⁹ World Health Organisation, 2007, *Everybody Business; Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*

- *Establishing a clear governance and accountability framework for the health system*
- *Getting the right funding mechanisms in place*
- *Managing capacity through integrated workforce planning and harnessing the innovations of technology, especially eHealth*
- *New patterns of leadership, including clinical and multidisciplinary team-approaches, and a culture of integration and participation for a new coordinated model of service delivery*

3.8 Leadership and Governance

Good leadership, governance and accountability are critical functions of any health system. This includes clarity at all levels, i.e. the roles of the Minister for Health and the Department of Health, the health services national body (the HSE), clinical leadership and governance throughout the healthcare system, as well as front line care provided in the community and hospitals. Leadership in practice is essential for service coordination in an integrated care system.⁸⁰ In this vein, healthcare practitioners throughout the system will need to develop strong leadership skills and capacity to deliver on the goals of integrated care.

The HSE Governance Structure

The Committee believes that the current HSE governance structure is not fit for purpose. An independent board needs to be put in place.

The Committee recommends that:

- *The Minister for Health is held responsible and accountable on a legislative basis for delivery of healthcare, the health system and health reform*
- *An independent board and Chair is appointed to the HSE at the earliest opportunity, by the Minister, following a selection process through the Public Appointments Service. Board membership reflects the skills required to provide oversight and governance to the largest public services in the State*
- *The Chair of the Health Service Board is accountable to the Minister for Health*
- *The Health Service Director General is accountable to the Board*

HSE management becomes a strategic, patient-focused ‘national centre’ carrying out national level functions, such as population needs assessment, strategy, planning and evaluation, in support of the service providers (currently grouped into 6/7 Hospital Groups, 9 Community Health Organisations (CHOs) and the National Ambulance Service (NAS)). Delivering a strategic, patient-

80 Hegarty et al., 2015; Leahy-Warren et al., 2016

focused ‘national centre’ will mean reducing the number of direct reports to the Director General. The role of the ‘national health service centre’ is to ensure the core functions of national strategy and service planning, operations management, national medical direction and the management of enabling services (for example, finance, HR, information and communications) are carried out at national level.

National health service directors with responsibility for delivering the core national level functions will be held accountable through the Director General and the Health Service Board. In this strategic national centre the roles of some of the current national directors will be subsumed into these core national level functions and clear direct and clear reporting links between those national directors, or chief officers, and service providers (i.e. Hospital Group CEOs, CHO Chief Officers, NAS & PCRS), will be established.

The Committee Recommends:

- *That the HSE Directorate becomes a more strategic and patient-focused ‘national centre’ with a reduced number of national directors reporting to the Director General*
- *That the National Directors will be relocated into other roles strengthening the functions required for the new mode of integrated care, for example relating to building strengthened leadership capacity in the community for primary and social care*

Given this more strategic model of national service level management and coordination, and the more direct leadership and accountability linkage between patient experience, frontline providers and senior management created through it, the work of integrating service provision is centralised, and becomes the heart of the system. ‘Integrated care (as the preferred health service delivery model) will be coordinated across care domains through Integrated Care Regional Organisations tasked with locally embedding the various initiatives for system strengthening, service coordination and network building as outlined in this report.

These will be particularly responsible for appropriate care coordination (acute, primary, social) in collaboration with the various emerging networks at CHO and Hospital Group level (including CHNs, and Integrated Care Programmes). Arrangements as to the best alignment of Regional, CHO and Hospital Groups will be determined during the implementation of the Programme. This will be achieved across different regions and based on devolved responsibility for the provision of services in accordance with national policy.

The Committee proposes that membership of Integrated Care Regional Organisations will include senior health care and clinical managers with statutory responsibility for health care delivery. Exact membership in each region will be determined by the ‘Health Service National Centre’, CHO Chief Officers and Hospital Group CEOs, working with the Sláinte Programme Implementation Office.

The role of the Integrated Care Regional Organisations will be to ensure timely access to integrated healthcare services in line with the reform programme. The role will include the following functions:

- *Resource allocation for integrated care as appropriate*
- *Staff recruitment for integrated care as appropriate*
- *Governance and co-ordination of established integrated care goals through the CHO/Hospital Group Networks*
- *Accountability through regular reporting to the ‘Health Service National Centre’ and managed through the:*
 - *National Service Plan*
 - *Integrated Care Programmes*
 - *Clinical Care Programmes*
 - *Clinical Governance Arrangements*
 - *Service Level Agreements etc.*

Good governance requires accessible and understandable reporting structures or processes that support open communication, integration and adaptation to change. These need to be ‘vertical’ in the sense of connecting the most senior decision-makers and those delivering the service at the frontline; but also ‘horizontal’ in connecting decision-makers within and across different care provision boundaries – whether clinicians, managers, coordinators, support staff or a whole range of caregivers. The following section proposes how horizontal integration can be achieved.

Horizontal Integration Across Community, Hospital and Ambulance Services

Along with the National Ambulance Service, the Community Health Organisations (CHOs) and Hospital Groups are currently the overarching structures of the public health service delivery. Hospital Groups were established to provide a coordinated approach between the different hospitals within the group and to link strategically with academic partners.

The goal of the CHO structure is to link primary, mental and social care providers as well as supporting population-based health and wellbeing. The nine CHOs are at different stages of development and are made up of 96 Community Healthcare Networks (CHNs, formerly called Primary Care Networks). The CHNs are the core building blocks of the new structure, broadly designed for an average population of 50,000 (within a range of 35,000-70,000) and have been defined where possible according to natural county and local health organisation (LHO) boundaries.⁸¹ They are the main conduit for continuity of care linking primary and social care

as well as other community stakeholders as shown in the case of the Integrated Care Programme for Older Persons. GPs work with both HSE CHO/CHN services and Hospital Groups and are a central enabler to delivering integrated care.

In the integrated model of care as proposed, it is essential that there is seamless care between the hospitals and community services in the best interest of service users. The challenge of delivering integrated care services is twofold – making sure continuous care is delivered to patients across primary and social care according to need, on the one hand; and ensuring continuity of access to secondary care in a hospital setting when required. The Committee endorses the new thinking for integration that focuses on *building connections rather than boundaries* and recommends continued implementation of mechanisms to counter fragmentation such as: activity-based funding at a systems-level (e.g. regional), integrated workforce planning, eHealth measures and Local Integrated Care Committees (LICCs) which currently manage integrated service coordination in several local areas.

In this context, local integration can work effectively in Ireland, as demonstrated by the Carlow-Kilkenny integration model, which is being embraced and adopted in other regions. Local Integrated Care Committees (LICC), which began in Carlow-Kilkenny, allow clinicians and management to work together in a formal structure. They give added value through innovation and enhanced acute and chronic care within the community with specialist back-up when needed. The LICC experience to date has shown that front-line staff can align to improve communication and collaboration, thus reducing risk, building services and improving outcomes for patients, to give greater job satisfaction to providers and value for money to the State.

The culture of connectivity and the breaking down of barriers through this process leads to service innovation and better patient management. This is achieved by both enhanced communication and by developing the ambulatory care model for acute and chronic disease presentations where hospital admission is the exception rather than the norm. There are some benefits of integrated care built on collaboration and structured contact through the LICC process.

To build this nationally, significant funding with protected time for GPs and all participants in local integrated care clinics is essential. This will encourage clinical leadership and integrated care at local level. Similarly hospital and community management participation is integral to the process as is involvement of mental health and social services. Participation and trust are key drivers of local integration. This allows the building of shared governance through clinical leadership and local participation of stakeholders. It also assists the decisive shift to primary care in a locally agreed manner that supports national health policy. This is the essence of collaborative, patient-centred, integrated care.

Recognising the international evidence on the negative impact of system re-organisation on reforms,⁸² the Committee believes that it is advisable to establish the simplest structural change possible in order to meet the requirements of integrated care. This will be achieved based on a phased transition to an integrated care model of resource allocation, accompanied by a governance structure to ensure accountability; information sharing and population health needs analysis. In this vein the Community Health Networks will remain on track as a core unit of health service coordination and provision.

Governance at regional level will be assured through the establishment of regional bodies designed on the basis of relevant analysis carried out by the Department of Health and the HSE for optimum organisation, given patient ‘self-containment’ patterns of access to health care, positive working relationships etc. The role of these regional bodies follows the overall rationale driving the implementation of integrated care throughout this report, i.e. system strengthening, service coordination and community network building. This approach recognises the value of geographical alignment for population-based resource allocation and governance to enable integrated care.

Regional bodies will have particular responsibility for resource allocation in line with the recommendations on funding, and funding mechanisms, set out elsewhere in this report. They will have neither policy role, nor political representation and will be held accountable to the ‘national body’ (HSE) by reporting on a regular basis to the relevant national directors, director general and ultimately, independent Board of the Health Service.

The Committee Recommends:

- *That greater alignment of service provision for integrated care across care domains is implemented at Community Healthcare Networks (CHN) level. This will include further mapping analysis and use of funding, information sharing and eHealth mechanisms*
- *The geographic alignment of Hospital Groups and Community Health Organisations will help to support population-based health planning and delivery. Further analysis and consultation should be undertaken to identify how alignment can best be achieved with minimal disruption to key structures including at Community Healthcare Networks (CHN) level*
- *Moving towards a form of regional health resource allocation with accompanying governance structures to formally connect Hospital Groups and Community Health Organisations for the provision of integrated care, using CHOs and CHNs as the core unit of health service coordination and provision*

- *The establishment of regional bodies that will be accountable for implementing integrated care at sub-national level by strengthening the local care provision system, ensuring service coordination between the different care domains, community network building and resource allocation for integrated or shared services*
- *Integrated care such as the Carlow-Kilkenny Integration Model (CKIM) which established the Local Integrated Care Committee (LICC) structures in the Ireland East Hospital Group, be supported and developed. This model encompasses the WHO strategies of implementing integrated care by;*
 - *Empowering and engaging people*
 - *Strengthening governance and accountability*
 - *Reorienting the model of care*
 - *Coordinating services*
 - *Creating an enabling environment*

Patient Safety and Clinical Governance

Patient safety is fundamental to the delivery of quality healthcare. The public must have confidence in the safety of our health service. However, there have been a number of reports which have set out significant failures within the system. It is essential that the health service learns from these failures, and implements recommendations from any investigations undertaken. Strong governance structures, clarity on reporting relationships and senior clinical leadership are among the key factors required to ensure this happens.

It is acknowledged that the delivery of healthcare is inherently risky, and its complexity is unlike other sectors and businesses. This was illustrated by the following quote from Atul Gawande, cited by the RCSI in its submission to the Committee: *“our ever changing world of modern medicine challenges us with 13,000 diseases, 6,000 drugs and 4,000 surgical procedures. ... to rescue a critically sick patient, 178 tasks must be carried out correctly each day of critical care management. Failure to perform these correctly may lead to a patient safety incident...”*

It is essential, therefore, that the right systems are in place to minimise harm, and to maximise clinical and cost effectiveness in order to deliver safe, high quality care. This means patient safety must be embedded in clinical and corporate governance. The role of governance was noted by the IHCA in its submission to the Committee: *“Organisation and corporate governance structures need to be strengthened to ensure that the quality and safety of care provided to patients is not restricted by budget, staffing and other limitations...”* Clinical governance is a component of the total governance of health service organisations through which they are responsible and accountable for:

- *Continuously improving the quality of their services*
- *Safeguarding health standards of care*
- *Ensuring best clinical outcomes for patient care*
- *Actively involving patients in the planning, providing and evaluation of their care*

It requires:

- *Commitment at all levels of management within the organisation including care providers*
- *The creation of an organisational culture that is conducive to the provision of high quality and safe care for patients and clients. This culture should be characterised by a shared passion for quality, openness, respect, support and fairness, no blame or retribution*
- *Procedures and practices are in place which ensure high standards of clinical performance, clinical risk management, clinical audit, ongoing professional development and well developed processes to investigate, take action and manage adverse clinical events*
- *Effective teamwork, managing health to ensure clinical efficiency and*
- *Effectiveness*⁸³

At his appearance before the Committee, Professor Tom Keane emphasised the importance of robust clinical governance.⁸⁴ *“What has been missing is what I call a clinical governance model and an expectation that once best practice is defined, then that is what actually will happen.”* He advocated for a legislated clinical governance model, and emphasised the importance of ensuring that, at the level of the hospital, *“...clinical governance ensures that the physicians or surgeons who work in a hospital meet a standard of care that is assessed and monitored locally... Ireland needs a clinical governance model that looks at credentialing quality of care and monitoring care at a local level.”*

The publication in 2012 by HIQA of the National Standards for Safer, Better Healthcare was a key milestone in improving regulation of healthcare. The Standards define clinical governance as, *“A system through which service providers are accountable for continuously improving the quality of their clinical practice, and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This includes mechanisms for monitoring clinical quality and safety through structured programmes, for example, clinical audit.”*

The HIQA National Standards⁸⁵ state that service providers should have clear accountability arrangements to achieve the delivery of high quality, safe and reliable healthcare. Recent work done in an Irish context highlights the importance of the integration of corporate and clinical

83 Scally, G., 1998. *Clinical Governance and the Drive for Quality Improvement in the new NHS in England*. *BMJ*, Volume 317, pp. 61-65

84 *The Cancer Strategy as a Case Study of Health Service Reform: Professor Tom Keane, 19th October 2016*

85 *HIQA National Standards for Safer Better Health Care (2012)*

governance, how real change will only happen when there is total management buy in across all aspects including human resources, finance, and eHealth.⁸⁶

A clinical governance framework should ensure that the highest level of authority for the organisation has a clear line of accountability down to the individual patient. This requires that structures and processes are in place to achieve this. Most frequently the Board of the organisation or hospital is responsible for ensuring that effective clinical governance structures and processes are in place. The international literature supports the view that board Members should be actively involved in clinical governance thereby sending a clear message to the whole organisation of their shared responsibility. Of equal importance is an interdisciplinary team approach to clinical governance, which ‘delivers what the patient needs and not just what the professional can deliver’.⁸⁷

Clinical governance in Ireland is at early stages of development although lacking legislative underpinning. A lack of accountability has been repeatedly demonstrated when adverse events occur. There are many reasons for this but the dominant reason is widespread deficiencies in clinical governance. There is now a unique opportunity to address the current shortcomings in clinical governance in Ireland.

Maintaining safe and high quality care can only be achieved when creating and sustaining a culture where safe and high quality care is everyone’s focus, actively upheld and implemented by everyone.

In this regard, the Committee notes the establishment in December last year of the National Patient Safety Office, with a programme of work that focuses on key patient safety policy initiatives including legislation.

The Committee Recommends:

- *That a blueprint for clinical governance across the health system be put in place in a timely and optimal manner*
- *This should be underpinned by legislation which specifies the structures, processes and responsibilities of boards, management and clinicians for the operationalisation of clinical governance within all organisations*

⁸⁶ HSE, 2014, *Report of the Quality and Safety Clinical Governance Development Initiative: Sharing our learning*

⁸⁷ HSE, *Planning for Health. Trends and Priorities to inform Health Service Planning 2017*

Governance of Section 38 and Section 39 Agencies

The Committee is of the view that it is not appropriate that so much of the Irish public health service is in private ownership. The Committee therefore welcomes the recent proposal from the Minister for Health to establish a Forum to examine this matter. It urges the drawing up of a detailed phased plan to provide for the divestment of these facilities over a reasonable period. At the start of this process, it will be necessary to compile a detailed audit of all publicly funded properties which are currently in private ownership.

In the interim, the Committee believes that it is essential that strict Service Level Agreements apply to the allocation of all public monies, combined with the proposed activity-based funding system.

The Committee is concerned about the proliferation of Section 39 organisations. It is the view of the Committee that the State has a responsibility for the provision of health services and that there has been an over-reliance on charities for this purpose. The Committee also recognises the important advocacy role which many charities perform. The Committee welcomes the Statutory Consultative Panel recently established by the Charities Regulator on the Governance of Charitable Organisations. However, it also believes that this should include proposals for a substantial rationalisation of this sector in order to achieve greater coherence and value for money.

3.9 Healthcare Funding Mechanisms

Section 4 of the report addresses the overall mix of funding requirements, sources and mechanisms to support a single tier system at a macro level. In this subsection, the Committee examines the best funding allocation model to support the delivery of integrated care. The current payment of health care services is done through direct payment within the HSE and contracting with providers through a variety of mechanisms and institutions. Current payment systems are based on a range of different factors. Work is underway to move away from institutional and incremental budgeting to activity based funding for acute care. This is a long and complex process.

Funding for GPs for medical card holders and for social care is more determined by per capita payments through contracts although the GP contracts have become more complex over time to cover other factors and it is likely that a new contract will bring some simplification. Other primary care providers are paid directly on a salary basis by the HSE. The National Treatment Purchase Fund (NTPF) also provides funding to private sector hospitals for public patients who are long waiters and for private long-term care facilities.

With a variety of mechanisms and processes involved in purchasing or resourcing care in silos, it is more difficult to integrate activity across different care settings and ensure that the patient has a quality and cost-effective pathway through the health care system. Financial factors are frequently a barrier to effective integrated care. This is especially the case where there are different parts of the system with different funding channels or mechanisms. Given the need to support integrated care and to make sure that incentives do not lead to over-provision or cost-shifting, there is a strong case for bringing together streams of funding and combining resource allocation decision-making across different services and levels of care as far as is practicable.

In particular, there would seem to be a strong case for pooled budgets across primary and social care and well-resourced and informed decision-making.⁸⁸ Strong incentives to share information and decision-making will be required for integrated care to work well. Good collaboration is essential and is possible as recent experience has highlighted in the UK. Different designs for integrated resource mechanisms are employed in England.⁸⁹ Good practice around collaborative budgeting between health and social care has also been outlined as an important strategy in Scotland.⁹⁰

Furthermore, any new system will need investment to make it work. It cannot be expected to work in the existing budget envelope because of pervasive budget pressures. Hence the need for transitional funding to help change the systems of governance and working (see Section 4).

The Committee Recommends:

- *That a phased pooling of funding to support integrated care and a simplification and harmonisation of current fragmented and disconnected resource flows to primary, acute and social care*
- *There is a need for a planned move towards a multi-annual budgeting process (3-5 years), to be phased in over the next 10 years*

88 Gavin, Katherine (2013) *An International Review of Integrated Health and Social Care in Community Healthcare Organisations – Report and Recommendations of the Integrated Service Area Review Group, HSE, Pgs. 110-149*

89 Mason et al 2014

90 Collins, Marissa & Donaldson, Cam (2016) *Resource allocation in integrated care settings: what works? Case of Health and Social Care Partnerships in Scotland. 16th International Conference on Integrated Care, Barcelona 23-25 May 2016, International Journal of Integrated Care*

Geographic Resource Allocation Model

It is no longer acceptable to have widespread inequities in geographic access to care. A key aspect of a universal single tier system is that the population can get good access to care no matter where they live. This requires an assessment of and provision of health care services which allow for equity of access and utilisation across the country. While some parts of the country currently have quite different models of care, it is important for a basic level of services to be provided for all.

There is a need to take into account population need, demographics, deprivation/poverty and even rurality and population dispersion in developing a resource allocation model for primary care and social care services. Previous work has been done by the Department of Health and the HSE, through the Health Intelligence Unit, in relation to the development of a resource allocation mechanism to ensure that sufficient staff of different cadres are available across the country to meet the needs of local populations.

This model should be updated and refined to help drive appropriate resource allocation to support the expansion and appropriate provision of the primary and social care workforce. Full implementation of such resource allocation processes will be at the heart of funding integrated care. Such a resource allocation model should be harmonised with the contracting process for private primary care providers, such as GPs with medical cards lists, and other community contractors. Incentives may usefully be offered to GPs to be situated in areas that need more primary health care resources but where they are currently absent, such as areas of social and economic deprivation and rural isolation.

Ultimately, it would be most effective to have a resource allocation funding model that related funding to all aspects of care within a specific area. Ideally such a funding model would be based both on activity based funding, the specifics of the local population, such as demographics, deprivation and dispersion, and even measures of local population health.

This funding model would then allocate resources both to Hospital Groups and Community Health Organisations and would encompass all hospital, primary and social care activity. This would allow the system to operate as a system and not as a disconnected or competing set of services and facilities. While this may be an ambitious and long-term goal it will prove to be a far more effective foundation for delivering integrated care.

This requires an expansion and extension of the activity based funding approaches currently being introduced in acute care settings and an alignment of financial management systems. Both of these are long-term tasks and appropriate steps for transition need to be assessed including regional alignment of CHOs and Hospital Groups.

The Committee Recommends:

- *Develop and utilise a Geographic Resource Allocation Formula to ensure the equitable allocation of resources based on both population characteristics and activity levels*

3.10 Healthcare Workforce

The global economic crisis caused severe austerity in Ireland and resulted in major changes within health staffing – almost half (43%) of public sector human resource cuts were made in the health service. Over the period 2008-2014, the number of directly employed whole-time equivalent (WTE) staff Members in the Irish health service fell by 7.2%. Front-line staff enjoyed a degree of protection resulting in a decrease in their ranks of only 2.9% compared to a 18.5% reduction in other health staff between 2008 and 2014.⁹¹

A moratorium on recruitment and promotions, starting in March 2009, helped facilitate much of the reduction. However, the desired savings from the moratorium were offset by a large increase in the use of agency staff in 2014 which has persisted. Further, a targeted Voluntary Early Retirement scheme introduced in 2010 caused the health service pension spend to grow by €226.8 million.

This scheme along with the moratorium on hiring and the use of agency staff, caused substantial losses of institutional knowledge and skills, and deep demotivation among the remaining staff members.

It also meant that the actual savings in payroll costs were much reduced. The resources spent on pensions and agency staff would have allowed the health service to hire an additional 3,800 staff.⁹²

Since 2014, there has been a substantial expansion in human resources although not to pre-crisis levels. A key goal set out in the major health policy document “Future Health, A Strategic Framework for Reform of the Health Service 2012-2015”⁹³ was a move away from hospital-centric care. Yet this did not happen in austerity and it has not happened in recovery.⁹⁴ This does little to support the expansion of primary and social care. Intentional efforts are needed to address this.

⁹¹ Williams, D, and Thomas, S, (2017) *The Impact of Austerity on the Health Workforce and the Achievement of Human Resources for Health Policies in Ireland (2009-2014) Under review Human Resources for Health*

⁹² *ibid*

⁹³ Department of Health (2012); *Future Health*

⁹⁴ Williams, D, and Thomas, S, (2017) *The Impact of Austerity on the Health Workforce and the Achievement of Human Resources for Health Policies in Ireland (2009-2014) Under review Human Resources for Health*

Integrated Model of Health Workforce Planning (WFP)

A key principle of the Committee is that: The health service workforce is appropriate, accountable, flexible, well-resourced, supported and valued

In order to be able to provide an expanded package of entitlements and to deliver a single tier system, the right workforce needs to be in place with appropriate management and support. Hence detailed work needs to be done on ensuring an appropriate supply and sustainability of motivated and highly trained human resources to meet the estimated demand.

There are difficulties with expanding human resources capacity. Training more health professionals, and particularly doctors, can be a slow process and one with a long time lag.⁹⁵ In such circumstances it is vital that a whole variety of options is considered and that issues around the appropriate skill-mix are identified across cadres and professions. Many tasks can be conducted by different cadres of health professionals and contractors in the community.

The Committee supports strongly the idea of promoting the best skill-mix throughout the system so that care is not delivered in inappropriate settings and is not provided by over-qualified staff. For instance, practice nurses, advanced nurse practitioners and pharmacists all have important roles to play in integrated care.

When estimating future need for human resources it is essential that there is an integrated workforce planning capacity within government. There is little use in workforce planning in silos in relation to doctors or nurses alone for instance. Expansion and substitution of traditional and new cadres is important to deliver quality care for an expanded package.

The HSE and the Department of Health are currently in the process of developing a National Integrated Strategic Framework for Health Workforce Planning. Under such a framework, health workforce planning will be informed by the current and future needs of the population, ensuring the workforce is in the right place, with the right skills and competencies to deliver care and better health outcomes. Health workforce planning is dynamic, it must support service delivery and service redesign which includes planning for changing skill mix, new healthcare roles, new competencies and task shifting. It requires an investment in staff training and upskilling. For workforce planning to be sustainable, it needs to be aligned with national health policy priorities, financial and service planning. Staff need to have a voice and a role in workforce planning and this cannot be left to analysts and policy makers.

95 Teljeur, C., Thomas, S., O'Kelly, F.D., O'Dowd, T. (2010). *General Practitioner Workforce Planning: Assessment of Four Policy Directions*. *BMC Health Services Research*, 2010, 10 (1), pg. 1

Further the Committee agrees with Dr Stephen Kinsella that:

- *“A well resourced unit dedicated to information collection and analysis at the Department of Health strategic level is required. Legislative backing for the data collection and modelling is typical in countries where workforce planning is most advanced*
- *A commitment to the generation of a minimum data set, and data quality indicators, is paramount for the quantitative measurement of supply, demand, geographical flow of patients, skills mix, newly qualified medical professionals, etc.*
- *The qualitative side of the work force planning process can not be neglected, and fora for the dissemination of information should be set up before any formal modelling takes place”⁹⁶*

Recruiting and Retaining Health System Workers

Careful estimation of the numbers and mix of required health professionals is not enough to deliver effective care. The health workforce is now an international commodity with professionals migrating in search of better terms and conditions and prospects.

While Ireland benefited from this substantially before the economic crash it is once again vulnerable to emigration not only from Irish trained professionals but also from those who were trained elsewhere and are temporarily residing and working in Ireland. Given the difficulties of much of the last decade in the health system, it is not surprising that the Committee has considered the testimony of demotivated staff with many considering migration or having already migrated. Others have gone to work in the private health sector.

As the economy recovers and prospects for renewed pay deals emerge the issue of pay should be addressed. However, it is vital that issues that were the causes of demotivation are understood and dealt with.

It is essential that first and foremost the capacity that is already there in the system is appropriately recognised, appreciated and rewarded. Appropriate motivation of staff frequently requires a broad package of measures that relate to good training prospects, supportive management, appreciation and well-functioning infrastructure and not just better salary levels.

The Committee Recommends:

- *That the HSE and the Department of Health must develop their integrated workforce planning capacity so as to guarantee sufficient numbers of well-trained and well motivated staff deployed in a targeted way to deliver care in the most appropriate care setting and that the Irish health system becomes a place where people feel valued and want to work. This will mean re-training of existing staff in many cases to ensure capabilities for integrated care*
- *That recruitment should take place at regional level or at a more local level if practicable, and in conjunction with local clinical managers*
- *That recruitment of hospital consultants and NCHDs should be to Hospital Groups rather than to individual hospitals, as part of meeting the medical staffing needs of smaller hospitals*
- *Staff will be recruited on the basis of the most appropriate skill-mix for the delivery of a new model of care, and with the aim of ensuring flexible teamwork.*

The New GP Contract

A new GP contract is due to be negotiated in 2017. The new contract provides an opportunity for the GPs to provide the core leadership role in delivering care outside of hospital in multidisciplinary primary care teams. The contract can facilitate new ways of working so that GPs are incentivised to carry out health promotion/public health work, disease prevention, the delivery of integrated care and the management of chronic diseases including mental health and multi-morbidities.

The new contract gives the opportunity to ensure that money is not a barrier to access GPs now or in the future, to ensure the availability of direct access to diagnostics and phlebotomy services outside of hospital for all GPs and to ensure required GP coverage in areas of high need such as rural and urban areas of deprivation. Potentially, GPs will be hired as salaried HSE staff in areas where it is hard to attract them. In order to extend primary care to the whole population more GPs and primary care staff are needed, as outlined in Section 2.

The availability of an appropriate ICT infrastructure such as unique patient identifiers, electronic patient records, and eReferrals will be central to the delivery of high quality integrated care by GPs.

The Consultant Contract

The Committee is recommending the ending of the provision of private care in public hospitals. In the future all public hospitals will only provide care for public patients. Currently the majority (81%) of consultants have contracts which enable them to work privately in public hospitals. The development of elective only hospitals in each Hospital Group could be an important counterbalance for consultants to private sector work, by creating new opportunities for the development of their specialist skills through elective work in the public sector.

3.11 Medicines and Medical Technologies

Ireland is a hub of medical technology development, with innovation resulting in new devices, software and pharmaceutical-based solutions. Public health service provision needs to evaluate the use of this technology on the basis of population-need, effectiveness and value-for-money. Health Technology Assessment (HTA) is the formal process of appraisal which examines the evidence for the safety, efficacy and cost-effectiveness of healthcare interventions including new medical technology. Ireland has an established HTA infrastructure with HIQA being the statutory authority with responsibility for HTA and the National Centre for Pharmacoeconomics (NCPE) being the body that specialises in reviewing HTA submissions from pharmaceutical manufacturers.

Medicines Management

Our health service faces huge challenges in seeking to secure access to new medicines for patients in a way that is both affordable and sustainable. In 2016, the medicines bill overall was over €2bn, up from under half a billion in 1998. Of this, €1.7bn relates to the community drugs schemes and within these, high tech drugs account for 34% of the total, up from 19% five years ago. It is in relation to high tech drugs, orphan drugs and novel treatment regimes that the major challenges will arise in future years, driven primarily by the increased cost and usage of recently introduced medicines and by the pipeline of new medicines. However, cost pressures are also driven by the increasing volume of use for current medicines.

The HSE has statutory responsibility for decisions on the pricing and reimbursement of medicines through the community drugs schemes.⁹⁷ Almost all new medicines are being subjected to Health Technology Assessment by the National Centre for Pharmacoeconomics (NCPE), the National Cancer Control Programme or the HSE Drugs Group.

⁹⁷ Health (Pricing and Supply of Medical Goods) Act 2013. While not provided for in legislation, applications may also be made to the HSE to have a medicine priced as a hospital medicine for the purposes of supply to or reimbursement by the HSE, State funded hospitals or related agencies

A recent OECD report⁹⁸ identified pharmaceuticals as one of two areas where operational waste is of particular concern. In that context, it identified the need for a focus on reducing the volume of unused medicines, increasing the use of generics or biosimilars, and seeking opportunities for lower prices through more effective procurement processes. The Committee recognises there is a significant focus on reducing the cost of medicines, including the Framework Agreement on the Supply and Pricing of Medicines, commercial negotiation with manufacturers supported by Health Technology Assessment and the development of a National Biosimilars Policy. The establishment of the HSE Drugs Management Portfolio is a further step.

However, this is a core area of expenditure that cuts across all aspects of our health service. Other than workforce, medicines represent the single largest area of expenditure within our health system. This area requires a strategic long-term approach, with a continued strong focus on assessment and evaluation, procurement and usage, including clinical effectiveness. The Committee believes it is essential that strategies and models in use internationally are examined in order to identify best practice.

Furthermore, the Committee is conscious of the negative implications of overprescribing from both budgetary and public health perspectives. It considers there is a need for appropriate oversight and audit of prescribing and dispensing patterns, including through the use of PCRS data where available.

The Committee Recommends:

- *Examination of strategies and models in use internationally to identify and implement best practice in medicines management, including evaluation, procurement and usage*
- *International collaboration and active cooperation with other EU member states, to share information and utilise all opportunities for joint negotiation, in particular through our membership of the European single market*
- *Appropriate oversight and audit of prescribing and dispensing patterns, including through the use of PCRS data where available*

Health Technology Assessment (HTA)

Ireland has strong and growing capacity for HTA appraisal that could be employed to achieve a more equitable and efficient health service. Any system of universal healthcare inevitably faces resource constraints and cannot provide every possible service. HTA offers a rational, equitable and objective means of deciding what services to provide and of prioritising resources to services that provide the greatest population health gain, irrespective of the individual patient's income or entitlement status.

The appropriate application of HTA can be used to rectify inconsistencies present in Ireland's current system, whereby some new, expensive and only modestly effective treatments are funded, while some existing services that offer good value for money are subject to long waiting lists and are only available free of charge to selected portions of the population, such as hip and knee replacements.

Employing HTA in this way would represent a broadening of its application to all health services from the current primary focus on new drugs spending.

The Committee Recommends:

- *A population health approach to HTA to aid evidence-based decision making for funding medical technology use in the public system*

eHealth

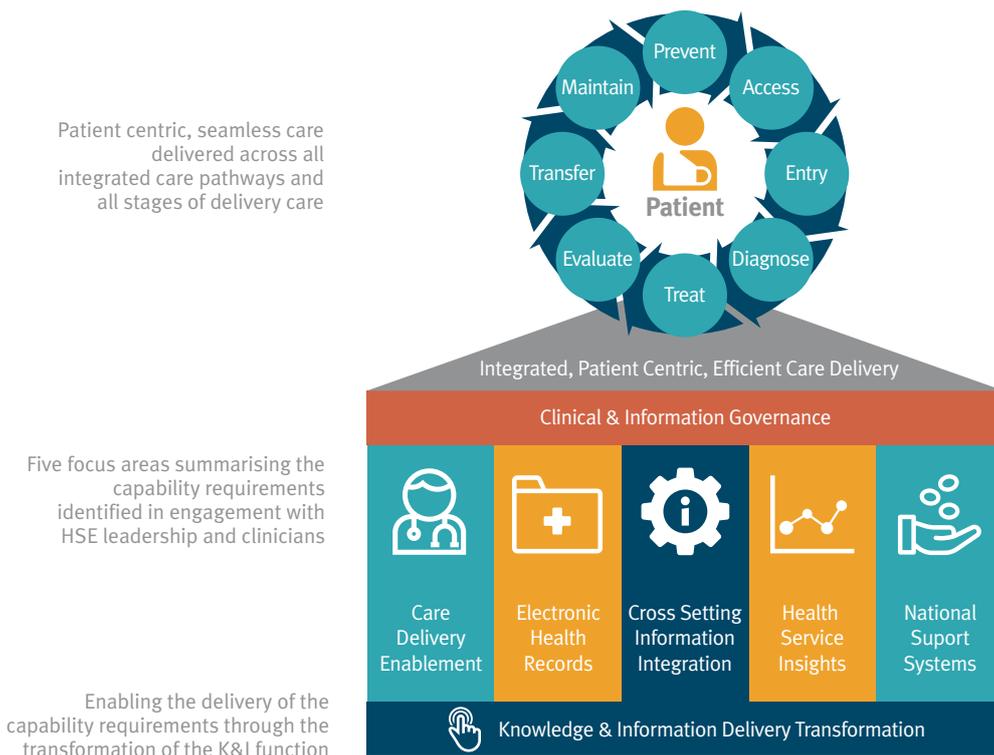
eHealth has the potential to support safer, more efficient, high quality health systems that are easier for residents to access. In recognition of the potential of eHealth, the HSE and the Department of Health, launched an eHealth Strategy for Ireland in 2015. Seven strategic programmes reflect priority areas and act as the catalyst for a change in how technology is delivered. Developments include the use of EHRs, currently being piloted through public maternity service in Cork and Kerry regions. The roll-out of the EHR system for Ireland's first 'digital babies' has been embraced by healthcare staff with early reports of high levels of efficiency and effective use of integrated patient information for quality health service provision. The Committee believes that the speedy implementation of the eHealth strategy is central to the successful delivery of integrated care. Within the suite of eHealth developments embedding the Electronic Health Record (EHR) system into service provision is paramount. As well as the EHR, eHealth (electronic health) resources make possible the electronic integration of all the various information and knowledge sources necessary to deliver quality integrated healthcare. Examples of eHealth include:

- *Electronic prescribing*
- *Online patient portals with access to medical records, appointment scheduling, secure messaging, resources for self care etc.*
- *Telehealthcare – where patients can communicate with health providers virtually*
- *Online referrals*

Using these and other technologies empowers patients to be active participants in their own healthcare; while the healthcare system gains valuable tools for managing, tracking and evaluating the provision of care. In most countries, a unique patient identifier is a key feature of the eHealth system. Incorporating a unique identifier to each patient’s eHealth account allows providers to have immediate access to accurate demographic and clinical information, to determine levels of eligibility, and to refer to the exact patient when communicating with other providers and caregivers.

This figure below from the eHealth knowledge and information plan (HSE, 2015) outlines the future health service capabilities required to deliver integrated care. These capabilities are distilled into five focus areas which are key to facilitating the seamless delivery of healthcare across integrated care pathways – these include attention to the care delivery environment, electronic health records, cross setting information integration, health service insights, and national support systems.

Figure 7: eHealth Strategy for Ireland



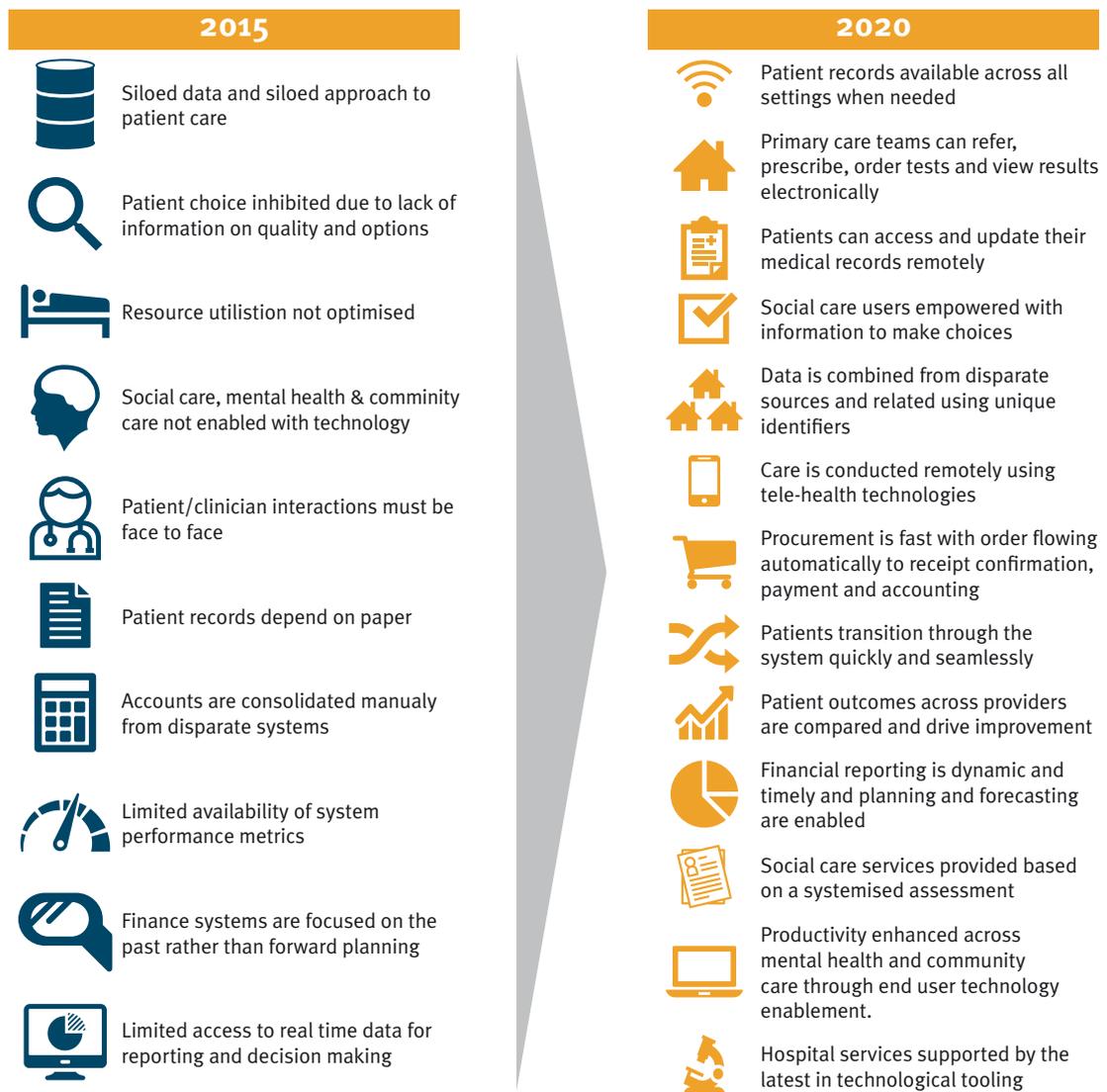
Plans for eHealth development are already underway throughout the Irish health system. Image 4 below outlines the future plans for eHealth comparing current provision with what is due to be in place by 2020.

In his evidence to the Committee, Mr Tony O’Brien, HSE Director General, indicated the individual health identifier will be rolled out in 2018. The adoption of the patient identifier is vital to understanding how the population, nationally and regionally, engages with the health system.

It will also provide necessary information on the geographical and service areas where resources are most needed, going forward.

On this basis and given that eHealth is a critical enabler of integrated care the Committee recommends continued strong support of this strategy – particularly ensuring the necessary funding for timely roll-out of the EHR system. Furthermore, given the critical nature of implementing eHealth the Committee recommends streamlining the approval-to-spend-process between the Department of Health and the Office of the Chief information Officer at the HSE.

Figure 8: Plans for eHealth comparing current provision with what's planned for implementation by 2020. In relation to 2015: It should be noted that some but not all parents receive a hard copy of their child's health record (the giraffe book).



The Committee believes that eHealth is the critical enabler to implement the change required to deliver an integrated, universal, high quality health system. Currently business change with respect to the eHealth Programme is not funded by the Department of Public Expenditure and Reform/Department of Health. Funding this and fast tracking other key elements of the eHealth programme, as well as securing funding not currently earmarked for projects (such as digital requirements for the New Children's Hospital, cloud, Electronic health records, EDs and Maternity) is the best way to progress and drive health system change. This budget line is contained in the transitional fund which is proposed in the Section 4 of this report.

The Committee Recommends:

- Continued strong support of the e-health strategy – particularly ensuring the necessary funding for timely roll-out of the EHR system and resourcing of the eHealth change processes
- The development of a national, integrated hospital waiting list management system
- Streamlining the approval-to-spend-process for the e-health strategy between the Department of Health and the Office of the Chief Information Officer at the HSE
- That the HSE develop guidelines addressing parental access to electronic health records of their children

3.12 Information and Research

The WHO states that a health information system “is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status”⁹⁹. Given this definition and following the established logic that data and reliable information are essential prerequisites to robust knowledge and better understanding¹⁰⁰, the Committee endorses the work on data integration and eHealth already in progress.

Nonetheless, it also acknowledges the importance of creating a learning environment and a proactive approach to culture change. This is a considerable challenge given the evidence that internal communications need improvement, and that many healthcare staff feel undervalued, unrecognised or unmotivated at work.¹⁰¹ There is a sense that a ‘blame-culture’ hampers learning and innovation. Here we address the issues of data integration, alignment of management systems and the necessary culture for integrated care.

The Data Landscape of the Irish Health System

The Irish health system has a wealth of data within individual organisations and branches of the system. Many improvements have been seen regarding the collation and dissemination of data using interactive portals such as Health Atlas Ireland and the Institute of Public Health of Ireland, to name two. However, due to problems that have persisted over the past decades, the challenges of effectively using data from multiple organisations remain the same. Many of these problems stem from a lack of coordination between the different contributors.

99 World Health Organisation (2017) *Health Systems Framework*, Geneva, Switzerland

100 Ackoff, R. (1973). *Science in the systems age: Beyond IE, OR and MS*. *Operations Research*, 21(3), 661-671

101 *Health Services Executive*, 2016

In many cases, the final data gathered confirms the existence of compartmentalised factions, as opposed to a well-coordinated interactive system. One of the principal issues that highlight this problem is the inability to coordinate and manipulate data into uniform geographical boundaries. Many bodies have, quite rightly, the desire to collect data in a way that meaningfully represents the populations and areas that they operate within. However, the continued absence of a common unit of geography substantially decreases the capacity for cross-organisational research. The adoption of such a unit would lessen the impact of changes to organisational boundaries, which in many cases leads to inconsistent reporting of data details year on year, making analysis of long term trends difficult or impossible. Given the stage of development of the CHOs and CHNs:

The Committee Recommends:

- *Community Health Networks (CHNs) as the optimal population level for data collection and integration to allow for meaningful, robust analysis and planning*

Similarly, the inability to track a patient’s engagement with individual services within the system continues to limit the effective use of existing data. The adoption of a patient identifier, as noted above, is vital to understanding how the population, nationally and regionally, engages with the health system and where resources are most needed. We believe addressing these issues will allow healthcare professionals and researchers alike to maximise the capacity of data to improve the functioning of the health system as a whole and enable the delivery of an integrated care system.

The Committee Recommends:

- *That developing the research capacity of clinicians, healthcare professionals and managers, is important in this context, as integrated care needs underpinning with robust evidence and evaluation. Working with academic partners is useful in this regard and optimizing available funding for applied and participatory research and training is encouraged*

Integrated Management Systems

Creating the right systems for data integration is not only a technical challenge, integrated care is also inhibited by the existence of fragmented management systems in relation to finance and workforce planning. There are numerous financial management systems throughout the health service, and fragmented organisational arrangements hamper integrated workforce planning. The Committee acknowledges the current capital allocation to the Department of Health that includes money for the development of one integrated financial management system.

The Committee Recommends:

- *The continued funding and development of integrated management systems for financial control and workforce planning. In this vein the Committee also recommends a focused initiative to learn from and expand the Integrated Care Programmes*

Change Management

The delivery of integrated care is a new approach to health service design and delivery that requires practical learning by people throughout the system. International research on learning organisations and systems shows that capacity problems such as staff recruitment and retention, or adaptability, become more manageable when a learning culture takes hold¹⁰².

Energy becomes less focused on ‘internal’ system problems and more on finding solutions to ‘external’ challenges such as coordinating service delivery. For integrated care in Ireland one of the greatest challenges is the creation of the right environment to enable interdisciplinary collaboration, new forms of cooperation, experimentation and organisational innovation. It is important therefore that reform and change work enables better service coordination by comprehensively addressing ‘system-related challenges’, ‘people-related challenges’ and ‘organisational-related challenges’. An enabling environment is essential and a critical feature of this is the leadership capacity necessary for ‘along journey requiring sustained political commitment’¹⁰³

The Committee Recommends:

- *Sustained resourcing of the change process as detailed in the Transitional Fund in Section 4 of the report*

Culture Change and Learning Environment

All of this data integration, aligned management systems, research literate healthcare professionals etc., needs the support of a culture that offers opportunities for creating effective knowledge and better understanding. Integrated care in practice is complex and not easy to accomplish. Communication that facilitates information flows is critical, especially information hard to share, as is time for reflection and creativity, learning new capabilities and establishing new capacity within and between organisational units. This form of capacity-building needs proactive action.

¹⁰² e.g. Kastango, N., & Jagiela, S. W. (2010). Collaboration makes the process better. *Industrial Engineer: IE*, 5, 42-46

¹⁰³ World Health Organisation, p.35 *WHO Global Strategy on People-Centred and Integrated Health Services Interim Report 2015*

The Committee Recommends:

- *Professional and personal skills training, new forms of dialogue across disciplines with new partners e.g. patients, other public bodies, and increased opportunities for learning on the job*
- *The development of a culture and mechanism for collaboration, integrated care and shared local governance between CHOs and acute hospitals*

3.13 Recommendations

In a complex, interconnected and integrated system, that is based on the new primacy of primary care, with senior decision makers being involved in all care pathways, the streaming of patients by general practice into and out of secondary care needs to be prioritised and standardised, both locally and regionally so that all patients have uniform and accessible pathways for appropriate hospital care when it is required.

In acute care where hospital assessment is needed, the principal of ambulatory care should apply in order to return patients to their homes when possible and medically appropriate. The emphasis for these patients should be on ambulatory emergency care (AEC), with rapid clinical assessment, investigation and treatment, leading to same day discharge and return to community as the default position. When less urgent consultant opinion is required, patients should be streamed to specialised OPD clinics that have rapid access pathways. Innovative solutions for timely consultant advice, especially for frail elderly, should be prioritised using technology assisted care, such as shared ICT platforms and Virtual Clinics.

When acute illness requires immediate hospital care, patients should be streamed where possible to the Acute Medical Assessment unit or the Acute Surgical Assessment Unit, etc., of the acute floor to allow for rapid vertical and horizontal integration of care between hospitals and community. This will reduce unnecessary admissions and avoid hospital-accelerated decline, adverse events, complications and costs. The emphasis is to build a seamless interface between primary and secondary care for acute and chronic disease with general practice playing a significant role through triage and gate-keeping of patients.

The preferred model of service delivery to be implemented in the Irish health system over the next 10 years is outlined through the recommendations and phasing set out below. This is based on international evidence, the Committee's definition of integrated care and the 'systems-based building blocks approach' used to model integrated care in this report. The first set of recommendations outlined respond to the six critical service delivery challenges identified as significant barriers to, or symptoms of the lack of, integrated care. These require concrete action in the short to medium term. Further recommendations are outlined under the headings of the WHO building-blocks framework.

3.14 Recommendations Addressing the Critical Challenges of Service Delivery

Critical Challenge 1: *Improve Population Health*

The Committee Recommends:

- *Strengthen mechanisms for the full implementation of Healthy Ireland including leadership from the Taoiseach, government wide and health system implementation, taking population health and wellness into account in all workings of the government, possibly through Health Impact Assessment, and the prompt development and publication of an Outcomes Framework for Healthy Ireland*

Critical Challenge 2: *Deliver Care at the Lowest Level of Complexity*

The Committee Recommends:

- *Use all available mechanisms and processes to ensure healthcare is delivered at the lowest level of complexity as is safe, efficient and good for the patients. This includes priority resourcing of primary and social care*
- *Develop a culture and mechanism for collaboration, integrated care and shared local governance between CHO's and acute hospitals*

Critical Challenge 3: *Provide Diagnostic Services within the Community*

The Committee Recommends:

- *Ensure significant expansion of diagnostic services outside of hospitals to enable timely access for GPs to diagnostic tests. Primary care centres should be the hub of community diagnostic services so that all patients can access diagnostics in these centres*

Critical Challenge 4: *Disentangle Private and Public Care*

The Committee Recommends:

- *Current unacceptable waiting times for public hospital care in emergency departments, outpatient clinics (OPD) and planned daycase and inpatient treatment must be reduced so that timely access is provided, based on need and not ability to pay*
- *Provide public funding to replace the €649m (2016 figures) private patient income annually expected in public hospitals between year two and six of the plan*
- *Consultants will ultimately only carry out public work in public hospitals. The provision of private care by consultants in public hospitals will be eliminated over a phased period. This will mean that all patients will be treated on the same, public basis in public hospitals, ensuring equity of access for all based on need rather than ability to pay. The Committee recognises and*

recommends that existing contracts may change through negotiation and the need for enhanced public only contracts for new entrants

- *An independent impact analysis should be carried out of the separation of private practice from the public hospital system, with a view to identifying any adverse and unintended consequences that may arise for the public system in the separation*
- *Careful workforce planning to meet current and future staffing needs, and measures to ensure that public hospitals (as well as all service provision units and centres) are/become an attractive place to work for experienced, high quality staff*
- *Robust workforce planning which ensures that we maximise the utilisation of the skills of every worker currently available in the health service*
- *Sufficient numbers of consultants and other health professionals to meet population need*
- *The successful re-orientation of care delivery to primary and social care settings so that most care is provided (publicly) outside of hospital*
- *One or a number of hospitals within each Hospital Group, as appropriate, should be designated as elective only*

Critical Challenge 5: Ensure a System – Wide Response to Emergency Department Waiting Times

The Committee Recommends:

- *Enable a system wide response to ED wait times so that integrated, patient-centred care is provided by enhanced primary and social care services including:*
- *Investment in hospital infrastructure and staffing in order to enhance capacity. The Committee recommends that the outcome of the Capacity Review currently underway should inform the detailed planning for the infrastructural investment provided for in the proposed Transitional Fund, as well as for the staffing required*
- *Investment in these non-hospital services so that the management of the vast majority of chronic diseases takes place outside of hospital*
- *The availability of direct access to diagnostics outside of hospitals for GPs*
- *Improved processes and efficiencies within hospitals*
- *Participation by service providers and engagement by the Implementation Unit (of this Reform Programme) with the Capacity Review to be completed in 2017 as part of the long-term solution to ED overcrowding and waiting list management*

Critical Challenge 6: Legislative *Underpinnings* for Maximum Wait Times

The Committee Recommends:

- *eHealth digital solutions be adopted and immediately resourced*
- *No-one should wait more than 12 weeks for an inpatient procedure, 10 weeks for an outpatient appointment and ten days for a diagnostic test*
- *Individual waiting lists are published by facility, by specialty*
- *Introduce a maximum wait time in EDs, working towards a four hour target*
- *Hospitals that breach guarantees are held accountable, through a range of effective measures including, ultimately, sanctions on senior staff, but not to the detriment of healthcare delivery*

3.15 Recommendations Relating to Systemically Modelling Integrated Care

Leadership and Governance

The Committee Recommends:

- *That the Minister for Health is held responsible and accountable on a legislative basis for the delivery of healthcare, the health system and health reform*
- *That under the new integrated care model of service delivery the Department of Health retains the Health Vote and that a more strategic Department continues its policy development and legislative role with an enhanced evaluation capacity*
- *An independent board and Chair is appointed to the HSE at the earliest opportunity, by the Minister, following a selection process through the Public Appointments Service. Board membership reflects the skills required to provide oversight and governance to the largest public services in the State*
- *The Chair of the Health Service Board is accountable to the Minister*
- *The Health Service Director General is accountable to the Board*
- *The HSE directorate becomes a more strategic, patient-focused ‘national centre’ with a reduced number of national directors reporting to the Director General*
- *Existing National Directors will be relocated into other roles strengthening the functions required for the new mode of integrated care, for example relating to building strengthened leadership capacity in the community for primary and social care*
- *Greater alignment of service provision for integrated care across care domains is implemented at CHN level. This will include further mapping analysis and use of funding, information sharing and eHealth mechanisms*

- *The geographic alignment of Hospital Groups and CHOs will help to support population-based health planning and delivery. Further analysis and consultation should be undertaken to identify how alignment can best be achieved with minimal disruption to key structures including at CHN level*
- *Moving towards a form of regional health resource allocation with accompanying governance structures to formally connect Hospital Groups and Community Health Organisations for the provision of integrated care, using CHOs and CHNs as the core unit of health service coordination and provision*
- *Establishment of regional bodies that will be accountable for implementing integrated care at sub-national level by strengthening the local care provision system, ensuring service coordination between the different care domains, community network building and resource allocation for integrated or shared services*
- *Integrated care such as the Carlow-Kilkenny Integration Model (CKIM) which established the Local Integrated Care Committee (LICC) structures in the Ireland East Hospital Group, be supported and developed. This model encompasses the WHO strategies of implementing integrated care by;*
 - *Empowering and engaging people*
 - *Strengthening governance and accountability*
 - *Reorienting the model of care*
 - *Coordinating services*
 - *Creating an enabling environment*
- *Put in place a blueprint for clinical governance across the health system in a timely and optimal manner*
- *This should be underpinned by legislation which specifies the structures, processes and responsibilities of boards, management and clinicians for the operationalisation of clinical governance within all organisations*

Healthcare and Funding Mechanisms

The Committee Recommends:

- *Phased pooling of funding to support integrated care and a simplification and harmonisation of current fragmented and disconnected resource flows to primary, acute and social care*
- *There is a need for a move towards a multiannual service planning and a multiannual budgeting process (3-5 years) to be phased in over the next 10 years*
- *Development and utilisation of a geographic resource allocation formula to ensure the equitable allocation of resources based on both population characteristics and activity levels*

Healthcare Workforce

The Committee Recommends:

- *That the HSE and the Department of Health must develop their integrated workforce planning capacity so as to guarantee sufficient numbers of well-trained and well motivated staff deployed in a targeted way to deliver care in the most appropriate care setting and that the Irish health system becomes a place where people feel valued and want to work. This will mean re-training of existing staff in many cases to ensure capabilities for integrated care*
- *That recruitment should take place at regional level or at a more local level if practicable, and in conjunction with local clinical managers*
- *That recruitment of hospital consultants and NCHDs should be to Hospital Groups rather than to individual hospitals, as part of meeting the medical staffing needs of smaller hospitals*
- *Staff will be recruited on the basis of the most appropriate skill mix for the delivery of a new model of care and with the aim of ensuring flexible team work*

Medicines and Medical Technologies

The Committee Recommends:

- *Examination of strategies and models in use internationally to identify and implement best practice in medicines management, including evaluation, procurement and usage*
- *International collaboration and active cooperation with other EU member states, to share information and utilise all opportunities for joint negotiation on medicines, in particular through our membership of the European single market*
- *Appropriate oversight and audit of prescribing and dispensing patterns, including through the use of PCRS data where available*
- *A population health approach to Health Technology Assessment to aid evidence-based decision making for funding medical technology use in the public system. This process is to be as transparent and timely as possible to ensure public awareness and understanding of decisions made*
- *Continued strong support of the eHealth strategy – particularly ensuring the necessary funding for timely roll-out of the EHR system*
- *The development of a national integrated hospital waiting list system*
- *Streamlining the approval-to-spend-process between the Department of Health and the Office of the Chief Information Officer at the HSE*
- *The HSE should develop guidelines addressing parental access to the electronic health records of their children*

Information and Research

The Committee Recommends:

- *The Community Health Networks (CHNs) are utilised as the optimal population level for data collection and integration to allow for meaningful, robust analysis and planning*
- *Developing the research capacity of clinicians, healthcare professionals and managers is important in this context as integrated care needs underpinning with robust evidence and evaluation. Working with academic partners is useful in this regard and optimising available funding for applied and participatory research and training is encouraged*
- *Sustained resourcing of the change process as detailed in Section 4*
- *The continued funding and development of integrated management systems for financial control and workforce planning*
- *A focused initiative to learn from and expand the Integrated Care Programmes*
- *Professional and personal skills training for new forms of dialogue across disciplines with new partners (e.g. patients, other public bodies), and increased opportunities for learning on the job*

3.16 Phasing and Implementation of Integrated Care

The implementation of integrated care is a long-term process that requires considerable shifts in understanding and mindset as well as sustained organisational development and the creation of enabling conditions such as embedded eHealth, the right funding environment and new forms of cooperation and care coordination.

Nonetheless, the Committee propose the following critical enablers as important stepping stones to be phased into the implementation process with a clear set of performance indicators, monitoring mechanisms and accountability touch points.

Obtain agreement on clear governance arrangements in three forms:

- *Alignment of governance across the health system between the Government, Department of Health and Health Service Executive (or its new equivalent)*
- *Alignment of governance within the health service (executive) between clinicians, managers and other decision-making domains*
- *Alignment of governance through the patient care pathway between the acute, primary, mental and social care domains (with links to health and wellbeing as appropriate)*

- *Prioritise the resourcing of the following critical patient-care and management systems:*
 - *eHealth*
 - *financial management*
 - *workforce planning (including defining the best culture and process of performance management and career advancement)*
 - *health service performance and accountability systems*
 - *health status and outcomes data integration*
- *Ensure appropriate funding mechanisms are embedded into the system*
- *Activity based funding at system rather than facility level coupled with clear resource allocation (model and systems)*
- *Define a process for evaluating and learning from health system reform and strengthen work already in train including the Integrated Care Programmes; and linking this learning with service delivery decision-making and workforce development and training, and establish mechanisms to show early wins as a result of implementing integrated care*

Section Four: Funding

This section sets out the vision for significant change in the funding of healthcare. It begins by restating key goals and principles which should provide a vision for a new funding model for the Irish health system. It explores the current financing of the Irish health budget and sets it in context internationally. It also explores the costs of funding a package of health service entitlements. Finally, the vision for funding reform is translated into phased annualised priorities and recommendations that can make the vision a reality. The Committee's Terms of Reference specify that the Committee:

- *Recognise the need to establish a universal single tier service where patients are treated on the basis of health need rather than on ability to pay*
- *Examine different funding models for the health service and make recommendations on the funding models that are best suited to Ireland and have these models fully costed*
- *Examine existing and forecast demand on health services, including the changing demographics in the Irish population*

Further, in its interim report published in August 2016, the Committee established the importance of identifying an appropriate funding model to implement Universal Healthcare. In addition key principles 4, 5 and 7 endorsed by the Committee identified the need for:

- *Care provided free at point of delivery, based entirely on clinical need*
- *Patients accessing care at most appropriate, cost effective service level with a strong emphasis on prevention and public health*
- *Public money is only spent in the public interest/for the public good,*
- *ensuring value for money, integration, oversight, accountability and correct incentives*

Such principles demand a substantial change in the way healthcare is currently financed in Ireland to implement a single tier health system.

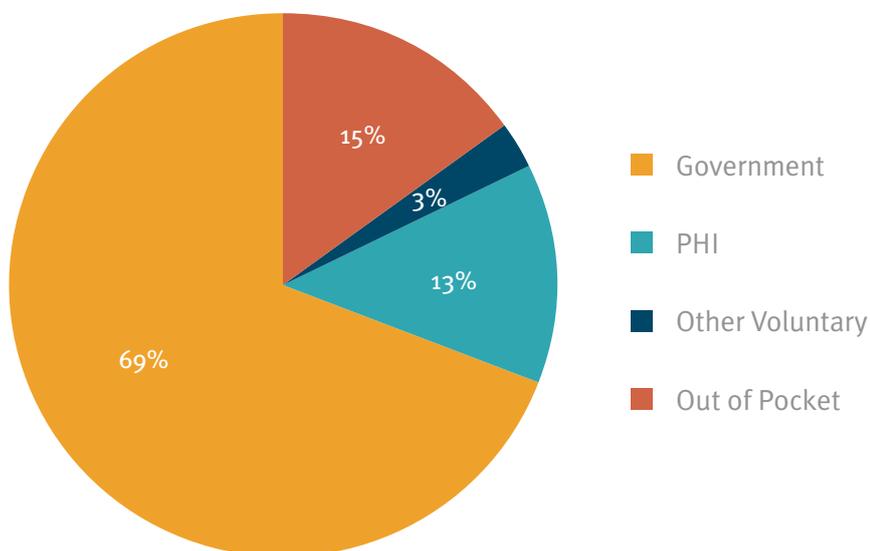
There are three key objectives for any healthcare funding system¹⁰⁴ and these tie in closely to the Terms of Reference of the Committee:

- *Ensuring everyone has access to a comprehensive range of*
- *Needed services especially for those who are less able to afford them*
- *Raising sufficient revenues to provide or purchase a comprehensive range of care*
- *Sharing or pooling risks across different subsections of the population*

4.1 Current Funding

As can be seen from Chart 5 below the majority of funding raised for the health care system in Ireland comes from general taxation, around 69%¹⁰⁵. In addition there are two other major sources of funding and these are out-of-pocket spending i.e. direct payments made to health care providers when patients access care, and funds raised through the Private Health Insurance to providers, accounting for 15.4% and 12.7% respectively.

Figure 9: The proportion of Ireland's health care spending from different sources (2014)



Source: CSO 2016

General taxation has several advantages in that it yields large amounts of money and it tends to be progressive, which means that the better off pay proportionately more than the less well off in society. But the current taxation-based funding of health care does not bring about free entitlement to healthcare at the point of delivery for all.

¹⁰⁴ Barbara McPake, Charles Normand and Samantha Smith (2013). *Health Economics. An International Perspective*. Routledge. Abingdon

¹⁰⁵ CSO 2016, *Ireland's System of Health Accounts, Annual Results 2014*

A medical card confers eligibility for free access to GP and hospital services but this is only available to less than 40% of the population. Yet capacity to provide many elements of primary care is often absent and there can be long waiting lists in the public sector even for those with medical cards. While those with medical cards do get free access to a broader pool of benefits, those without one are entitled to virtually no free care at the point of delivery. For those without a medical card or a GP visit card, full market prices are paid for GP visits. Hospital treatment is subject to out-of-pocket payments for those without medical cards or private health insurance.

As evidenced in Section 3, current funding patterns are associated with long waiting lists for many procedures and concerns about the quality of care as also outlined in Section 3.

Epilepsy Ireland, in reference to a 2014 survey of their Members regarding medical costs, stated that:

“It is a huge concern to us that so many experienced cost barriers to essential services. In our survey 58.64% said cost was a barrier in relation to GP care, 52.04% said it was a barrier in respect of A&E and 44.7% said it was a barrier due to other costs such as essential lifesaving emergency medication costs” (Epilepsy Ireland)

Two other funding sources have played a significant role in supplementing taxation based funding; out of pocket payments and private health insurance. Relying on out of pocket payments causes inequity and unmet need. Indeed over the recent recession out of pocket payments increased substantially. This increased the financial burden on households as each person had to pay, on average, an additional €120 per person per year to access the same health services.¹⁰⁶

Furthermore unmet need increased sharply between 2010 and 2014 pushing Ireland above the EU 28 average,¹⁰⁷ suggesting an increased number of people were unable to afford or access care for a general medical examination or a dental examination. The Committee has recognised that the critical features of universal health care and a single-tier system are the protection of all from financial hardship and the provision of care when needed.

Private health insurance (PHI) occupies a unique role in the Irish setting providing faster access to care in both public and private provider settings. Nevertheless, the benefits only accrue to those who are able to afford to pay the premium for health insurance. Over the recent recession PHI cover dropped from a high of 52% of the population in 2007 to just under 44% at the end of 2014 from where coverage has staged a slight recovery, standing at 44.8% in September 2016. Nevertheless, the existence of PHI, while related to faster access, reinforces a two-tier health system, particularly for elective acute care, which runs counter to the aspirations for a single-tier health system.

¹⁰⁶ Thomas, S., Burke, S, Barry, S. (2014). “The Irish Health-Care System and Austerity: Sharing the Pain” *The Lancet* 383 (3 May 2014)

¹⁰⁷ OECD 2012, *Health at a Glance: Europe 2012*, OECD Publishing

4.2 International Comparability

By international standards Ireland spends a significant amount of resources on health care, as can be seen in Chart 6 which compares health funding as a proportion of GNP and GDP per capita in Ireland against the OECD average. While historically below the average Ireland is now higher in the table and this raises questions about value for money. One explanation for the increase shown in Chart 2 is that the economy contracted during the recession while the health sector received some protection¹⁰⁸. As the Irish economy expands again, health funding as a proportion of GNP will decline.

Figure 10: Current Health Care Spending as a Proportion of GNP and GDP Per Capita Ireland and OECD 2000-2014)



Source CSO and OECD 2016

A key cause of Ireland's relatively high spending may well be its emphasis on an expensive model of healthcare delivery. Too much emphasis has been placed on providing care in acute settings without appropriate use of, and investment in, primary and social care. Moving to a better model of service delivery should prove more efficient and eventually cheaper though investment is needed to help reform. Furthermore, the continued use of expensive temporary staff within acute hospitals is symptomatic of a system which can achieve better value for money (see Section 3).

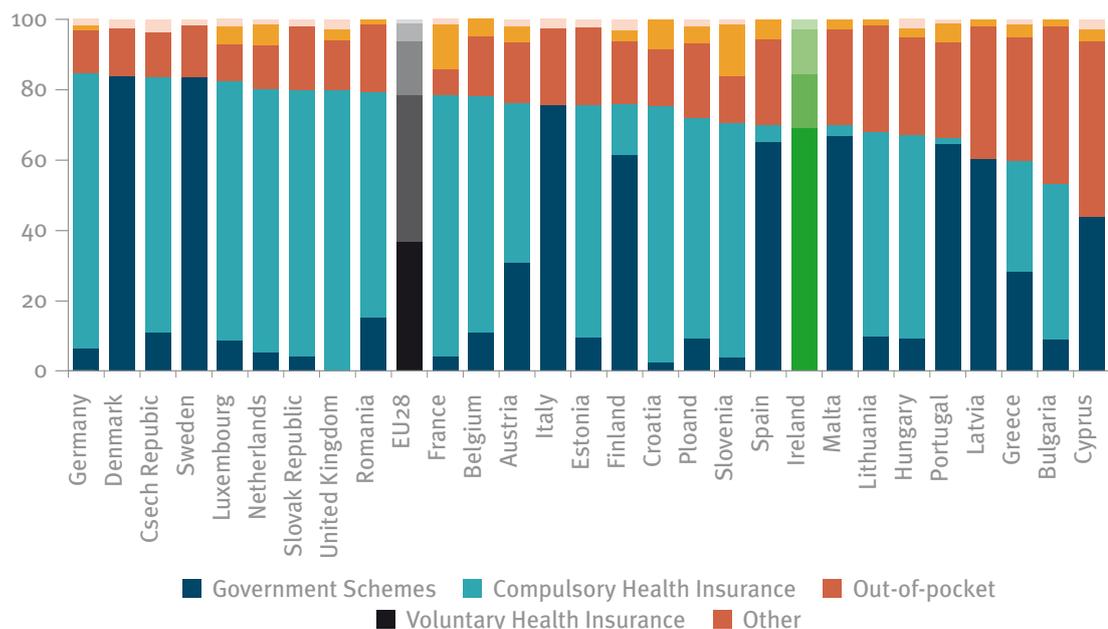
¹⁰⁸ Thomas, S., Darker, C. (2013). *Which is the right model of Universal Health Insurance for Ireland?. Integrated Care for Ireland in an International Context. Challenges for Policy Institutions and Specific Service User Needs.* T. O'Connor. Cork, Oaktree Press

A further cause of Ireland’s high spending by international standards is also the growth of private healthcare spending levels which are now quite high, 2.9% of GDP in 2015, which is the 6th highest across the EU 28. Correspondingly, Ireland’s share of funding coming from solidarity spending, whether from taxation or compulsory social insurance as indicated by the blue bars in Chart 7 below, is quite low by European standards, 20th out of 28 EU countries. One critical factor is the size and scope of the established PHI system. The only other countries with similar optional private insurance spending patterns are France and Slovenia.

However, in both these countries PHI is supplementary, which means it is bought in addition to the publicly funded package, and largely covers the costs of out of pocket payment rather than gaining faster access. The key feature in Ireland is that PHI allows faster access to care within the publicly funded system. The Committee has noted that despite the size of the private health insurance sector in Ireland the proportion of funds devoted to out of pocket payments is still quite high. The Committee also noted that this implies that PHI could do more in the Irish setting to reduce out of pocket spending.

“...while we spend a considerable amount of money on health care, the amount we spend does not seem to deliver outcomes and access to healthcare that are commensurate with our spend. This suggests there are deep-seated issues around efficiency and equity within the system.” (John Armstrong, Health Economist)

Figure 11: Current Health Expenditure by type of Financing 2014 (EU 28)



Source OECD 2017

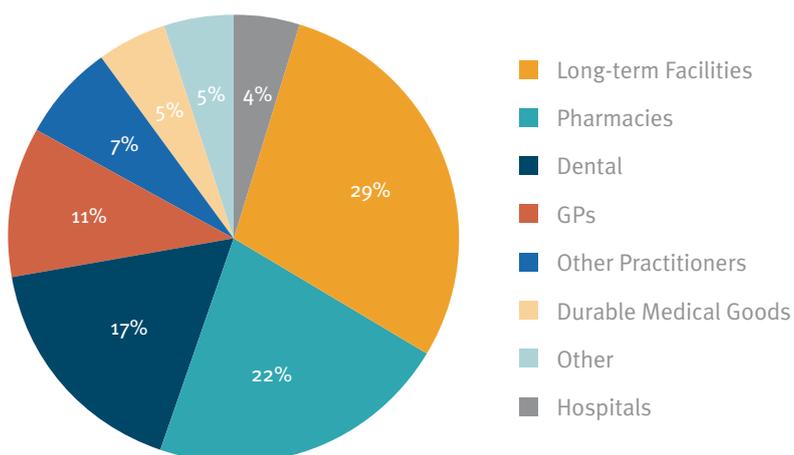
4.3 Evaluating Options

Drawing on learning from international experience and the realities of the current economic situation the Committee has appraised various funding options for moving to a universal single-tier health system.

Out-of-Pocket Spending

Out of pocket funding does not help to achieve a single-tier health system, where people get access on the basis of need and not ability to pay, as it blocks access for some and causes hardship for others. Many out of pockets payments in Ireland are problematic. They currently pay for items which the Committee firmly believes should be part of free entitlements for all.

Figure 12: Distribution of out of pocket payments by households by type of care (2014)



Source: CSO (2016)

Moving away from out-of-pocket payments to publicly-financed services has been a significant theme for East and Southeast Asian countries, such as Thailand and South Korea, who are pursuing and achieving Universal Health Care.¹⁰⁹ However, such transitions are rarely achieved in one phase and require persistence and strong political commitment.

There are questions about how quickly Government can bridge the funding gap. Given the impact of the recent recession in Ireland, the growing demographic demands and the identified need for additional health finances, it is imperative for Government to find sufficient resources in a sustainable way.

109 Tangcharoensathien, V., S. Limwattananon, W. Patcharanarumol and J. Thammatacharee (2014). "Monitoring and Evaluating Progress towards Universal Health Coverage in Thailand." *PLoS Medicine* 11(9): e1001726

Private Health Insurance

Currently in Ireland PHI confers an advantage in terms of faster access to care.

“An Irish College of General Practitioners survey of GPs commissioned by the Irish Cancer Society this year, 2016, highlighted the public private divide in stark terms. 88.5% of GPs surveyed said a patient’s ability to pay affected their ability to access diagnostic tests used to detect cancer.” (Irish Cancer Society)

This being the case, it is impossible to see how the current *optional PHI* model can support a universal health care system with a single-tier, as discussed below. Indeed there are only two options whereby PHI can help support a universal single-tier system and these are also discussed below (Options 2 and 3).

Option 1: A mandatory, comprehensive and competitive private health insurance system In this option everyone has PHI which purchases care on their behalf. There is a complex series of subsidies to ensure everyone gets cover and the system is a single-tier in that there is no fast-tracking into public care. Nevertheless, the affordability of such an option for Government and households will always be a key concern. The ESRI costings of the UHI model proposed by the 2011 Government demonstrated the unaffordability of this option for Ireland¹¹⁰. Indeed, internationally health care systems that rely on private insurance financing, such as in Switzerland, the Netherlands, Japan and the USA, tend to be more expensive and typically encounter problems of cost escalation¹¹¹.

Even beyond this concern there are key arguments against this option which relate to several factors:

- *The evidence suggests that, under this model, the small size of the population in Ireland is not large enough to sustain more than one efficient insurer*
- *Insurance benefits from economies of scale in purchasing health care*
- *UHI reforms are very complex. This leads to higher, not lower, regulation costs with additional administrative and oversight capacity required. Further, there is a lack of transparency because of the complex funding flows and subsidies*

¹¹⁰ Wren, M., Connolly, S., Cunningham, N. (2015). *An Examination of the Potential Costs of Universal Health Insurance in Ireland*. Dublin, ESRI

¹¹¹ Thomas, S., Darker, C. (2013). *Which is the right model of Universal Health Insurance for Ireland?. Integrated Care for Ireland in an International Context. Challenges for Policy Institutions and Specific Service User Needs*. T. O’Connor. Cork, Oaktree Press

- *There are potential problems with equity where the basket of care does not cover all necessary services and all associated co-payments*
- *There is little prospect for efficiency gains through competition in rural areas in Ireland because of shortage of providers and a lack of contestability of markets¹¹²*

Option 2: A mandatory and supplementary private insurance system for out of pocket payments similar to the schemes in France or Slovenia, which have lower levels of unmet need

In this second option PHI does not purchase care from the core package but reimburses out of pocket payments by patients. Both France and Slovenia have such schemes where patients are reimbursed for their direct payments. In addition they have policies which then subsidise the costs of such supplementary insurance for those least able to afford care¹¹³. The aim of this is to avoid financial hardship or unmet need caused by out-of-pocket payments. This could potentially cover costs additional to the core basket of services that a person is entitled to, through the proposed new Cárta Sláinte.

Option 3: A private insurance system that covers private care in private hospitals or other privately provided primary and social services for those who choose to buy it

In this third option PHI will not be integral to a single-tier system and will no longer confer faster access to better quality health care in the public sector, or according to a prescribed universal package of healthcare. In this scenario private insurance is limited to covering private care in private hospitals. The population would then still be able to choose whether to have additional private insurance cover for treatment in a private hospital above and beyond universal access to public health care.

The Committee understands that there are key ramifications of this policy option. Hospitals would no longer be set targets for private income. Consequently, there would be a funding gap of approximately €649m which represents PHI funding of public sector hospitals in 2016. Nevertheless, this is only 4% of the current public sector budget. In all three of these options those with PHI will not be able to get preferential access over those who do not except on the basis of their medical need which is independent of their insurance cover.

¹¹² Ryan, P, Thomas, S, Normand, C, *Translating Dutch: challenges and opportunities in reforming health financing in Ireland.*, *Irish Journal of Medical Science*, 178, (3), 2009, p245-248

¹¹³ Chevreul K, D.-Z. I., Bahrami S, Hernández-Quevedo C and Mladovsky P. *France (2010). "France: Health system review" Health Systems in Transition* 12(6): 1-291

Taxation Based Funding

As noted earlier the majority of funds for health-care in Ireland come from general taxation through the budgetary process. This is unlikely to change substantially. A radical shift away from taxation-based funding would require a large tax rebate because of the size of the health budget. This would be very difficult to organise and unlikely to occur with the support of all economic stakeholders. Recent budgets have seen a restoration of year on year budget increases for health of around 7% for both 2016 and 2017.

A key question for the Committee is whether taxation-based funding of healthcare can expand to fill the gap left by removing out of pocket payments and private insurance payments to public providers and hospitals. While some efficiencies may be gained by moving care out of hospitals and into primary and community care settings it is unlikely that these will be realised in the short-term, and not before the capacity in primary care has increased. Thus any expansion in entitlements will have to be matched by increased funding. At the same time funding must increase to match the already growing health need, the drivers of which include an aging population and a growing burden of chronic disease.

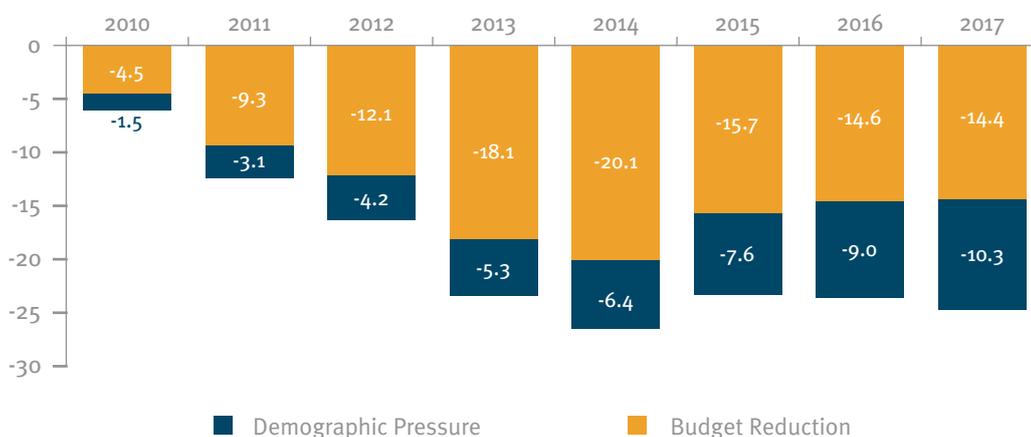
It is estimated that annual budget increases would need to be at 1.4% to cope with demographic pressures, and at 3% to cope with demographic pressures and medical inflation/advancing technology before any expansion of entitlements is possible.¹¹⁴ Further research on the budgetary implications of demographic pressures is currently underway by the ESRI and the results of this can be folded into future budgetary projections.

According to the HSE, there have been substantive real budgetary reductions during the recent recession, producing a pronounced, cumulative impact on funding (see Chart 9 below) and creating a backlog of unmet need.¹¹⁵ In 2017, as outlined in a HSE report, the public budget would need to increase by almost 25% to match changing demographics and compensate fully for the recession related budget reductions¹¹⁶. This would increase the government's current health budget substantially. It is important to note though that the full effect of these budget reductions has not been felt because of efficiencies made in the health sector and some cost-shifting onto households. Also better value for money is clearly possible by changing the model of care. Nevertheless, the pressure from population demographics is still notable and there is a significant backlog of unmet need.

¹¹⁴ Department of Health, 2015, *Projected Demographic Effect on Health Service Costs in 2015*

¹¹⁵ Health Service Executive, 2016, *Primary Care Reimbursement Service (PCRS) Statistical Analysis of Claims and Payments 2015*

¹¹⁶ Smyth et al (2017) *Planning for Health: Trends and Priorities to Inform Health Service Planning 2017. Report from the Health Service Executive*

Figure 13: Cumulative Budget Reductions and Demographic Pressures Combined 2010-2017¹¹⁷

Source: Smyth et al (2017) *Planning for Health: Trends and Priorities to Inform Health Service Planning 2017. Report from the Health Service Executive*

The lesson of the last decade is that healthcare funding is vulnerable to cuts during tighter fiscal times. With the current economic uncertainty surrounding Brexit it will be important to futureproof health system funding as far as possible from international economic setbacks.

A first step to achieve this is to develop multi-annual budget cycles to help preserve funding stability and increase predictability for managers and providers. A second step is to consider some form of protection or earmarking of health budgets either in their entirety or for certain priority activities. The Committee is keen to see specific ring-fencing of budgets for primary care and mental health. A third step may be the need for a transition fund to compensate for the years of underfunding, which has created a backlog of unmet need, and enable capacity expansion and new models of care to be developed.

Social Health Insurance

An alternative funding option is Social Health Insurance (SHI). Social health insurance has a long history in Europe but has also gained ground elsewhere, particularly in East Asia and East Europe. It is similar in some instances to taxation-based funding, which provides access according to need and payment according to ability. However a notable feature of SHI systems is that health care funding is kept separate from general taxation to some degree and goes to a specific fund or funds.¹¹⁸ One advantage of earmarking funds is that there is some protection of funding to healthcare. Rather than the health budget being subject to negotiations and competition from other sectors, earmarking can help to protect funding stability. These funds can finance care by

¹¹⁷ Smyth et al (2017) *Planning for Health: Trends and Priorities to Inform Health Service Planning 2017. Report from the Health Service Executive*

¹¹⁸ Barbara McPake, Charles Normand and Samantha Smith (2013). *Health Economics. An International Perspective*. Routledge. Abingdon.

contracting with providers which can be in the public and private sectors. Hence with a SHI model there is a split between the purchaser and the provider of care.

In terms of contributions and entitlements to care the basic SHI model has much in common with taxation-based financing. A key difference relates to the fact the SHI funds are kept separate and earmarked to some degree. This transparency has a distinct advantage in monitoring and planning expenditure. Secondly there is a bigger focus on defining a precise package of care which is balanced against available resources.

Finally because of the notion of insurance there is more of a consumer mind-set than in a taxation model. The performance of taxation and SHI systems are very similar. SHI systems tend to have slightly higher costs and also may be more fragmented.¹¹⁹ However increasingly the two systems are hard to tell apart as SHI systems use tax subsidies and taxation systems use contracting methods.¹²⁰

Indeed, a key development in almost all SHI systems in Europe is that they are no longer pure in terms of being entirely funded by payroll earmarked deductions but they are frequently subsidised from taxation and other sources. Indeed, it is increasingly difficult to differentiate where SHI systems start and tax-based systems finish.

“The paying options are many if we had a single health insurance fund – not-profit single payer, including premiums, anti-obesity taxes, wealth taxes etc., to ensure that the fund is adequate and allows for a surplus for capacity building etc.” (Adelaide Health Foundation)

Indeed, a specific variant of a social health insurance scheme is a single fund often referred to as National Health Insurance. Recent successful examples have been in Lithuania and Taiwan.

The advantage of a single fund over multiple funds is the simplicity of arrangements and the bigger purchasing power of a single purchaser.¹²¹ In addition, a National Health Insurance Fund has the ability to build up reserves in times of economic growth which can be used in times of austerity and which cannot be allocated elsewhere. The funding of health services is thus less impacted by economic circumstances. This counter-cyclicality, or ability for funding not to be dictated by the variability of the economy, is the mark of good financial governance. Lithuania offers valuable lessons of careful social insurance fund management through austerity.¹²²

¹¹⁹ Wagstaff, A. (2010), *Social health insurance reexamined*. *Health Econ.*, 19: 503–517

¹²⁰ Thomas, S., Evetovits, T. and Thomson, S (2015) *Analysis of the Health System in Slovenia. Evaluating Health Financing. Final Report. October 2015. European Observatory on Health Systems and Policies, World Health Organization and Ministry of Health, Slovenia*

¹²¹ Thomas S and Darker, C (2013) *Which is the right model of Universal Health Insurance for Ireland?* in, editor(s) Tom O’Connor, *Integrated Care for Ireland in an International Context. Challenges for Policy, Institutions and Specific Service User Needs*, Cork, Oak Tree Press

¹²² Kacevičius, G., Karanikolos, M. (2014). *The impact of the crisis on the health system and health in Lithuania. Economic crisis, health systems and health in Europe: impact and implications for policy*. F. J. Thomson S, Evetovits T, Jowett M, Mladovsky P, Maresso A, Cylus J, Karanikolos, M, Kluge H. Maidenhead, Open University Press

4.4 Preferred Design

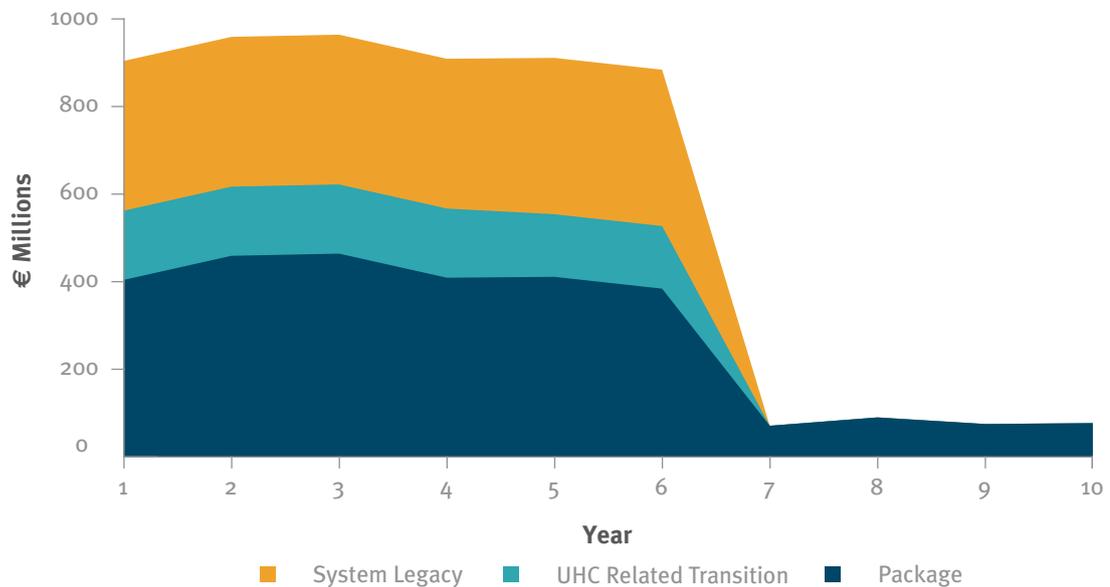
Solidarity Funding

The Committee recognises the advantages of both the taxation and social health insurance models. Both are superior forms of health system funding rather than relying on out of pocket payments or private health insurance. Nevertheless, while taxation is the main funding source for healthcare in Ireland it has not raised sufficient sustained funds to provide entitlements to care, free at the point of delivery. On the other hand, there is no history of social insurance in Ireland to build from and currently barely any funding being channelled through this mechanism.

Instead, it is proposed that a model is developed which encompasses the benefits of taxation with additional earmarking of funds. Under this model a single-tier system is funded through a combination of general taxation revenues and earmarking of some taxes, levies or charges into a single National Health Fund (NHF). This will help build more transparency, sustainability and independence into health funding. This fund will be a single dedicated channel of funds for the health sector. The National Health Fund will allocate resources across all levels of care and will directly report to the Minister of Health. A single fund, rather than many purchasing mechanisms, will also better incentivise integration of services and accountability as outlined in Section 3.

“There is a need to have a radical shift in healthcare priorities in order to develop services to ensure that there is a meaningful rehabilitation pathway for those who experience brain injury. This requires systemic change in terms of the way our health services are provided and funded. Addressing the current ‘silos’ in terms of funding for our health services must be a priority in any reform of healthcare in Ireland.” (Acquired Brain Injury Ireland)

As the system moves towards the single-tier model it will become less reliant on out of pocket payments and private health insurance. Out of pocket payments will be reduced as entitlements are expanded, as set out in Section 2. The effect on households of reducing out of pocket spending and reducing their reliance on private health insurance all other things being equal, is shown in Chart 10 below. In the funding model proposed, more of the costs are borne by the system rather than through direct expenditure by household, and hence are funded by the whole population.

Figure 14: Effect on households of reducing out of pocket spending and private health insurance.

Those with private insurance will still be able to get access to care as public patients in public hospitals but they will no longer have preferential and faster access to such public care. Their access to care in private hospitals will not be affected.

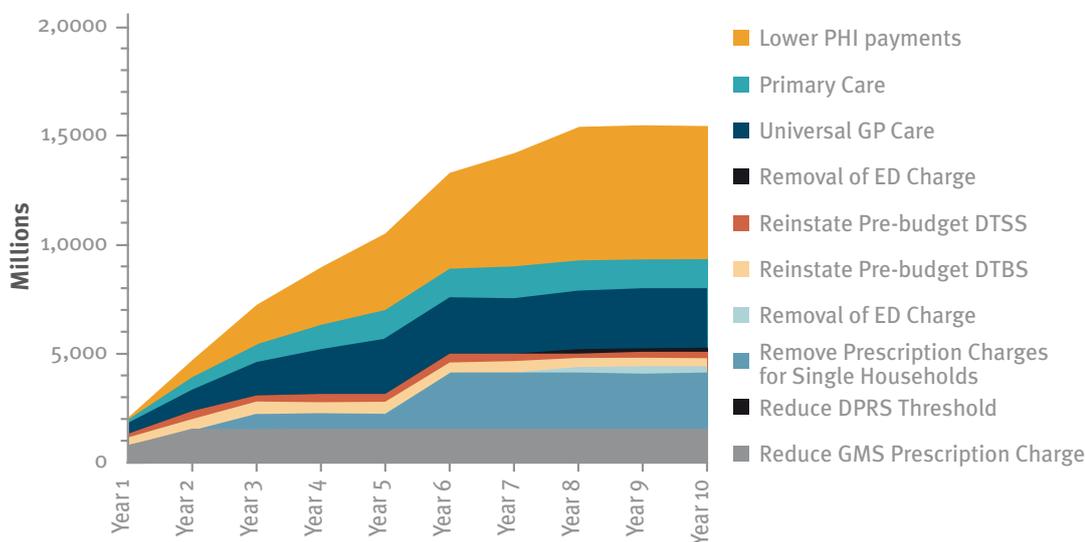
This is part of the “disentangling of private treatment in public hospitals” (Brian Turner). “Ireland is not unusual in having a mixture of public and private funding and delivery of healthcare services. However, where it is unique is in the overlap of the private and public sectors... The 10-year plan for the Irish health system should aim to reduce these overlaps, both in funding and delivery.” (Dr Brian Turner, Health Economist, UCC)

The Committee is strongly committed to the principle of disentangling the public and private acute healthcare sectors. This is important to guarantee that access or faster access is not related to ability to pay and that financial hardship is not caused for those seeking health care. This needs to be achieved by reform of health funding mechanisms and incentives and greater accountability, transparency and oversight, as discussed more fully in Section 3.

As shown in Chart 11 below, the overall impact on households will be:

- *Significantly reduced out of pocket payments to access many aspects of primary and social care, with free GP care and no public hospital charges*
- *Some reduction in out-of-pocket payments for drugs, with lower prescription charges and lower drug payment thresholds*
- *Lower hospital charges and*
- *Less need for private health insurance*

Figure 15: “Estimated total reduction in out-of-pocket costs and PHI expenditure for households”



Such a shift in funding mechanisms will also produce some efficiencies, as private funding sources have higher regulation and collection costs. Expansion of the general government health budget in the last two years has been at a rate of 7% per year. The Committee recommends that this expansion should be continued at least over the next five year period. After demographic and medical technology/innovation costs, which will account respectively for 1.6%¹²³ and 1.4% increases in the Budget each year, this would leave 4% of the budget, over €500 million per year, and increasing with economic growth, to redress the backlog of needs and allow the system to expand entitlements.

The Committee is aware of the potential for significant growth in medical technology/innovation costs and in response proposes that Health Technology Assessment (HTA) is used to rectify inconsistencies whereby some new, expensive and modestly effective treatments are funded, while existing services that offer good value for money are subject to long waiting lists. Employing HTA in this way would represent a broadening of its application to all health services from the current primary focus on new drugs spending as outlined in Section 3.

Even if the annual increase in the Government Health Budget were only 5%, because of more limited economic growth, this would leave 2% of the budget for funding of the delivery of universal healthcare, giving an additional €300 million per year. The expansion of the package elements costed in Section 2 will largely be funded within this amount. However, there may be a need to supplement the budget for specific early years health initiatives being newly included in an annual budget.

¹²³ This is slightly higher than the estimate of the health budget impact of demographic change estimated in Department of Public Expenditure and Reform (2016) Budgetary Impact of Changing Demographics 2017-2027

In addition, the National Health Fund will utilise a population-based resource allocation formula to guide the allocation of resources to primary and social care and ensure that there is equity of access to healthcare across the country, as outlined in Section 3. Such a funding model will help integrated care delivery, will promote geographic equity and ensure that there are no longer gaps in service provision. In its submission to the Committee, Age Action identified the need to “... *develop population-based (needs-based) funding to assist with planning and ensure equity*” (Age Action)

John Armstrong’s submission highlighted the fact that “*strains are emerging around the geographic access to certain treatments, in particular in relation to accessing primary care services in certain parts of the country.*”

Transitional and Legacy Funding

Transitional or transformation funds have been used or explored in a variety of country contexts to initiate a substantial reform programme in health care. Examples include the State of New York, England, Denmark and Canada.¹²⁴ For change to happen investment is needed. Significant change cannot be squeezed out of resources already allocated to already stretched regular health care activities and services. These case studies show that required investment includes both physical and programme infrastructure, but also an investment in staffing, and even in substantially increasing operational costs on a temporary basis, where different models of care require capacity to be expanded rapidly.

For example some of the programmes focus more on capital investment, as in Denmark, and others on system change, as in New York. Nevertheless, the costs associated with such programmes can often be very significant. The New York programme is due to cost over €8 billion from 2014/15 to 2019/20 and aims to make a 25% reduction in avoidable hospital use.

The Danish hospital transformation programme initially designed in 2007 was also planned to cost approximately €8 billion. Recent research by the HSE suggests the costs of investments to shift the balance of care range from €2.3-€2.9 billion, outside of the costs of delivering universal healthcare.¹²⁵ In the Irish case, investment will be required both in new ways of working and infrastructure.

It is important to note that the Irish health system does not have the capacity currently to provide all the entitlements required and mandated by the Committee, as outlined in Section 3. Therefore it is important to expand the capacity of the system to deliver quality care. The removal of out of pocket payments for some components of care will require an expansion of capacity to cope with

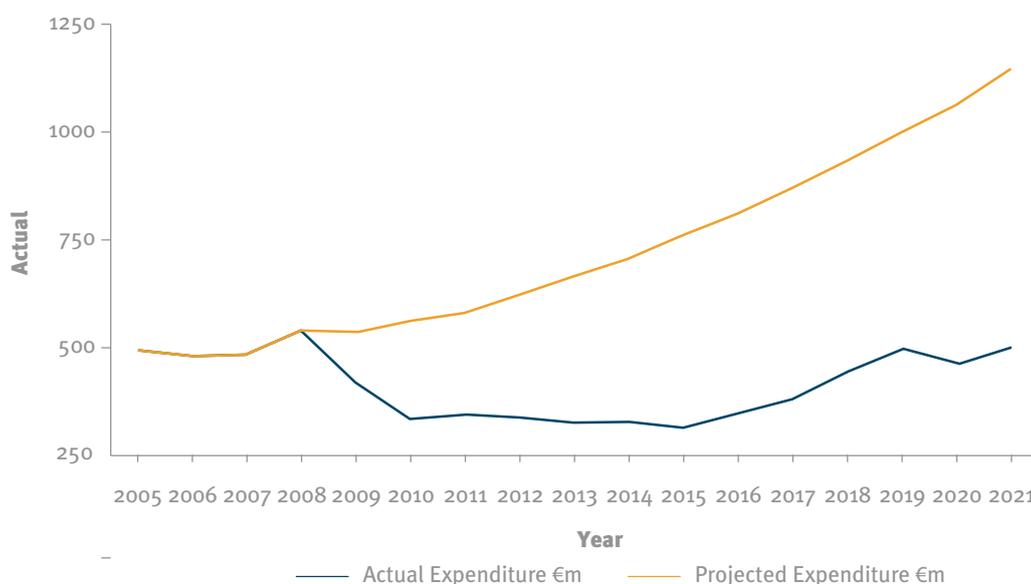
¹²⁴ New York State Department of Health 2012, Charlesworth et al 2015, The King’s Fund 2015 i,ii

¹²⁵ HSE 2017, *Shifting the balance to high value care*, March 2017

additional demand. Consequently, there will need to be investment in training capacity for health professionals to guarantee sufficient numbers to deliver the new entitlements.

Another key area for transitional funding will be for the structures and processes which are critical to the implementation of the recommendations of this report. This includes the funding of an independent Programme Implementation Office to implement all of the Committee's recommendations, as outlined in Section 5. Another key component is the eHealth architecture to support integrated care, and the introduction of the proposed new Cárta Sláinte. Further, failure to invest in capital funding was a hallmark of the recent recession, with actual capital funding falling short of planned funding by around €3 billion between 2008 and 2017.¹²⁶

Figure 16: Health Capital Expenditure



Hence transitional funding for universal health care (UHC) will be required for renovation and expansion of our public hospital capacity, diagnostic capacity within primary care centres and the accelerated building of primary care centres, in order to:

- *Change the way of providing services, expand capacity in primary and social care and where relevant in acute care to provide universal services through investment in human resources and infrastructure, and*
- *Develop the appropriate additional or realigned governance structures, evaluation and implementation capacity for the Committee's recommendations as outlined in Section 5*
- *Compensate the public health system for the cuts caused by austerity, particularly around capital funding and investments which are needed to deliver a single tier system*

This one-off investment in the health sector will provide significant momentum to develop the system to allow it to provide single tier access for all to quality care. The funding will be for capital projects, new structures, new equipment, additional staff training capacity and new services. A key aspect will be the expansion of the e-Health initiative estimated to cost €875 million to 2030 (HSE 2017).

Table 3: Transitional and Legacy Funding (Years 1-6) Sources: HSE (2016, 2017)

Component	Cost (€m)
eHealth	875
Primary Centres and OOH	120
Community Diagnostics	60
Training Expansion	
– GPs	235
– Consultants	178
– Other Primary Care	252
System change	50
Renovation and Hospital Bed Capacity	1,230
	€3,000

It is argued that the €3 billion lost to capital funding be restored and targeted into the transitional fund. This matches closely with the figures produced by the HSE (2017) noted earlier. Key differences however, relate to the fact that some of the HSE's transition items have already been covered in Section 2. The Committee's recommended €3 billion transitional fund will also enable capital renovation and expansion for acute hospital capacity where required. It is suggested that €500 million per annum for the next 6 years will be required for this. The Committee was unable to prepare a more detailed costing within its limited timeframe for the publication of this report. This is an important area that needs follow up by the Implementation Office, the Department of Health and the HSE, to ensure effective investment in change.

Nevertheless, the HSE's work on transition funding and capital requirements will form a useful basis for further work. Where there are planned additional capital funding projects, these must not breach EU rules on state capital spending limits. To ensure that the required capital projects proceed, it may be necessary to utilise additional Public Private Partnerships. These are already in place in the Irish healthcare sector and the Committee believes should be expanded to allow for the necessary investment. The Committee appreciates that it is for the Government of the day to resolve how this transitional funding should be resourced. The Committee believes that a targeted re-investment programme is vital to lay the foundations for a quality single-tier health system for the future.

Overall Cost and Funding Summary

It is important to provide an overview of the costs and funding needed to deliver the recommendations contained in this report, and this section provides that summary. Table 4 highlights the three critical components: the cost of the expansion of entitlements and reduction of out of pocket payments; the one-off costs of transitioning the system to Universal Health Care; it also includes expanding the workforce and the costs of addressing some of the system legacy capital investment issues. In the funding model proposed, more of the costs are borne by the system rather than through direct expenditure by household, and hence are funded by the whole population. Table 4 below shows the additional costs for the system which are associated with the shift to the new single-tier model.

With these costs being funded centrally, individual households will incur less direct expenditure. In the future, people will no longer have to pay to attend their GP, may pay less for drugs, will no longer be subject to hospital in-patient charges and will not be subject to out-of-pocket costs relating to other community-base services. Reliance on private health insurance may also fall as access to our public healthcare system improves. It is estimated that as the expanded entitlements are phased in, household direct expenditure overall will fall by around €148m each year on average, through reductions in out-of-pocket costs and some reduced private health insurance costs. When the strategy is fully implemented (Year 10), households overall will be paying an estimated €1.482bn less in direct personal health expenditure or between €285 and €294 per person.

The Committee also believes that the additional investment in our health system now is necessary to ensure that it remains affordable and sustainable in the long-term. Better value for money will be achieved by ensuring that care is delivered at the lowest level of complexity that is clinically appropriate, that most care is delivered in primary and community settings, that the necessary priority is given to health promotion and preventive care, and that there is a strong focus on medicines management. The proposed resource allocation funding model, implementation of the e-health strategy, continued development of integrated management systems and more effective use of data will all support improved efficiency.

Table 4: Additional costs associated with introduction of the Single Tier System

	Total	Per Year
Expansion of Entitlements	€2,844m	€284m (average expansion each year)
UHC Transition	€918m (over 6 years)	€157m
System legacy	€2,082m (over 6 years)	€347m

Sources: Population projections from CSO (2016)

4.5 Phasing

There are two elements of phasing around funding. One relates to the development of a new arrangement for financing the Irish health system and specifically in relation to the establishment of a National Health Fund and resolving which funding flows go into this fund. The second concerns the resourcing of the transition fund and the development of additional capacity of the system to deliver the expanded package of care. Both of these need to dovetail with the expansion of entitlements over the ten year period, as specified in Section 2. As noted, the transition and legacy funding is focused into the first six years of the reform period. The additional and incremental costs associated with the expansion of entitlements occurs over the whole ten years but the largest annual expansions are front-loaded over the period.

4.6 Committee Recommendations

- *Establishment of the National Health Fund*
- *Funding flows into the NHF will include a mixture of general taxation and specific earmarked funds, to be decided by the Government of the day*
- *Guaranteed expansion of health funding by between €380-465 million per year, for expanded entitlements and capacity to delivery universal healthcare*
- *Implementation of transitional and legacy funding arrangements to a total of €3 billion over 6 years, to boost reinvestment into one-off system changing measures, training capacity and capital expenditure*
- *Earmarking/ringfencing of funds to health care priorities, such as expanded primary and social care, palliative care, and mental health*
- *Ringfence savings that will arise from reduced tax-relief costs as people move from PHI to avail of improved public health provision and allocate these to expansion of entitlement and transitional funding*
- *Disentangle public and private health care financing in acute hospitals. Remove ability of private insurance to fund private care in public hospitals*

Section Five: Implementation

One of the strongest concerns of the Oireachtas Committee on the Future of Healthcare is to ensure that this is not just another report on the health sector which is not implemented. A key focus for the Committee outlined in its Terms of Reference is for it to:

*Examine and make recommendations on how best to orientate the health service **on a phased basis** towards integrated, primary and community care, consistent with highest quality of patient safety, **in as short a time-frame as possible***

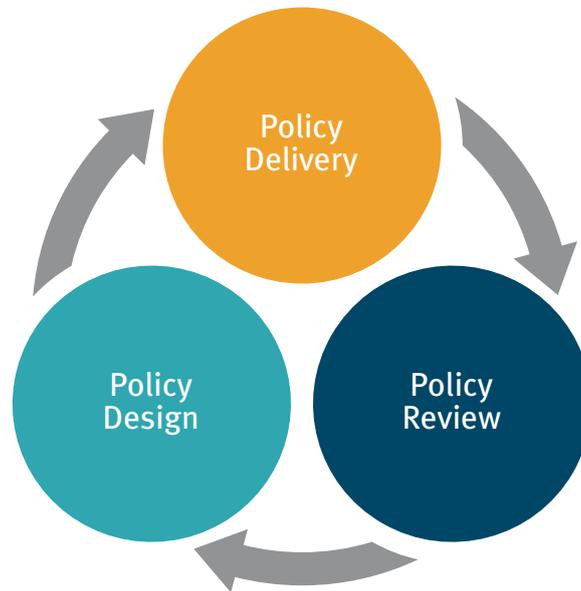
A further key principle of the Committee is to:

*Create a modern, responsive, integrated public health system, comparable to other European countries, through building long term public and political confidence in the delivery and **implementation** of this plan*

In order to deliver on this, mechanisms for implementation are as important as the report's recommendations themselves. With this in mind, the Committee recommends that progress on the report's implementation begins immediately and is adequately resourced to ensure effective delivery. It is vital that there is no gap between the presentation and endorsement of the report and the implementation of its findings.

Below, the Committee sets out clearly the steps that must be taken to ensure effective implementation in this section. These provide the big-picture blueprint for a project plan to be developed by the Programme Implementation Office as one of its first actions and against which the implementation effort will be measured.

The previous sections of this report outline the dimensions, strategies and recommendation to deliver a single tier system – what needs to be done. This section outlines the 'how' it should be done, aware that the nature of the policy cycle means that the policies should be continually designed, refined and reviewed as they are delivered.

Figure 17:

This section also outlines the phasing of the recommendations to ensure coherence across different components of the reform process and that delivery is done “in as short a timeframe as possible”.

5.1 Enablers for Implementation

An analysis of the critical factors in implementing and sustaining the National Cancer Control Programme found four key phases of large system change:

- *understanding the need for change*
- *framing the change*
- *undertaking the change and*
- *sustaining the change*¹²⁷

Similarly Fixsen (2005) breaks down the implementation process into four stages and suggests enablers for each stage (see Image 6). Analysis of previous reform experience also outlines powerful enablers to ensure effective implementation, highlighting the importance of such things as political will, legislation, a lead implementation agency, authority, resources and capacity.¹²⁸

¹²⁷ http://www.effectiveservices.org/downloads/Guide_to_implementation_concepts_and_frameworks_Final.pdf

¹²⁸ <https://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4c-equality-equity-policy/problems-policy-implementation>

Figure 18: Implementation enablers and stages

Implementation enablers	Stages of implementation			
	1 Exploring & preparing	2 Planning & resourcing	3 Implementing & Operationalising	4 Business as usual
Stakeholder consultation and buy-in	█	█	█	█
Leadership	█	█	█	█
Resources	█	█	█	█
Implementation teams		█	█	█
Implementation plan		█	█	█
Staff capacity		█	█	█
Organisational support		█	█	█
Supportive organisational structure		█	█	█
Communication		█	█	█
Monitoring and evaluation			█	█
Learning from experience			█	█

5.2 Political Will and Leadership

This Report is the product of extensive and intensive cross-party collaboration and dialogue. This high level of political support must be carried through into the implementation so that the momentum built to solve the chronic problems of the Irish health system can be sustained.

The Committee Recommends:

- *That progress on the Report’s implementation begins immediately and is adequately resourced to ensure effective delivery*
- *That the Dáil is briefed, and there is a debate on the progress of the report, by the Minister of Health every four months in the first year, to gain momentum, and every six months thereafter. This will help maintain progress, continue high-level political involvement and further consolidate sustained action and support*

“Shaping, forming and sustaining this single-tiered, universally accessible, public health service (including ownership and delivery), will require political consensus stretching far beyond the normal electoral cycle. It will require this, and future, governments, and oppositions, to accept that the transformational change required cannot be interfered with for political reasons. This will be important particularly during the transitional period when additional investment, both current and capital, will be required and when existing incentives, targeted at private healthcare, will have to be phased out.” (Irish Nurses & Midwives Organisation)

5.3 Programme Implementation Office and Board

It is vital to have one agency with the specific remit to lead on the delivery of the reform programme. This agency, the Programme Implementation Office, will be specially designed and adequately resourced to successfully deliver reform on this scale. Given the high level importance of the reform programme, its visibility and the need for interdepartmental coordination between health and finance:

The Committee Recommends:

- *Setting up an Implementation Office under the auspices of An Taoiseach by July 2017 with a remit to oversee and enable the implementation of this plan and develop a detailed implementation plan for the Reform Programme*
- *The Implementation Office will work closely within the HSE and will have representation on the management teams at both national and regional level, and will report directly to the Minister for Health*
- *Identify and recruit a senior level (equivalent to Secretary General), highly independent Lead Executive with specific experience in change management by July 2017*
- *Recruit all staff by October 2017, with the majority being external recruits*
- *A Cabinet Sub-Committee is established whose remit is to oversee the Implementation Office and review the implementation of this plan*
- *The Sub-Committee will enable the Programme Office to conduct its remit and assist with the overcoming of obstacles. It will provide political support for the Office allowing it to exercise independent monitoring of key milestones*
- *The Implementation Office will be supplied with appropriate financial resources (up to €10 million for its lifecycle) and relevant human resources with proven capacity in leadership, programme management, project management, content expertise and communication*
- *Establishment of the Implementation Office, with all necessary infrastructure*
- *As one of its first actions, the Implementation Office will devise a detailed implementation programme project plan for each year of the plan, identifying key milestones which can be monitored across sectors (see later discussion on the phasing of recommendations) by December 2017*
- *That a first draft of the detailed implementation project plan will published by the end of 2017. It will be based on the deliverables detailed in this report and will operationalise the phased implementation of the reform*

5.4 Legislation

There are several important areas for legislation associated with the programme of reform. These relate to key values and principles to embed into the Irish health system, new governance structures, funding mechanisms, and organisational realignment and enhancement.

- *Legislate for the new HSE Board*
- *Legislate for the National Health Fund and new funding mechanisms for the transitional funding, legacy funding and package expansion components, as required*
- *Enact the Irish (Sláinte) Health Act which will provide the legislative basis for a universal entitlement to a broad package of health and social care for everyone living in Ireland with maximum waiting times and a Cárta Sláinte through:*
 - *Introducing Heads of Bill by 2017 for phased entitlement expansion to include all Irish residents by 2023, as described in Section 2*
- *Introducing legislation by Spring 2018 for the following waiting time policies, to be implemented on a phased basis by 2023:*
 - *No-one should wait more than 12 weeks for an inpatient procedure, 10 weeks for an outpatient appointment and ten days for a diagnostic test*
 - *Individual waiting lists are published by facility, by specialty*
 - *Introduce a maximum wait time in EDs, working towards a four hour target*
 - *Hospitals that breach guarantees are held accountable through a range of measures including sanctions on senior staff, but not to the detriment of healthcare delivery*
- *Legislate for accountability – that the Minister for Health is ultimately responsible for delivering health system change and for the delivery of care to the population. Staff at all levels within the health systems are also accountable their delivery of relevant aspects of the health service to the population through specific, known performance measure and support for the development of needed skills to promote improvement*
- *Legislate for national standards in clinical governance, national and local accountability structures right down to community and hospital levels, so that clinical governance covers all clinical staff including consultants*

5.5 Resources

It is vital that the programme is adequately resourced for effective implementation. This requires both the funding of the expansion of entitlements and transition but also resources for the programme implementation structures and change process, including:

- *Allocate €50 million to system governance change including €10 million for the Implementation Office*
- *Identify, recruit and retain experienced and motivated professionals to populate the Implementation Office*
- *Allocate €155 million per year (for years 1-6) for transitional funding to support delivery of the new model of Universal Health Care*
- *Allocate €345 million per year (for years 1-6) to address system legacy issues and bring capital renovation and new eHealth infrastructure*
- *Allocate an additional €380-465 million each year to expand entitlements over the first six years*
- *Ring-fence at least 10% of the health budget to mental health, and 3% to health and wellbeing. A review of the international evidence suggests that it is difficult to benchmark similar comparator spending for primary care. Instead the focus should be on substantial targeted investment in this area, as recommended in this report*

5.6 Communication

A communications strategy must be developed, and continually updated and refined, for the entire 10-year life of the implementation programme. Informed by skilled communications professionals, it will be vitally important to communicate the key messages of the reform process to the general population and also to services providers whose participation in the change process is key to its effective implementation. Communication needs to focus on the huge benefits of the reform programme to the general population and highlight the ongoing progress made towards it, including quick wins and major victory points. This will be vital in creating and maintaining goodwill and solidarity, which in turn will facilitate effective implementation.

The Following Steps are Suggested:

- *Set up a website and devise a public awareness campaign to communicate to the Irish people the main components of the reform programme, showing who can expect to get what and when. Part of this will be a really accessible website where people can find out what they get now and what they will be entitled to over time as milestones are reached*

- *Media campaigns to highlight early milestones achieved and successful expansion of care. By generating compelling evidence, those who are opposed may be won round or at the least contained*
- *Key milestones in the Programme will be identified and monitored, and progress, or lack thereof, toward their achievement will be published on the website through publicly accessible dashboards*
- *Communicate and consult with health service staff on rolling out of the Programme to ensure effective planning for and delivery of integrated care*
- *Identify and utilise policy champions to endorse the reform programme and celebrate its achievements on an on-going basis*
- *Communications training for key personnel in the Implementation Office, the HSE, the Department of health, and among other important stakeholders in implementation*

5.7 Effective Monitoring and Evaluation System

Ongoing effective monitoring and evaluation is a prerequisite for ensuring successful reform. The complexity of large reform processes means that they are rarely delivered exactly as originally conceived as unexpected issues arise and changes and adaptations have to be made. Corrective action must be based on the best possible evidence supported by appropriate and accurate information flowing through the health system.

- *Establish and monitor key performance indicators for the achievement of the implementation of this programme*
- *Legislate for ready access granted to the Implementation Office, the HSE, and the Department of Health to all health data (held publicly and privately) required for performance monitoring and evaluation and the development of a mandatory data basket to be collected*
- *Establish appropriate, secure and complete data sharing between the Implementation Office, the HSE and the Department of Health and other relevant entities*
- *Regular evaluation of progress presented to the Cabinet Sub-Committee and to the Oireachtas*
- *Enhanced evaluation capacity within Department of Health and HSE to support the requirements of the Implementation Office and the programme*
- *Utilisation and commissioning of independent research and evaluation on specific topics as required*

5.8 Culture Change and Organisational Enhancement

The motivation and goodwill of staff in the Irish health system is vitally important to the delivery of a quality health care system. It is also a key part of implementation. Where reform fatigue has set in, clear vision, effective management, support, appreciation and better prospects need to be articulated and delivered to allow change to support the delivery of a single tier system.

Organisational reform recommendations include:

- *Structural change/alignment*
- *Devise local implementation plans*
- *Resource change processes to deliver new model of integrated care*
- *Support organisational, professional, and all health system contexts*
- *to introduce this programme*

5.9 Clear timetable for Implementation of Key Recommendations

It has been important to set out the architecture and infrastructure of implementation in the preceding sections. It is also important to present an overview of the recommendations and their phasing. Consequently, as a basis for planning, monitoring and evaluation of the Committee's recommendations Table 5.10 below outlines an overview of the sequencing and timing of implementation in relation to key activities. This is drawn from each of the sections of the report detailing the Committee's recommendations and key actions in relation to Entitlements and Access, Integrated Care, Funding and Implementation.

While it will be important for the Programme Office to develop this in more detail, the table presents:

- *Information on phasing, to determine feasibility given capacity and funding constraints*
- *Early expansion of entitlements and targets for achievement which will help build momentum and support*
- *Information on logical sequencing and consistency across different elements of the programme*
- *Guaranteed expansion of health funding by €380-465 million per year, in years one to six, for expanded entitlements and funding of additional capacity to deliver universal healthcare*

5.10 Timeline for Committee Proposals

Table 5

Key Actions	Years									
	1	2	3	4	5	6	7	8	9	10
ENTITLEMENT										
Health and Wellbeing										
Increase health wellbeing budget	x	x	x	x	x	x	x	x	x	x
Publish implementation plan and Outcomes Framework for Healthy Ireland	x									
Strengthen Government-wide and health system mechanisms to implement Healthy Ireland	x	x	x	x	x	x	x	x	x	x
Strengthen Child Health and Wellbeing services	x	x	x	x	x					
Removing or reducing charges										
Removal of inpatient charges for public hospital care	x									
Reduce prescription charge for medical card holders	x	x								
Reduce drug payment threshold			x		x					
Halve the drug payment threshold for single headed households	x									
Primary Care										
Expand diagnostics in primary care (investment will be frontloaded in year one but may include additional Transitional Funding in later years)	x									
Counselling in primary care	x	x	x							
Universal GP Care	x	x	x	x	x					
Universal Primary Care	x	x	x	x	x					
Staff child & adolescent mental health teams, old age psychiatry, child liaison, and Intellectual disability MH care.	x	x	x	x	x					
Expand Palliative Care	x	x	x	x	x					
Expand Home care	x	x	x	x	x					
Expand services for people with disabilities	x	x	x	x	x	x	x	x	x	x
Reinstate pre economic crisis budget to Dental Treatment Services Scheme	x									
Devise a universal minimum dental package	x									
Public Hospital Services										
Increase numbers of public hospital consultants				x	x	x	x	x	x	x
Expanding public activity in public hospitals and replacing private patient income received by public hospitals		x	x	x	x	x				
FUNDING										
Establishment of the National Health Fund	x	x								
Guaranteed expansion of health funding by between €380-465 million per year for expanded entitlements and capacity in the early years of the plan, and continued funding expansion at reduced levels over the remaining years.	x	x	x	x	x	x	x	x	x	x

Key Actions	Years									
	1	2	3	4	5	6	7	8	9	10
Earmark/Ringfence funds to health care priorities (such as expanded primary and social care, palliative care, and mental health)		x	x	x	x	x	x	x	x	x
Implement transitional funding arrangements (€3 billion over 6 years)	x	x	x	x	x	x				

INTEGRATED CARE

Integrated workforce planning to promote integrated care	x	x	x	x	x	x	x	x	x	x
Implement clinical governance and accountability at every level of the health service including legislating for clinical governance	x	x	x							
Fast-tracking eHealth developments	x	x	x	x	x	x				
Phased implementation of waiting list guarantees		x	x	x	x					
Elective hospitals in Hospital Groups			x	x	x	x	x	x	x	X
New resource allocation mechanisms and structures to be developed and implemented as determined by Programme Office	x	x	x	x	x					
Establishment of HSE Board	x									
Geographical alignment of CHOs and Hospital Groups	x	x								
HSE becomes more strategic national centre	x	x	x	x	x					
Development of regional bodies	x	x	x	x	x					

IMPLEMENTATION

Establish Implementation Office	x									
Establish Cabinet Subcommittee for oversight of Implementation Office	x									
Legislation for entitlements and waiting list guarantees	x	x								
All other required legislation	x	x	x							
Communication	x	x	x	x	x	x	x	x	x	x
Monitoring and Evaluation	x	x	x	x	x	x	x	x	x	x

The Reform Programme is ambitious and radical and one that, with sustained effort, will deliver a single tier healthcare system in Ireland. Nevertheless key challenges to be faced include ensuring fast establishment of the Implementation Office, developing effective linkages between the Implementation Office and the Department of Health and HSE, and mitigating stakeholder opposition to the reform process. Continued high level political support, a well-resourced Implementation Office and effective communication capability will do much to implement the required reform programme.

Appendix 1: Analysis of Submissions Received

To assist in preparing its final report and recommendations, in July 2016 the Committee invited written submissions from interested representative bodies, individuals and groupings. A request for submissions was published on the Oireachtas website in July 2016, outlining the Committee's Terms of Reference and providing guidelines for structuring recommendations along the themes of 1) *Strategy*, 2) *Integrated Care and Primary Care* and 3) *Funding Model*.

The Committee received 167 written submissions by 26 August 2016. The submissions were received from many different sources, and represented a broad range of concerns and viewpoints. In order to analyse the submissions, they were divided into a number of stakeholder profiles, as outlined in Section 2. The themes which emerged from the analysis were identified, and then grouped within the framework of the three main themes identified in the call for submissions.

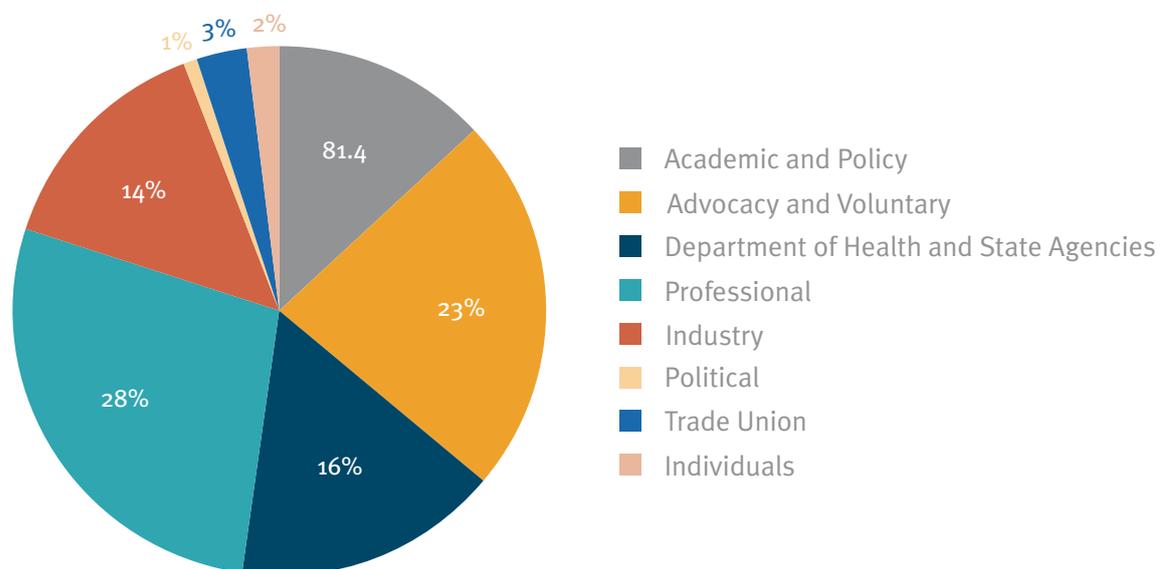
An overview of responses within the three themes is provided in Section 3. Further analysis of each theme is provided in Sections 4-6. Section 4 outlines Theme 1 – Strategy. Section 5 outlines Theme 2 – Integrated Primary Care and Community Care. Finally, Section 6 looks at stakeholder views regarding the Funding Model.

Stakeholder Profiles

The submissions were analysed by stakeholder type and profiled into the following groups:

Table 6

Stakeholder Profile	No. of Submissions	% of Total Submissions
Academic & Policy	22	13%
Advocacy & Voluntary	39	23%
State Agencies	26	15%
Professional	47	28%
Industry	23	14%
Political	2	1%
Trade Union	4	2%
Individuals	3	2%

Figure 19: Stakeholder profiles

Subcategories

In order to analyse the broad range of perspective within the determined stakeholder categories, Academic & Policy, Advocacy and Voluntary, Department of Health and State Agencies, Professional and Industry groups were broken down into a number of sub-categories. It should be noted that some submissions could have potentially fallen under more than one category, but for the purposes of analysis each submission was assigned to one category only.

Table 7

ADVOCACY AND VOLUNTARY GROUPS

Disease or Condition Specific Advocacy Groups	Number of Submissions	Population or Group Specific Advocacy Groups	Number of Submissions
Neurological and Spinal	5	Older People	2
Respiratory	2	Disabled People	2
Heart Conditions	2	Carers	2
Other Chronic Conditions	4	Children and Youth	10
Rare and Genetic Diseases	2	Homeless and Marginalised	4
Other	2	Rural	2
Total	17	Total	22

PROFESSIONAL GROUPS

Healthcare Providers	Number of Submissions	Professional Representative Bodies	Number of Submissions
Individual healthcare providers	18	General practice	3
Private hospitals, healthcare provider groups and PCCs	9	Allied healthcare professionals	7
		Acute care and specialists	6
		Training and regulation	5
Total	27	Total	21

INDUSTRIAL GROUPS

Industry Groups	Number of Submissions
Health Insurers	3
Pharma and MedTech	13
Healthcare Industry Sector	5
Other	2
Total	23

ACADEMIC AND POLICY GROUPS

Academic and Policy Groups	Number of Submissions
Academic Groups	5
Condition Specific	6
Economists	3
Research & Rights	8
Total	23

Note: Submissions from the HSE National Clinical Programmes provide valuable detail on the Programmes. They are not included in this theme-based analysis

Overview of the Three Themes

Thematic analysis of submissions received yielded significant consensus on the need for an integrated care model with a re-orientation of services towards primary care.

“It is our opinion that an integrated care model will best serve the public with regards to clinical outcome, cost and sustainability. We believe that a decisive shift of resources and activity to Primary Care (PC) is possible and will create a better health service.” (National Association of General Practitioners (NAGP))

Submissions from the Advocacy Group and the Individuals Group mainly focused on strategy, discussing a range of significant access issues and the need for integrated care. The key priority for most groups was to work towards an accessible, integrated system in which most services are provided in the community.

The Academic Group submissions offered many points of consensus, such as the need to expand primary care, enable management of chronic disease in the community and develop integrated care pathways across the system. This group included economist stakeholders, who mainly expressed the view that universal, single tier health care is a goal to work towards, but that increasing access to public healthcare services should be a main priority. Submissions from the Professional Group spanned a broad range of stakeholders across the primary and acute care areas, including the voluntary and private healthcare sectors. There was consensus that all aspects of care need to be further integrated, with defined clinical pathways and protocols, provided in the community where possible.

While this group generally felt that free at the point of access healthcare was desirable, they also considered that significant additional capacity and resourcing would be needed. It was also broadly felt that service and staff planning for the health service should be evidence-based. IT development was discussed as an important enabler of integrated care, service planning and research.

The Trade Union Group agreed on a need for a universal, single tier healthcare service. However, they felt that a significant transition period would be required to plan, resource and implement the systemic and contractual changes necessary to convert the current system. Political submissions advocated for a patient-centred universal system healthcare system. This group highlighted the need for enablers of change, such as investment, process efficiencies, long-term planning and political consensus.

Industry Groups also addressed a broad range of themes including strategy and funding models. Within this group, there was broad consensus that the public healthcare system should work with the private sector in a strategic way to keep the insurance market stable and to invest in clinical research. These groups argued that innovation is needed in the healthcare system, and that there should be increased incentivisation to deliver quality care within the system and to focus on patient health outcomes. Common themes among the various State Agencies included the fundamental importance of integration across primary, community and acute services, as well as the critical requirement for implementation of the eHealth strategy and electronic health record.

Theme 1 – Strategy

Q1 What are the key priorities for inclusion in a ten year plan for the health service?

Priorities for a ten-year plan for the health service included a range of access issues, health promotion and prevention, IT systems, mental health, implementation of existing strategies and rights-based healthcare.

Quality of Access to Services

Access was identified across the board as a major issue in the healthcare system. There was strong agreement that equality of access to services should be a key priority for future healthcare planning.

“Under the current health and social care system, people with dementia and their carers face serious barriers in equity of access and outcomes from the point of diagnosis to end of life.”
(Alzheimer Society of Ireland)

The most pressing concern of Advocacy groups was equitable access to timely, high-quality care based on need, not income. Stakeholders within this group emphasised a number of obstacles relating to accessing services, as set out below.

Long Waiting Lists

The issue of waiting lists was referenced in many submissions. A significant number of Advocacy groups cited long waiting lists as a key issue for the patients they represent, especially patients who do not hold PHI.

“Patients going through the public system are often subjected to waiting lists and delays, while those with greater resources and health insurance get faster treatment, often on public hospital sites.” (Irish Heart Foundation)

“Waiting lists illuminate the reality that for decades OUR health care-system which is managed and planned by people has failed Irish Society. Waiting lists; for timely access to outpatient appointments, elective surgeries, access to hospital beds, tests, specialist consultants, GPs, community services etc. ultimately cost lives and cause injury to patients.” (Irish Patients Association)

This issue was also recognised by Professional Groups as a priority:

*“The priority should be to definitively address the current unacceptable waiting lists.”
(The Irish Hospital Consultants’ Association (IHCA))*

Geographic Variation in the Availability of Services

Geographic variation in availability of services as a barrier to access was noted particularly by Advocacy groups and Professional Groups. They indicated this variation is especially evident in homecare packages, rehabilitation services, palliative care services and other community-based services.

“Serious delays for some newly injured patients in accessing rehabilitation... Shortage and post code lottery of community services such as PA hours, physiotherapy, occupational therapy and counselling. (Spinal Injuries Ireland)

“Inequity of available services and service provision across the country needs to be addressed. While the Clinical Care Programmes strive to address this problem to some degree, the patient care pathway may continue to be negatively influenced by geography unless each piece of the pathway is well defined and implemented equally in all areas.” (Irish Society of Chartered Physiotherapists)

Concern was expressed that certain services are only available to medical card holders, and that this creates cost barriers for non-medical card holders in accessing essential medical and social services.

“A medical card gives access to many services which are unavailable to patients without a medical card, such as public health nurses.” (Irish Heart Foundation)

Difficulties Accessing Homecare Packages due to Lack of Availability

A broad range of Advocacy groups, including groups representing people with disabilities, older people, carers and those with neurological conditions pointed to difficulties in accessing homecare packages. It was felt by these groups that adequate provision of homecare services would enable people to stay independent for longer and avoid residential care. Many groups expressed the view that statutory entitlement to homecare packages and community care, equivalent to the Fair Deal scheme for nursing home care, is needed.

*“Provide a statutory basis for the allocation of home care. Entitlement will ensure public bodies develop, fund, plan and make available comprehensive services to support independent living.”
(Age Action)*

This issue was also highlighted in relation to the needs of patients awaiting hospital discharge.

“The increasingly difficult task of securing home care packages particularly for those with complex needs who have newly acquired injuries has in effect blocked the system for many patients. Local HSE disability managers regularly inform the Hospital that local budgets cannot support the very costly and complex care packages required for NRH patients.” (National Rehabilitation Hospital)

Lack of Specialist Services for Neurological Conditions and Rare Diseases

Advocacy groups representing patients with neurological conditions and rare diseases highlighted the lack of availability of specialist services, such as rehabilitation and rare disease specialist consultants.

“There are no rehab facilities in Ireland for those who need to be ventilated. These high level injuries often experience long waits to receive rehabilitation in the UK or Northern Ireland. Once rehab is completed, patients are often re-admitted to the acute hospital or to a regional hospital whilst waiting on care packages.” (Spinal Injuries Ireland)

Provision of Services Free at Point of Access

Many across the stakeholder profiles advocated submissions that a full range of services should be available free at the point of use.

“The Alliance believes that curative, rehabilitative, long-term nursing, ancillary and prevention services as well as medical goods should be free at point of access.” (Health Reform Alliance)

However, there was even greater consensus, including among GPs, that GP and primary care should be prioritised as being free at the point of access.

“...there should be open access and patients’ entitlements should be free at the point of delivery in the community.” (Mallow Primary Healthcare Centre)

“ICGP supports primary care and general practice free at point of contact. Most OECD countries have removed cost barriers to general practice and primary care services, either through free access (taxation or insurance funded) or subsidised payments.” (Irish College of General Practitioners (ICGP))

Academic and Professional Groups agreed there should be equitable access to healthcare services based on need, not ability to pay. However, within the Professional Group, healthcare providers focused on the need to improve the current provision of services. Trade Unions advocated for a 24/7, seven-day universal single tier service, “where both access and quality are guaranteed regardless of income”. However, like GPs, they argued that any expansion of entitlement would be subject to significant increase in capacity. Many Advocacy groups recommended expanding the

existing medical card system to cover groups with long-term conditions, based on need rather than income. This included in particular groups that represent people with disabilities, chronic conditions and rare genetic diseases:

“A key recommendation was the extension of the discretionary medical card scheme to those with epilepsy who are income ineligible. It is a huge concern to us that so many experienced cost barriers to essential services.” (Epilepsy Ireland, referring to its 2014 survey on medical costs)

Inequality of Access for Marginalised Groups

Inequality of access to healthcare based on socio-economic status or marginalisation was a concern expressed by a small number of groups. The Community Platform, a network of 29 national networks and organisations in the community and voluntary sector, expressed the importance of developing an inclusive Health Policy. Deep End Ireland discussed healthcare inequality and the Inverse Care Law in its presentation to the Committee. It highlighted the role healthcare inequality caused by socio-economic factors plays in adverse health outcomes for patients from disadvantaged areas.

“We need health policy that recognises the reality that the people most likely to die are getting a much poorer health service than the rest of the population, and that supports GPs and primary care teams working in deprived areas to effectively manage health problems in our patients.” (Deep End Ireland)

Advocacy groups representing the homeless population recommended increasing the provision of targeted primary care services in order to bridge the equity issues faced by this particular group.

“Targeted services are primary care services offered at points of contact with homeless people (e.g. hostels, food-halls). Homeless people have expressed a clear preference for having targeted services over mainstream services. The use of targeted services has been shown to improve access to healthcare and decrease the burden on secondary care services.” (Safetynet, health care for homeless people)

Health Promotion and Prevention

There was consensus across all stakeholder groups that prevention should be a significant part of any future healthcare strategy.

“A sustainable healthcare system will not be possible unless prevention and self-management is prioritised, resourced and rewarded.” (Royal College of Physicians of Ireland (RCPI))

Within the Advocacy group, children’s groups and groups representing patients with chronic conditions particularly supported putting prevention at the centre of health system reform.

Trade unions and Professional stakeholders also emphasised the need for preventative measures and public health education in relation to chronic disease. Many submissions referenced the Healthy Ireland strategy, expressing strong agreement that it represents a positive policy direction in terms of prevention and should be fully resourced and implemented.

“We strongly support the Healthy Ireland and its direction of travel. Governments need to invest in it and regularly monitor the Health Status of our Population.” (Heartbeat Trust)

Mental Health

Mental health was a recurring issue mentioned across the stakeholder groups. There was consensus that significant improvement and investment in mental health services for all groups is needed as part of an integrated approach to health and social care.

Groups which highlighted concern with the deficiencies in current services included those representing children, the older population, people with disabilities, people with chronic conditions and disadvantaged populations. Advocacy groups representing children and youth were particularly concerned about deficiencies in mental health services for children throughout their developmental stages, from lack of focus on perinatal and infant development up to delays in access to counselling and mental health services for older children and adolescents through CAMHS (Child and Adolescent Mental Health Services).

“One of the most effective ways of tackling the mental health “epidemic” now and for future generations is to focus on improving mental health from the very beginning, given how significant this period is “in laying the psychological foundation for later life.” (Galway Early Years sub-committee)

A number of submissions mentioned *A Vision for Change*, noting that many of its recommendations have not been implemented.

“In recent years, despite the publication of a Vision for Change (Department of Health & Children 2006), mental health services for children have not shown any notable improvement.” (Children in Hospital Ireland)

Some Advocacy and Academic Group stakeholders discussed the current lack of integration between services as an issue for patients who have co-morbid diagnoses of mental health conditions with chronic conditions, addiction and/or disability.

“Particular groups of individuals, including people who are homeless, those with a co-morbid diagnosis of mental health in intellectual disability (MHID), and people with a dual diagnosis of mental health and substance misuse experience significant challenges in accessing appropriate care.” (Mental Health Reform)

Rights-Based Approach to Healthcare

Some stakeholders, particularly those which discussed issues of mental health and disability, referenced a rights-based approach to healthcare in their submissions. Mental health groups, including service providers, also advocated for a rights-based approach to healthcare.

“To date, people with experience of a mental health difficulty as a group are one of the least protected in terms of their rights. They are also one of the most socially excluded, experiencing prejudice and discrimination in all areas of their life in the community.” (Mental Health Reform)

The UN Convention on the Rights of Persons with Disabilities (UNCRPD) was also referenced.

“This reorientation of services is also mandated under articles 19, 25, and 26 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which the current government is due to ratify in the coming months. The articles stipulate access to a range of in-home, residential and other community support services necessary to support independent living and inclusion in the community.” (Disability Federation of Ireland)

Implementation and Expansion of Existing Strategies

Across all submissions there was broad consensus that existing strategies are commendable but need to be implemented further. Examples cited included *Healthy Ireland, The National Neurology Programme, A Vision for Change, the National Plan for Rare Diseases, Better Outcomes Brighter Future, The National Dementia Strategy, The National Positive Ageing Strategy, The National Policy and Strategy for the Provision of Neuro-Rehabilitation Services in Ireland 2011-2015, The Carers Strategy and A Healthy Weight for Ireland Obesity Policy and Action Plan.*

Advocacy, Academic and Professional Groups generally agreed that the National Clinical Programmes (NCP) (joint initiatives between the HSE and RCPI or RCSI) are a positive development. Continued support, development and expansion of these programmes was recommended. *“The National Clinical Care Programme in Epilepsy was established in 2010... Much has been achieved to date with the ongoing roll out of this programme and continued investment is needed to sustain its’ vital role in improving epilepsy care.” (Epilepsy Ireland)*

IT Systems, Data and an Electronic Health Record

The need for improved IT systems and the implementation of an electronic health record was consistently highlighted across all stakeholder groups. It was agreed that IT systems are essential to enable record-sharing across services, but also that data collected would facilitate research and future service planning.

“The creation of a human and digital network that allows universal, real-time access to relevant information is vital to achieving this, with I.T. playing a key role... Video technology, data and calendar sharing will enable clinical networks to react quickly, increase productivity, reduce duplication, and avoid missed appointments... A unique patient identifier system is essential, and we welcome its introduction later this year.” (NAGP)

“Provision of effective, integrated care for people with neurological conditions is significantly constrained by the lack of information systems both in the hospital and community.” (Neurological Alliance of Ireland)

“The alignment of Information and Communications Technology (ICT) between GPs and hospitals with a shared Electronic Health Record (EHR) is critical.” (Dr Ronan Fawsitt and Professor Garry Courtney, Carlow-Kilkenny Hospital Model of Care Group)

IT systems and the need for data collection was an overarching concern for many in the Advocacy, Academic and Industry groups. Research stakeholders emphasised the need for development and embedding of research in the Irish healthcare system. They put forward the view that a “research-active healthcare system” results in better outcomes for patients, better planning and policy development and also a more attractive working environment for recruiting and retaining clinical staff. There was also an emphasis on the need for access to “real world data” in order to facilitate clinical research and to measure outcomes.

“In addition to driving better health outcomes for individuals, communities and populations, investment in health research results in direct cost savings, improved reallocation of resources, objective and concrete data on access, quality, cost and outcomes, improved cost effectiveness and innovative models for the delivery and financing of healthcare.” (Medical Research Charities Group)

Q2. What are the key challenges, in your view, to achieving a “universal single tier health service, where patients are treated based on health need, rather than ability to pay”?

Across the stakeholder groups, a variety of challenges were identified by both service users and service providers, but there was agreement that universal single tier healthcare should be a goal to work towards. The focus of those in the Advocacy group was largely on access and entitlement to services.

“In the long term, a system of Universal Health Care, free at point of use, should be considered.” (Care Alliance Ireland)

Some in the Academic Group emphasised the need for an agreed definition of universal healthcare.

“Although an international consensus has developed about the merits of universal healthcare, the definition of universality can vary... The end deliverable goal of universal healthcare (UHC) should be agreed by the Committee, including a definition of universal healthcare.”

(Adelaide Health Foundation)

Provider Capacity

Amongst Professional Groups, in particular GPs and allied healthcare professionals, staffing capacity was seen as a significant issue. They put forward the view that the current shortage of staff is an impediment to meeting current demand and an obstacle to any future development of universal healthcare.

“ICGP supports increasing access to general practice and primary care, contingent on building capacity in personnel, IT infrastructure and built infrastructure in existing premises.” (ICGP)

“The Committee must accept that moving to a universal, fully integrated, single tier public health service presents a number of workforce planning challenges, not least of which is understaffing.”

(Irish Congress of Trade Unions (ICTU))

Allied healthcare professionals emphasised the negative effect that staffing moratoriums and the inability to fill vacant posts have had on capacity.

“The development of an optimum physiotherapy workforce was still in its infancy, when recruitment embargoes and reductions in staffing numbers were introduced in recent years.

The physiotherapy workforce is therefore relatively low in number and cannot meet current demands.” (Irish Society of Chartered Physiotherapists)

The retention of graduates in the Irish healthcare system was also cited as a significant barrier to expanding capacity in primary care. Groups representing GPs and nurses, stated that current working conditions would need to improve in order to attract staff and stem the growing emigration of Irish graduates to other healthcare systems.

“Training GPs, only to see them emigrate to other health systems, is not cost-effective.

Recruitment and retention of GPs begins with the provision of an adequately resourced general practice system.” (ICGP)

The Royal College of Surgeons in Ireland (RCSI) conducted a survey of doctors who emigrated from Ireland regarding reasons they chose to work abroad rather than stay in Ireland. The results showed that limited career and training opportunities in Ireland were among the main deterrents for graduates, along with the offer of better pay from abroad.

“Numerous studies have reported that Irish health professionals are demoralised and dissatisfied with working conditions in Ireland and are leaving in increasing numbers. The RCSI Doctor Emigration Project highlights that understaffing, limited career opportunities, a lack of flexible training options, high levels of non-core tasks, long hours and better pay overseas are driving doctors to consider practicing medicine abroad.” (RCSI)

Current GP Contract

There was clear consensus across groups representing GPs that the current GP contract is a barrier to a primary-care orientated health service. There was agreement that the capitation-based contract does not incentivise chronic disease management in general practice, and that current working conditions for GPs need to be improved in order to recruit and retain new staff. Some GP groups suggested that other aspects of general practice be factored into a new GMS contract, such as extra provision for GPs in deprived areas.

“Negotiate a new GP contract with all stakeholders – one that is supported and fit for purpose. The key to the new contract is management of chronic disease.” (Dr Ronan Fawsitt and Professor Garry Courtney, Carlow-Kilkenny Hospital Model of Care Group)

Role of Private Health Insurance

The role of PHI was mainly raised by the Academic, Trade Union and Industry groups. Among them, there was acceptance that PHI is an embedded part of the Irish healthcare system; however, there were differing views on what its role should be. Health insurers argued that PHI and access to a private healthcare system eases pressure on the overburdened public system and that existing initiatives should be protected in order to keep the PHI market stable.

“Given that the private healthcare sector plays a crucial role in the national healthcare system with nearly half the population electing to purchase PMI, there is a growing need for the government to continue to support and ensure we have a sustainable PMI market which is strongly focused on delivering high quality, affordable healthcare to its customers.” (Voluntary Health Insurance Group)

One health insurer argued for the removal of private care from public hospitals.

“The evolution of legislation within the health insurance market has led to private health insurers being forced to drive consumers into public hospitals... This has created inequity for public patients, but also for private patients who are paying twice to receive the same service... The logical conclusion is that if equity is to be achieved within the public health system, the HSE should cease providing all private health care services and concentrate its services to public health.” (Irish Life Health)

Submission from the Academic Group discussed the position of PHI in the system at present, highlighting that PHI functions buys patients quicker access to care. This equity issue was highlighted across a range of submissions. *“An ICGP survey of GPs commissioned by the Society this year highlighted the public private divide in stark terms. 88.5% of GPs surveyed said a patient’s ability to pay affected their ability to access diagnostic tests used to detect cancer.” (Irish Cancer Society)*

“Taxes paid for 77% of health expenditure in 2013. Yet in our primarily tax-funded health system, people with private health insurance have quicker access to healthcare compared to fellow taxpayers without insurance.” (Health Reform Alliance)

Trade unions argued that the State should cease to subsidise private healthcare and PHI as part of a universal, single tier healthcare system. They suggested such monies should instead be invested in building up the public healthcare system.

“The move to this funding model must also include the phased abolition of all tax reliefs pertaining to private health insurance.” (Irish Nurses and Midwives Organisation (INMO), in relation to universal, single tier healthcare)

Some submissions indicated a belief that it would not be possible to completely remove PHI from the system.

“... a PHI market and private hospital sector already exist and will therefore form part of the Irish health system into the future.” (Dr Brian Turner, Dept. of Economics, UCC)

However, they recommended that the overlap between public and private provision of healthcare should be reduced, and that eligibility and access to the public system should be broadened. Alternative functions for PHI were suggested, including buying better hospital accommodation, or services not listed in the universal basket of care.

“A coherent way of making two-tier access more equitable would be to adopt a funding system whereby a core of cost-effective services for all conditions were provided in the universal tier of care and other less cost-effective treatments were left for the private insurance market to fund if

individuals wanted to pay for them.” (Dr James O’Mahony, School of Medicine, TCD)....and “... those with private health insurance may be permitted to use such insurance to pay for better accommodation (e.g. a private room) but not to access treatment more quickly.” (Dr Brian Turner, Dept. of Economics, UCC)

Q3. What actions are needed to plan for, and take account of, future demographic pressures (population growth, ageing population), and their impact on the health system?

The theme of demographic pressures on services emerged across the board. Population growth, the rising numbers of older people, the growing numbers of people living with complex needs and the increased instance of chronic disease and co-morbidity combined to create escalating demand for all health and social care services. A health promotion and disease prevention approach was also highlighted as essential for the management of demographic pressures. Further actions are set out below, grouped under the headings of strengthening and integration of primary care and social care services and “one step up” redesign of workforce.

Strengthening and Integration of Primary Care and Social Care Services

Advocacy groups emphasised pressures of demographic change in relation to chronic disease, disability and palliative care. Difficulties many patients have in accessing adequate and timely community services were discussed across the Advocacy groups, especially for neurological and rehabilitation services. There was consensus across all groups that in order to facilitate integrated care, primary and social care services need to be strengthened. Some within the Advocacy group highlighted the negative effect budget cuts have had on provision of services in the community.

Deficits in home and community care were mainly raised by groups representing older people and people with disabilities. As previously discussed, there was consistent agreement that homecare should be legislated as a statutory entitlement.

“To meet the preferences of people living with dementia to live in the community, and recognising the broader societal impact of the condition such as that on family carers, a key priority in a ten-year strategy is entitlement to care, particularly entitlement to home-based care such as home help, post-diagnostic (e.g. cognitive stimulation and rehabilitation therapies, counselling), information services, social clubs, befriending, respite, day care etc. with appropriate options for supported/assisted living.” (Alzheimer Society of Ireland)

A number of submissions from the Advocacy group, including chronic disease groups, homelessness groups and neurological condition groups, recommended case management for patients with complex patterns of service use. They argued that having a case manager or key

worker would facilitate a co-ordinated, integrated approach to treatment and individualised support for patients receiving treatment from different agencies. *“Case management for complex cases that require interdisciplinary, cross-agency working must become an embedded feature of our health service.” (Acquired Brain Injury Ireland)*

Primary Care Centres

Some GP groups recommended the further development of Primary Care Centres or advocated for Primary Care Resource Centres, which would serve as a health and social care services hub for a catchment area. *“The current Primary Care Centres only benefit a small number of GPs and patients. If re-designated as “resource centres” they can serve as diagnostic and service hubs that support patient-focussed care with full engagement of all local GPs.” (NAGP)*

Workforce and Re-Design of Roles

There was consensus amongst those in the Professional Group that existing professional roles within the health and social care workforce can and should be re-designed to maximise skills. This re-design of clinical roles could be utilised in primary care to enable GPs, nurses and allied healthcare professionals to provide services currently focused in hospitals.

“Redesign professional roles (e.g. nurses, pharmacists, physician associates, physiotherapists, nutritionists, social workers) to enable all to work to the top of their abilities.” (Royal College of Surgeons of Ireland)

Groups which advocated for expansion of their roles included GPs, nurses, physiotherapists, pharmacists and optometrists. Nurses and allied healthcare professionals argued that their skills could be maximised through greater responsibility in treating and referring patients in the community. They argue that expanding their roles in this way would be a more efficient re-distribution of services, more cost-effective than acute services and would reduce the burden on GP surgeries and on acute waiting lists. GP groups also advocated for the expansion of nursing and allied health professional roles within primary care teams.

However, the IMO put forward the view that the focus should be on expanding capacity in general practice instead of allocating GP tasks to allied healthcare professionals. The INMO suggest that assessing future need in the system will involve a “review of roles and functions” to ensure “full utilisation of skills”, but do not specifically advocate for expansion of roles. Organisations representing GPs with special interests proposed that some minor surgical procedures currently carried out in the acute setting could be performed instead in GP surgeries by suitably qualified GPs, improving cost-effectiveness and reducing acute hospital waiting lists.

“The PCSA believes that a strategy which espouses greater care delivery in the community should look to the example of community surgery as a model of a patient-centred, high quality and cost effective alternative.” (Primary Care Surgical Association)

Theme 2 – Integrated Primary and Community Care

Q4. What steps are needed to move from the current model towards a model based on integrated primary, secondary and community health care?

All stakeholder groups agreed that the healthcare system should move in the direction of an integrated care model. There was consensus that diagnosis, treatment, disease management and step-down care should be provided at the lowest possible level of complexity. As discussed earlier, there was strong agreement that investment in IT systems, and in particular, an Electronic Health Record, is essential in order to facilitate integrated care, investment in IT systems. *“The ICGP recommends all health professionals maintain clinical notes on electronic records. The costs of implementing new IT infrastructure, and on-going maintenance, will need to be adequately resourced by government, in agreement with GP representative bodies. ICGP also recommends the continued involvement of the General Practice Information Technology (GPIT) Project with the HSE and Department of Health, in national IT projects and eHealth Ireland, to ensure integration of health records.” (Irish College of General Practitioners)* It was also generally agreed by all groups that prevention needs to be prioritised, especially in relation to chronic disease. Improvements in access for patients and better working conditions to attract necessary staff into the system were seen as key enablers to integrated care. The need for appropriate, governance structures also emerged in submissions from the Professional, Industry and Trade Union groups.

Governance, including Clinical Governance

Governance (corporate or clinical) and management was discussed mainly in submissions from Professional Groups. The existing governance arrangements in the HSE were seen as problematic by some stakeholders.

“...an effective HSE board and independent chair should be reinstated, ideally with a well-resourced, fresh and new management team.” (Professor Frank Keane, former Joint Lead, National Clinical Programme in Surgery)

Other submissions, including from doctor representative groups, referenced the role of clinicians in leadership and management as an important dimension of governance. *“[A] key roadblock is the lack of accountable effective Executive Clinical Directorate Structures, at National, Hospital Group and Community and Primary Care Level, and within the Health Insurance sector.”* (Heartbeat Trust)

“The integration of both executive and clinical leadership is a key enabler to the redesign of efficient, patient-centred healthcare.” (RCSI)

Dr Ronan Fawsitt and Professor Garry Courtney of the Carlow-Kilkenny Hospital Model of Care Group proposed that *“with the formation of Hospital Groups and CHOs, a new relationship needs to emerge between primary and secondary care. General practice should be involved in the design, governance and decision-making of these new structures.”*

The IHCA considers that *“it is essential that the current focus of governance is rebalanced to facilitate increasing clinical governance input at organisational board level to prioritise the delivery of safe, high quality, timely care to patients.”*

The Irish College of Ophthalmologists identified the need for a clinical governance framework in order to support quality of care. *“Implementing an appropriate clinical governance framework would support the provision of quality services by ensuring integrated care via clear referral pathways and formalised networks and enabling a culture of continuous quality improvement.”*

The link between governance and quality was also highlighted by the Pharmaceutical Society of Ireland which said that *“...good governance of the service is considered essential...The design and management of the service should be underpinned by principles of quality and risk management and incorporate a system of audit and review...”*

The RCSI recommended legislation to underpin Hospital Groups in order to enable them to deliver on their potential. *“Good structures drive good outcomes. Enact legislation to underpin the agreed hospital groups and reforms to deliver on Group potential to better support patient care and hospital sustainability.”*

Voluntary Providers

Governance also featured to some extent in discussion of the role of voluntary and non-statutory providers.

“We would ask that the Committee also consider the delivery of healthcare within the third sector. The sector is a significant contributor and is a vital resource in the delivery of healthcare in Ireland. Sadly it is often overshadowed by poor governance and a lack of regulation but this should not detract from the valuable contribution made by the highly skilled professionals who are employed by the healthcare charities and not for profit organisations.” (LauraLynn Children’s Hospice)

Voluntary and private healthcare providers said that they are providing essential services not available directly from the HSE and can operate more flexibly than statutory services.

“Section 39 organisations bring a necessary flexibility and agility to the HSE’s service provision.” (Rehab Group)

Q5. What are the key barriers to achieving this, and how might they be addressed?

Key barriers which were identified as impeding integrated care included siloed budgeting, and structural and organisational issues.

Siloed Budgeting

Some in the Advocacy, Professional and Academic Groups cited siloed budgeting as a barrier to integration of services and movement across the health and social care system. There was general agreement, especially from Advocacy groups, that a “whole of government” approach is needed to sectoral budgets.

“One of the major barriers to chronic disease care in the current system is the separation of the health and social care systems with entirely separate budgetary and decision-making processes.” (Irish Heart Foundation)

There was suggestion by some Professional and Academic stakeholders that between organisations there is perverse incentive to integrate budgets, as individual organisations fear losing part of their block budget allocations.

“Funding structures need to facilitate the breakdown of these divisions and allow for speedy movement of patients down the continuum of complexity where there needs can be met while reducing the cost to the health service as they improve.” (National Rehabilitation Hospital)

Some concern was expressed about the current lack of IT budgetary control systems.

“The health service spends €13 billion a year, with information systems that would be shockingly bad for a turnover of €1.3 million. It is not an exaggeration to say that the CEO of a hospital with a budget of €600 million has much less useful day-to-day operational and financial information than the manager of his or her local Super-Valu branch. The current ICT strategy is beginning to address this, but it needs to reach out into the community services and the electronic records used by GPs as well.” (Professor Anthony Staines, Department of Nursing and Human Sciences, DCU)

Structural and Organisational Issues

Organisational and structural issues within the HSE were cited as an obstacle by some Professional stakeholders, including governance issues which were discussed earlier.

“Eliminate top heavy structure in the HSE.” (Association of Occupational Therapists of Ireland)

“The HSE is too big, too bureaucratic...our system is over administered and while clinical directorships have improved management slightly, there is insufficient autonomy for medical professionals and inadequate financial responsibility because of the nature of the funding.” (Dr Truls Christiansen, Wicklow Primary Healthcare)

As solutions, changes were recommended which could be made within the existing structure such as process improvement (such as adopting a LEAN approach in healthcare management to develop organisational understanding of, and focus on, key processes), and giving staff throughout the HSE more responsibility and authority.

“Presently hospital managers are unable to create the conditions for sustained local, front line improvement because they are overwhelmed by the directive driven, compliance orientated and target-obsessed approaches of central HSE management.” (Professor Frank Keane, former Joint Lead, National Clinical Programme in Surgery)

Pharmaceutical and medtech stakeholders advocated for increased innovation and efficiencies in the Irish healthcare system. They recommended enabling further collaboration between the healthcare system and industry partners.

“Recently, IMDA and the Mater Misericordiae University Hospital have decided to work together to share best practice in lean principles. The objective is to share expertise across both sectors and to learn from each other. Over the past 5 years, IMDA have set up similar partnerships in lean (o8) between companies and the results have been impressive. Should this partnership prove beneficial, the scope of the programme of work could be expanded to other hospitals and industries.” (Irish Medical Devices Association)

Q6. In your experience, what are the key roadblocks you encounter in your particular area of the health service?

As set out earlier, Advocacy Groups highlighted a number of roadblocks across the health service, mainly relating to access, lack of entitlement to community-based services and lack of integration of services. Others are discussed in the section below.

Lack of Direct Access to Diagnostic Services in Primary Care

There was clear consensus that a lack of access to diagnostic services from primary care is a significant roadblock in the present system, and would be an obstacle to achieving a primary-care orientated health system.

“GPs are unable to access radiological, cardiac and endoscopy investigations for non-private patients... GPs must therefore refer patients to Outpatient Departments or Emergency Departments. This is wasteful of OPDs, EDs, compounds delays and represents a clear level of medical risk for public patients in delayed diagnoses.” (ICGP)

GP groups stated that providing diagnostic services outside of hospitals, such as in primary care centres, would enable them to deliver more effective care to patients and significantly reduce waiting lists for diagnostic services in hospitals.

“For Primary Care to deliver its full potential, it must learn to work seamlessly with Secondary Care through new structures such as LICCs, CHOs and HGs, and also develop its own autonomous diagnostic services that are based in the community and not in the hospital.” (NAGP)

Lack of Integration between State Agencies

A broad range of Advocacy groups cited lack of integration between State agencies as an obstacle to accessing services. Examples included a lack of cohesion between mental health agencies and other services such as maternity services, addiction services and child protection services.

“There is a lack of integration and cooperation between services and agencies and as a result many young people are not being provided with support specific to their needs... Health (including mental health and disabilities) and child protection services sitting in separate departments is reportedly causing difficulties in terms of budgeting and coordination.” (Irish Society of Prevention of Cruelty to Children)

The lack of integration between residential care and primary and acute care was also noted by disability groups, while groups representing older people noted lack of coordination between health services and local authorities for services such as sheltered housing.

“Stronger cross departmental links between the housing and health sectors at national and local levels are necessary to implement Government policy as outlined in the Positive Ageing Strategy... there is no local authority mechanism to enable the development of housing-related support services to support independent living by older people.” (Sage Forum on Long Term Care)

The National Rehabilitation Hospital in its submission highlighted the existence of roadblocks at the hospital interface. *“Major blocks in the rehabilitation continuum of care are evident both at the acute stage prior to admission to the hospital and at the discharge phase.”*

Q7. How would you ensure buy-in from health care professionals to progress towards an integrated health care model?

The submissions from the Professional Group and the Trade Union group identified current issues with staff morale across the healthcare system, at both primary and secondary level. It was suggested that there is a sense of “reform fatigue” and that staff buy-in to any change will be a challenge. *“The current public health service, in particular the Hospital sector is increasingly difficult to work in. We have never seen morale as low.” (Dr Michael O’Mahony, Galway University Hospital)*

The sentiment which emerged from the Professional and Trade Union submissions was that in order to facilitate change and reform within the health system, working conditions must be improved. This relates to issues set out elsewhere in this analysis, such as addressing capacity issues, the “one step up” re-design of roles, the re-negotiation of the GMS contract and improved governance. *“Moving to a universal single tier public health service presents major workforce planning challenges. Any new system must put in place conditions of employment that will make our health system the employer of choice for the most talented staff.” (Irish Congress of Trade Unions)*

The RCPI pointed to the experience of implementing the National Clinical Programmes. *“The experience of the NCPs shows that change of work practice and service design are possible, where there are clear targets, inputs across disciplines, and a shared vision for improving patient outcomes.”*

Q8. Are there any examples of best practice that the Committee should consider? Please refer to any evidence you have to support this.

Two best practice models which were cited more than once across the submissions were Scotland and New Zealand's Canterbury Model.

Scotland's Healthcare System Scotland's healthcare system was cited as a best practice model by diverse stakeholders. The examples of good practice discussed were in several different areas – citizen engagement, quality improvement and integrated care initiatives.

“Scotland has been quite instrumental in advancing participatory, citizen-led processes in re-designing policies and services. This implies a shift in power from professions to the public and includes innovative forms of using public funds such as participatory budgeting.” (Professor Thilo Kroll, Professor of Disability and Public Health, University of Dundee)and “In Scotland, evidence has shown an upward trajectory in approvals since the introduction of PACE (Patient & Clinician Engagement) groups, highlighting the importance of their contributions in ensuring the most effective treatments are available to patients.” (Celgene, Biopharmaceutical Corporation)

Professor Frank Keane's submission recommended Scotland's Quality Improvement hub (QI Hub) as a quality improvement system which could be adopted in the Irish context.

“Irish QI should have a co-ordinated centre for training, learning and standardisation, as with the Scottish QI Hub – perhaps tendered for by an academic institution(s).”

Advocacy groups and allied healthcare professionals also cited data for Scotland on the benefits of patient-centred, multi-disciplinary integrated care and self-referral within primary care.

“Alzheimer Scotland has produced an Eight Pillar model for integrated health and social care. This model addresses the social implications of dementia, demonstrating how these can be tackled most effectively by coordinating the full range of health and social care interventions to meet individual needs.” (Alzheimer Society of Ireland)...and “The Scottish Government, in particular, have been highly successful in restructuring the delivery of primary eye care services by devolving provision to community optical practices.” (Association of Optometrists)

Canterbury Model in New Zealand

Dr Ronan Fawsitt and Professor Garry Courtney cited the Canterbury Model in New Zealand as a best practice model for integrated care. This model is notable for its emphasis on primary care and community intervention. *“In New Zealand, the Canterbury integration model, using primary care reform has led to significant improvements in service efficiencies with reduced costs.”*

(Dr Ronan Fawsitt and Professor Garry Courtney, Carlow-Kilkenny Hospital Model of Care Group)

The NAGP submission cited evidence from a study of the Canterbury model of integrated care, which included targeted hospital-avoidance programmes, and concluded that *“integrated health systems with high-quality out-of-hospital care models are likely to curb growth successfully in acute hospital demand, nationally and internationally.”*

Theme 3 – Funding Model

Issues concerning the funding model were discussed by far fewer stakeholders overall than issues of strategy and integrated care. Advocacy groups largely did not offer views on the health service funding model, focusing instead on equality of access and entitlements.

“Equality of access and outcome should be a guiding principle for any funding model.”

(Alzheimer’s Society of Ireland)

Q9. Do you have any views on which health service funding model would be best suited to Ireland?

Of those from the Academic Group who offered a view on funding models, the predominant view was that a tax-funded model should be pursued rather than a social insurance model. Some Professional stakeholders advocated for a social insurance model. The Irish Dental Association noted that a type of social insurance is already in use in the system, with the Dental Treatment Benefit Service. Economists noted that the current system is funded through a mixture of revenue streams, and that this is typical of health systems internationally.

“In the absence of any strong evidence that a move to social health insurance would bring significant advantages, the current tax financed system should be maintained, as a change in the funding mechanism would entail significant costs in terms of time and resources.”

(Dr Brian Turner, Department of Economics, UCC)... and ...“It is clear from the international literature that all countries are moving more and more towards a mixed system for the funding of healthcare expenditure.” (John Armstrong, Health Economist)

Q10. Please outline the specifics of the financing, payment methods and service delivery (purchaser and provider) of the model you are advocating

Responses mainly focused on aspects of budgeting and payment mechanisms.

Financing – Budget Pooling and Ring-Fencing

As previously discussed, siloed budgeting and lack of integration between State agencies were cited as obstacles to integrated care. Many stakeholders recommended an integrated, flexible, “whole of government” approach to budgets.

“Flexibility between sectoral budgets is crucial for a streamlined and cost-effective health service which can meet the needs of individual patients and their Family Carers.” (Care Alliance Ireland)

Some Advocacy Groups also argued that funding should be ring-fenced for health promotion, community care services and homecare packages.

“The Committee should consider setting a definite, ring-fenced percentage of health spending on health promotion and health protection to grow incrementally over a five year period.” (Rehab Group)

Payment Methods – Activity Based Funding

Submissions from the Industry group, as well as from the Advocacy and Professional Groups, supported the introduction of activity-based funding (ABF) across the system. *“An activity-based funding model, rather than one based on historical budgets, should be deployed across the health service and not only confined to acute hospitals.” (Family Carers Ireland)* However, voluntary hospitals and palliative care consultants warned that activity-based funding might not be optimal for the complexity of palliative care. Within the Advocacy group, Age Action discussed needs-based rather than activity-based funding for older persons.

“Since 2014, block grant funding of hospitals is being replaced gradually by Activity-Based Funding (ABF) (formerly Money Follows the Patient) with payment now based on episodes. This is not conducive to addressing the complex care needs of older people. The challenge therefore is to implement a pathway mechanism where ‘Money Follows the Patient’ from the acute hospital to the community to meet need and to facilitate the timely provision of home care packages.” (Age Action)

Purchaser-Provider Split

While structural issues did not feature strongly in the submissions as a whole, the implementation of a purchaser-provider split was mentioned by a limited number of stakeholders, particularly from across the Academic, Professional and Industry groups. *“Within this system there should be a purchaser (Healthcare Commissioner) and provider (Department of Health, HSE) split.” (Professor Frank Keane, former Joint Lead, National Clinical Programme in Surgery)* The Health Information and Quality Authority (HIQA) put forward the view that a purchaser provider split, with the option of multiple purchasers, such as individuals and local commissioners, would be the best option for transparency and accountability.

“Commissioning frameworks can provide for national, regional and local procurement arrangements that are person-centred and address local needs.” (HIQA)

ICTU takes a less prescriptive approach, suggesting that *“organisational restructuring, planned or underway, will need to be reviewed in order to reflect the structures necessary to deliver the single tier healthcare service. The final organisational structure that emerges must be simple, integrated and readily understood by the general public”.*

Q11. What are the main entitlements that will be provided under your funding model?

Responses on the question of entitlement have been set out as part of the discussion on access in Section 4. A further issue which emerged was the use of Health Technology Assessment and cost-effectiveness assessments to determine what services should be made available. This approach was advocated in some submissions from economists and other stakeholders.

“The model I propose is a pragmatic retention of the two tier system, but with a prioritisation of access to cost-effective services within the universal tier... the universal tier would be to provide meaningful access to cost-effectiveness services without rationing; in other words “to do the basics well for all”....” (Dr James O’Mahony, School of Medicine, TCD) However, concerns were expressed that the “conventional HTA process” raises issues in relation to access to orphan drugs: *“The system for evaluating, funding and prescribing orphan drugs must be overhauled to provide equity, efficiency and transparency.” (Genetic and Rare Disorders Organisation)*

Appendix 2: List of Submissions Received

Submissions can be viewed [here online](#).

Acquired Brain Injury Ireland
 Adelaide Health Foundation
 Age Action
 Alere, US supplier of point-of-care diagnostic tests
 Alice Gormley Occ. Therapist
 All Ireland Institute of Hospice and Palliative Care (AIHPC)
 All Together in Dignity Ireland
 Alpha Group, Healthcare, Mallow, Co. Cork
 Alzheimer Society of Ireland.
 Anne Lawlor, member of the public, Chair of 22q11 Ireland Support Group
 Arthritis Ireland
 Arts Council Health Service Executive Arts and Health Working Group
 ASSERT Centre, College of Medicine and Health, University College Cork.
 Association of Hospital Chief Executives.
 Association of Occupational Therapist of Ireland (AOTI)
 Association of Optometrists Ireland (AOI)
 Asthma Society
 Cancer Trials Ireland
 Care Alliance Ireland, Network of Voluntary Organisations Supporting Family Carers
 Celgene, Biopharmaceutical Company
 Centre for Medical Health LSE, Acute Mental Health Services
 Children in Hospital Ireland
 College of Psychiatrists of Ireland
 Community Law and Mediation
 Connolly for Kids Hospital Group
 COPD Chronic Obstructive Pulmonary Disease Helpline
 CSC, Global Healthcare IT Company
 Danone Nutricia Early Life Nutrition
 Deep End Ireland Group, GP Practice in Disadvantaged Areas
 Dept. of Health
 Diabetes Ireland Adult Diabetes
 Diabetes Ireland Paediatric Diabetes
 Disability Federation of Ireland,
 Dr Truls Christiansen, Wicklow Primary Healthcare Centre
 Dr Elizabeth Cullen, HSE
 Dr Aiden Devitt Consultant Orthopaedic Surgeon Galway University Hospitals
 Dr Brian Turner UCC
 Dr Cathal O’Sullivan, Consultant Microbiologist and Infectious Diseases Physician
 Dr Eoin Sheehan, Orthopaedic Surgeon
 Dr Ronan Fawsitt and Professor Garry Courtney, Carlow/Kilkenny Hospital/GP group
 Dr Fergal Twomey, Dept. Palliative Medicine, Milford Care Centre, Castletroy, Limerick
 Dr John Barton, County Galway
 Dr Mark Mathews GP
 Dr Tom Kennedy GP
 Dr James O’Mahony, School of Medicine, TCD
 Dr Joanne Nelson, Clinical Director of Child and Adolescent Sexual Assault Service, Galway
 Dr Michael O’Mahony, Galway University Hospital
 Dr Patrick Nash, Chief Clinical Director, Saolta, University Hospital Galway
 Dublin Academic Medical Centre (DAMC)
 Dublin Dental University Hospital
 Dublin Neurological Institute.

Edenpark Surgery, Edenmore, Raheny,
Filed as Deep End Group.

Epilepsy Ireland

Equality and Rights Alliance

Eugene Breen, Mater Hospital, Dublin

Extra Special Kids Group of Ireland.

FAMILY Carers Ireland

Family Therapy Association of Ireland.

Federation of (Ophthalmic and Dispensing)
Opticians (FODO)

Galway Community Mental Health

Galway Early Years Sub-Committee

Galway Saolta University Hospital

Genetic & Rare Disorders Organisation (GRDO)

Geraldine McCabe, Member of the Public

Green Party

Healthcare Enterprise Alliance

Health Information and Quality Authority (HIQA)

Health Insurance Authority

Health Reform Alliance

Health Research Board

Health Service Commissioning structure
proposal V1.1

Heart Children Ireland

Heartbeat Trust, National Heart Failure Charity

Helium Arts, Children's Arts & Health Organisation

HIQA

HSE Arts and Wellbeing Group

HSE Central submission

HSE Cystic Fibrosis Programme

HSE Dermatology Programme

HSE Dr Mary T. O'Mahony

HSE National Clinical Programme in Pathology

HSE National Diabetes Programme

HSE National Programme for Sepsis

HSE National Programme on Transport Medicine

HSE Programme for Older Persons

HSE Programme for Paediatric Diabetes

HSE Submission on Acute Medicine

HSE Programme for Palliative Care

HSE UL Hospital Group Submission

IMO, Irish Medical Organisation

IMSTA (The Medtech industry)

Irish Association for Infant Mental Health.

Irish Cancer Society

Irish College of General Practitioners (ICGP)

Irish College of Ophthalmologists,

Irish Congress of Trade Unions (ICTU)

Irish Dental Association.

Irish Farmers' Association

Irish Heart Foundation

Irish Hospice Foundation

Irish Hospital Consultants Association

Irish Life Health

Irish Medical Devices Association (IMDA)

Irish Nurses and Midwives Organisation (INMO)

Irish Nutrition and Dietetic Institute (INDI),

Irish Patients' Association

Irish Pharmaceutical Healthcare Association

Irish Pharmacy Union

Irish Platform for Patient Organisations, Science
& Industry – IPPOSI

Irish Rheumatology Health Professionals Society

Irish Rural Link, a voice for rural Ireland

Irish Skin Foundation (ISF)

Irish Society for Colitis & Crohn's disease,

Irish Society for Disability and Oral Health

Irish Society of Chartered Physiotherapists (ISCP)

Irish Society of Clinical Nutrition and Metabolism
(IrSPEN)

Irish Thoracic Society

Irish Vape Vendors Association

ISCP, Irish Society of Chartered Physiotherapists

ISPCC, Irish Society for the Prevention of Cruelty
to Children

John Armstrong Actuary/Health Economist

Katharine Howard Foundation, Infant Health
& Wellbeing

Kieran Henry, Advanced Paramedic

Laois Faculty ICGP, MIDOC Members & Medical
Board Portlaoise

LauraLynn
 Laya Healthcare (LHC)
 LloydsPharmacy Ireland
 Mallow Primary Healthcare Centre (MPHC)
 Meath Special Hands Group
 Medical Research Charities Group (MRCG)
 Medtronic, Global Leader in Medical Technology
 Mental Health Reform,
 Michael Power, Clinical Programme Lead,
 Critical Care Programme
 MSD Ireland
 Mundipharma Pharmaceuticals Ltd
 NAGP National Association of General Practitioners.
 NALA, National Adult Literacy Agency
 National Clinical Programme Lead, Dr Michael Power
 National Clinical Programme for Epilepsy
 National Clinical Programme for Neurology
 National Clinical Programme for Rare Diseases,
 National Clinical Programme for Rehabilitation
 Medicine
 National Clinical Programme for Rheumatology.
 National Clinical Programme in Dermatology.
 National Clinical Programme in Pathology
 National Clinical Programme in Radiology.
 National Rehabilitation Hospital
 National Treatment Purchase Fund
 Neurological Alliance of Ireland
 NHI, Nursing Homes Irl.
 North East Doctor on Call Submission
 Nua Healthcare
 Nursing & Midwifery Board of Ireland
 Nutricia Advanced Medical Nutrition
 Patient Hotel Solutions
 Perinatal and Infant Mental Health Special Interest
 Group (PIMHSIG)
 Pharmaceutical Society of Ireland's (PSI)
 Pre-Hospital Emergency Care Council,
 Primary Care Dermatology Society of Ireland
 Primary Care Surgical Association
 Private Hospitals Association
 Professor Anthony Staines, Professor of Health
 Systems, DCU
 Prof Frank Keane, Retired Consultant
 Colorectal Surgeon
 Prof Ken McDonald, Heartbeat Trust
 Prof Pollock Towards National Universal Health Care
 Systems
 Professor Thilo Kroll, UCD School of Nursing
 Rehab Group
 Rotunda Hospital Executive Management Team
 Royal College of Physicians of Ireland
 Royal College of Surgeons of Ireland
 Safetynet, main coordinator of primary care services
 for homeless people
 SAGE
 Saolta, Dr Pat Nash
 Séamus Healy
 Senator Colette Kelleher
 Shire Pharmaceuticals
 Simon Communities of Ireland (Sam McGuinness)
 SIPTU
 Sorcha O'Reilly, member of the public
 Spinal Injuries Ireland
 St Patrick's Mental Health Services.
 Súil Eile Submission
 Tom Beegan & Associates, Plan to Integrate
 Disability Services
 Trauma and Orthopaedics`Programme
 Trinity College Dublin, see Dr James O'Mahony
 Voluntary Health Insurance Group
 Voluntary Hospices Group submission
 on Palliative Care
 West Cork Arts Centre

Appendix 3: 10 Year Budgeted Costings to Expand Entitlements

Table 8

Key Measures to Expand Entitlements	Details	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
1. EXPAND HEALTH AND WELLBEING											
1.1 Increase Health and Wellbeing Budget	Increase from previous year	€16,848,480	€18,031,277	€19,297,109	€20,651,804	€22,101,602	€23,653,197	€25,313,679	€27,090,750	€28,992,575	€31,019,544
	Cumulative Spend	€16,848,480	€34,879,757	€54,176,866	€74,828,670	€96,930,272	€120,583,451	€145,897,131	€172,987,881	€201,980,456	€233,000,000
1.2 Resource and develop Child Health & Wellbeing service	Increase from previous year	€8,292,780	€8,292,780	€8,292,780	€8,292,780	€8,292,780	€0	€0	€0	€0	€0
	Cumulative spend	€8,292,780	€16,585,560	€24,878,340	€33,171,120	€41,463,900	€41,463,900	€41,463,900	€41,463,900	€41,463,900	€41,463,900
2. REDUCE AND REMOVE CHARGES											
2.1 Remove Hospital Inpatient Charges	Increase from previous year	€25,000,000	€0	€0	€0	€0	€0	€0	€0	€0	€0
	Cumulative Spend	€25,000,000	€25,000,000	€25,000,000	€25,000,000	€25,000,000	€25,000,000	€25,000,000	€25,000,000	€25,000,000	€25,000,000
2.2 Reduce GMS prescription charge	Increase from previous year	€66,795,500	€66,795,500	€0	€0	€0	€0	€0	€0	€0	€0
	Cumulative Spend	€66,795,500	€133,591,000	€133,591,000	€133,591,000	€133,591,000	€133,591,000	€133,591,000	€133,591,000	€133,591,000	€133,591,000
2.3 Reduce DPS threshold	Increase from previous year	€0	€0	€75,030,000	€0	€0	€184,898,000	€0	€0	€0	€0
	Cumulative Spend	€0	€0	€75,030,000	€75,030,000	€75,030,000	€259,928,000	€259,928,000	€259,928,000	€259,928,000	€259,928,000
2.4 Halve DPS threshold for single headed households	Increase from previous year	€1,750,000	€0	€0	€0	€0	€0	€0	€0	€0	€0
	Cumulative spend	€1,750,000	€1,750,000	€1,750,000	€1,750,000	€1,750,000	€1,750,000	€1,750,000	€1,750,000	€1,750,000	€1,750,000
2.5 Removal of Emergency Department charge	Increase from previous year	€0	€0	€0	€0	€0	€0	€0	€17,000,000	€0	€0
	Cumulative spend	€0	€0	€0	€0	€0	€0	€0	€17,000,000	€17,000,000	€17,000,000
3. PRIMARY CARE EXPANSION											
3.1 Expansion of Primary Care Diagnostics	Difference from previous year	€25,000,000	€0	€0	€0	€0	€0	€0	€0	€0	€0
	Cumulative spend	€25,000,000	€25,000,000	€25,000,000	€25,000,000	€25,000,000	€25,000,000	€25,000,000	€25,000,000	€25,000,000	€25,000,000
3.2 Counselling in Primary Care	Increase from previous year	€2,200,000	€2,200,000	€2,200,000	€0	€0	€0	€0	€0	€0	€0
	Cumulative Spend	€2,200,000	€4,400,000	€6,600,000	€6,600,000	€6,600,000	€6,600,000	€6,600,000	€6,600,000	€6,600,000	€6,600,000
3.3 Psychology in Primary Care	Increase from previous year	€2,500,000	€2,500,000	€0	€0	€0	€0	€0	€0	€0	€0
	Cumulative spend	€2,500,000	€5,000,000	€5,000,000	€5,000,000	€5,000,000	€5,000,000	€5,000,000	€5,000,000	€5,000,000	€5,000,000
3.4 Universal Primary Care	Difference from previous year	€53,120,000	€53,120,000	€53,120,000	€53,120,000	€53,120,000	€0	€0	€0	€0	€0
	Cumulative spend	€53,120,000	€106,240,000	€159,360,000	€212,480,000	€265,600,000	€265,600,000	€265,600,000	€265,600,000	€265,600,000	€265,600,000
3.5 Universal GP Care	Difference from previous year	€91,000,000	€91,000,000	€91,000,000	€91,000,000	€91,000,000	€0	€0	€0	€0	€0
	Cumulative spend	€91,000,000	€182,000,000	€273,000,000	€364,000,000	€455,000,000	€455,000,000	€455,000,000	€455,000,000	€455,000,000	€455,000,000

Key Measures to Expand Entitlements	Details	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
4. SOCIAL CARE EXPANSION											
4.1 Palliative Care	Increase from previous year	€8,036,157	€8,900,125	€9,856,977	€10,916,701	€12,090,355	€0	€0	€0	€0	€0
	Cumulative spend	€8,036,157	€16,936,282	€26,793,259	€37,709,960	€49,800,000	€49,800,000	€49,800,000	€49,800,000	€49,800,000	€49,800,000
4.2 Homecare	Difference from previous year	€24,000,000	€24,000,000	€24,000,000	€24,000,000	€24,000,000	€0	€0	€0	€0	€0
	Cumulative spend	€24,000,000	€48,000,000	€72,000,000	€96,000,000	€120,000,000	€120,000,000	€120,000,000	€120,000,000	€120,000,000	€120,000,000
4.3 Expansion of services for people with disabilities	Difference from previous year	€29,090,855	€29,090,855	€29,090,855	€29,090,855	€29,090,855	€29,090,855	€29,090,855	€29,090,855	€29,090,855	€29,090,855
	Cumulative spend	€29,090,855	€58,181,711	€87,272,566	€116,363,422	€145,454,277	€174,545,132	€203,635,988	€232,726,843	€261,817,699	€290,908,554
5. MENTAL HEALTH PROGRAMMES											
5.1 Community Child and Adolescent Mental Health Teams	Difference from previous year	€9,146,083	€9,146,083	€9,146,083	€9,146,083	€9,146,083	€0	€0	€0	€0	€0
	Cumulative spend	€9,146,083	€18,292,166	€27,438,248	€36,584,331	€45,730,414	€45,730,414	€45,730,414	€45,730,414	€45,730,414	€45,730,414
5.2 Adult Mental Health Teams	Difference from previous year	€8,899,440	€8,899,440	€8,899,440	€8,899,440	€8,899,440	€0	€0	€0	€0	€0
	Cumulative spend	€8,899,440	€17,798,881	€26,698,321	€35,597,762	€44,497,202	€44,497,202	€44,497,202	€44,497,202	€44,497,202	€44,497,202
5.3 Old Age Psychiatry	Difference from previous year	€3,772,766	€3,772,766	€3,772,766	€3,772,766	€3,772,766	€0	€0	€0	€0	€0
	Cumulative spend	€3,772,766	€7,545,532	€11,318,298	€15,091,064	€18,863,830	€18,863,830	€18,863,830	€18,863,830	€18,863,830	€18,863,830
5.4 Child and Adolescent Liaison	Difference from previous year	€1,000,000	€1,000,000	€0	€1,000,000	€1,000,000	€0	€0	€0	€0	€0
	Cumulative spend	€1,000,000	€2,000,000	€0	€3,000,000	€4,000,000	€4,000,000	€4,000,000	€4,000,000	€4,000,000	€4,000,000
5.5 Intellectual Disability Services	Difference from previous year	€2,125,000	€2,125,000	€0	€2,125,000	€2,125,000	€0	€0	€0	€0	€0
	Cumulative spend	€2,125,000	€4,250,000	€0	€6,375,000	€8,500,000	€8,500,000	€8,500,000	€8,500,000	€8,500,000	€8,500,000
6. DENTISTRY EXPANSION											
Re-instate pre-budget DTSS	Increase from previous year	€17,000,000	€0	€0	€0	€0	€0	€0	€0	€0	€0
	Cumulative spend	€17,000,000	€17,000,000	€17,000,000	€17,000,000	€17,000,000	€17,000,000	€17,000,000	€17,000,000	€17,000,000	€17,000,000
7. PUBLIC HOSPITAL ACTIVITY EXPANSION											
7.1 Expand public hospital activity by replacing income for private activity in public hospitals	Increase from previous year	€0	€129,800,000	€129,800,000	€129,800,000	€129,800,000	€129,800,000	€0	€0	€0	€0
	Cumulative spend	€0	€129,800,000	€259,600,000	€389,400,000	€519,200,000	€649,000,000	€649,000,000	€649,000,000	€649,000,000	€649,000,000
7.2 Consultants	Increase from previous year	€0	€0	€0	€17,000,000	€17,000,000	€17,000,000	€17,000,000	€17,000,000	€17,000,000	€17,000,000
	Cumulative spend	€0	€0	€0	€17,000,000	€34,000,000	€51,000,000	€68,000,000	€85,000,000	€102,000,000	€119,000,000

Table 9

	Increase on Previous Year	Cumulative Spend
Year 1	€395,577,062	€395,577,062
Year 2	€458,673,827	€854,250,888
Year 3	€463,506,011	€1,317,756,899
Year 4	€408,815,430	€1,726,572,328
Year 5	€411,438,882	€2,138,010,895
Year 6	€384,442,036	€2,522,452,931
Year 7	€71,404,534	€2,593,857,465
Year 8	€90,181,605	€2,684,039,070
Year 9	€75,083,430	€2,759,122,501
Year 10	€77,110,399	€2,836,232,900

Footnotes and Methodology to Budgeted Costings

The costings included in the Committee's report were developed drawing in available data in the public domain (e.g. the HSE monthly performance and management data reports and Primary Care Reimbursement Schemes (PCRS) annual reports). It should be noted that a significant number of formal Committee information requests were made to the HSE and the Department of Health seeking the most up to date additional data, so that costings could be prepared in areas such as primary care and mental health.

In some areas, costings were based on projections for the years ahead, given current expenditure and expanded to the whole population or benchmarked with international comparisons, e.g. budgets in health and wellbeing. In other areas, utilisation and unit cost data was used to cost workforce expansion e.g. primary care. In respect of palliative care and mental health, cost projections are based on data previously submitted to the Department of Public Expenditure and Reform, and the Department of Health for service expansion to meet population needs.

The footnotes below provide further details in respect of each specific area. The figures as presented throughout the report represent the best available data to the Committee within the time constraints of the Committee's work.

The Committee's Overall Analysis was Informed by:

- An extensive international literature search
- use of the best available data including additional background material and analysis carried out on behalf of the Committee arising from an extensive series of information requests
- Extensive consultations and additional background material provided by the HSE, the Department of Health, the Health Intelligence Unit, the HSE HR section, meetings with the Department of Health Finance officials, information requests from the Committee.

1. Expand Health and Wellbeing

1.1 Increase health and wellbeing budget – €233 million over ten years

The Health and Wellbeing Budget for 2017 is €233.3 million (**HSE 2017 National Service Plan**).

The current budget allocation for health and wellbeing represents 1.7% of the total HSE budget, or 2.7% of total national health expenditure (HSE, National Service Plan, 2017, Health at a Glance, OECD Health at a Glance 2015/6). Internationally, high spending countries spend between 4% and 6% on preventive health budget. Therefore the Committee is proposing a doubling of the HSE health and wellbeing budget over a ten year period in order to bring Ireland in line with international norms.

1.2 Resource and develop a universal child and wellbeing service – €41 million over first five years

This proposal is based on hiring 900 additional community registered general nurses across the nine Community Health Organisations (CHOs). This would free up the Public Health Nurses who have specialist child health training to carry out their child health work and develop universal child health and wellbeing services. It is costed at €41 million and delivered in the first five years of the plan. These figures are based on a proposal for a universal child health and wellbeing service prepared for the OCFH by the HSE National Child Health Director.

2. Reduce and Remove Charges

2.1 Removal of inpatient charges for public hospital care – €25 million in year one

This costing is based on the 2016 annual income from inpatient charges for public hospital care which was €25 million (**HSE December Performance Management Data Report**)

2.2 Reduce Prescription Charge for Medical Card Holders from €2.50 To €1.50 in Year 1 & to 50 Cent In Year 3 – €66.7 Million in Year One, a Further €66.7M in Year 3 Totalling €133.6 Million

The OCFH recommends the reduction of this charge for all under 70 year olds from €2.50 to €1.50 in Year 1 at the cost of €67 million, the further reduction to 50 cent in Year 2 at the cost of €133.5 million. The elimination of the 50 cent charge would cost an additional €33.3m, totalling €167 million. The €2.50 fee per item generated an estimated €166,988,750 in revenue in 2015 (**HSE, Primary Care Reimbursement Scheme Annual report 2015, 2016 data is not yet available**). If the charge is reduced by 40% in Year 1 to €1.50 that represents a gap of €66,795,500 in current revenue trends that would need to be replaced through additional funding. Reducing the charge by an additional €1.00 per item to 50 cent in Year 2 would increase the gap between current and projected revenues to €133,591,000. If the 50 cent charge were later removed, an additional €33,397,750 would be needed to fully replace the revenue currently generated by prescription charges.

This data was obtained from Primary Care Reimbursement Scheme annual reports and modelled to uptake at the €1.50 and 50 cent charges. A similar methodology was previously used to model the increased cost of the charges on people.¹²⁹

2.3 The Committee Recommends Reducing the Drug Payment Scheme Threshold from €144 Per Month to €120 and €100 at a Cost of €75 Million in Year 3 and a Further €185 Million in Year 6, Totalling €259 Million.

The Committee's cost projections are based on analysis of historic PCRS data. For example, in 2015, over 1.3 million people were eligible for the DPS and 269,930 (20.7%) availed of this scheme, at the cost €67 million to the State in 2015. (*PCRS Annual Report, 2015*)

The CoFH recommends reducing the payment to €120 by Year 3 at an estimated cost of €75 million and further reducing it to €100 per month in Year 6 costing an additional €184 million, leading to a total annual cost of €259 million by Year 6. These figures are based on the differences between demand and costs in 2015 and demand and costs when the thresholds were at similar levels in 2011 and 2009. In 2011, when the monthly threshold was €120, 1.5 million were eligible and 429,102 (28.26%) availed of the scheme. The net cost to the State was €142.1 million. In 2009, when the threshold was €100, 1.58 million were eligible and 663,127 (41.8%) availed of the scheme, at a net cost of €259.9 million. A similar methodology was previously used to model the increased cost of the charges on to people¹³⁰

129 Thomas, S, Burke, S, Barry, S. *The Irish health-care system and austerity: sharing the pain*, *The Lancet*, 383, (9928), 2014, p1545 – 1546

130 *Ibid*

2.4 Reducing the Drugs Payment Scheme Threshold for Single Headed Households in Year 1

The Committee recommends reducing the Drugs Payment Scheme threshold for single headed households to €72 per month.

This is a strong financial protection measure, costing approximately €1.75 million each year. This will mostly benefit single people and lone parent households with chronic diseases. Expenditure on prescription charges for single-headed households was estimated based on the Household Budget Survey 2009-10 as being €3.5 million each year. Yet to be published research by the Centre for Health Policy and Management and the WHO, determined that single headed households were disproportionately impacted by out-of-pocket payments for health expenditure. The Committee recommends reducing the threshold for single headed households to €72 per month. This is a relatively affordable financial protection measure, costing approximately €1.75 million each year. This will mostly benefit single people and lone parent households with chronic diseases. Expenditure on prescription charges for single-headed households was estimated based on the Household Budget Survey 2009-10 as being €3.5 million each year. The Committee's analysis is based on a conservative estimate to halve this cost for households to €1.75 million; however, demand may increase as seen in the DPRS figures between 2009 and 2015.

2.5 Removal of Emergency Department Charge in Year 8

Based on current income from the Emergency Department charge, this will cost €17 million each year. (*HSE December 2016 Performance Management Data Report*)

3. Primary Care Expansion

3.1 Expansion of Community Diagnostics and Shifting Treatment From the Acute Sector to the Community

In the absence of data on costings for community diagnostics, this figure was drawn from the HSE 'Shifting the balance to high value care report' March 2017 drafted for the Oireachtas Committee which costed community diagnostics at €15 million and the extension of Community Intervention Teams and Outpatient Parenteral Antimicrobial Therapy (OPAT) which allows people who traditionally would have been treated in hospital beds to be treated at home in the community at €9.7 million.

Counselling in Primary Care

The Committee recommends extending counselling provided by private providers through GP/primary care referral – at a cost in the order of €6.6 million over three years

The allocation for this service in 2016 was €6.5 million (figures were submitted by HSE lead on this to OCFH). Currently this service is only available to medical card holders. The projections are based on doubling this spend over a three year period.

3.2 The Committee Recommends Developing Public Psychology Services in Primary Care – At A Cost in the Order of €5 Million Over Two Years to Get This Service Up And Running. This Would Fund 114 Assistant Psychologists, 20 Child Psychologists and Allow for the Development of a CBT Online Resource.

This costing is based on a proposal from the HSE Mental Health Division to the Department of Public Expenditure and Reform, provided to the COFH, following an information request. While the above proposal of extending access to private counselling represents a short term solution to meet unmet mental health needs at the lowest level of complexity, building up timely access to HSE hired psychologists is the best solution in the long term. This will cost €5 million initially. The funding to achieve this is included in the total costing envelope, and will be delivered during the first two years of the plan. Further funding will be required thereafter (depending on need and uptake) to make this service universal.

3.4 Universal GP Care – €455 Million Over Five Years

The Committee proposes extending access to GPs to the whole population by extending GP care without charge to an additional 500,000 people each year for the first five years of the plan. This measure will be rolled out through an income threshold which will allow approximately 500,000 new people each year gain access to GP care without charge. Estimated individual average utilisation increase from getting access to free care is consistent across household surveys at 1.3-1.4 additional visits per year per person, yielding an additional 3.3m visits.

Estimating current reimbursement rates per visit from PCRS funding patterns to GPs implies an additional cost of approximately €455 million (2.551 million people to be newly covered, 4.1 visits per year, from Healthy Ireland Survey 2016, @ €43.5 per visit).

A number of sources were used to support the analysis including;

- *Healthy Ireland Survey 2016 Summary Findings*¹³¹
- *Anne Nolan, Yuanyuan Ma, Patrick Moore (2016) Changes in Public Healthcare Entitlement and Healthcare Utilisation among the Older Population in Ireland, TILDA;* ¹³²
- *A Model of Demand for and Supply of General Practitioner and Practice Nurse Services in the Republic of Ireland. A Handbook. 2012. Department of Health – Research Consortium led by Centre for Health Policy and Management. Trinity College Dublin, prepared for Department of Health* ¹³³

3.5 Universal Primary Care – €265.6 Million Over First Five Years of the Plan

The *Primary Care – A New Direction (2001)* policy proposed a primary care team model designed to cater for populations of 3-7,000 people. Apart from GPs, the team in this model includes health care assistants, home helps, nurses/midwives, an occupational therapist, a physiotherapist, speech and language therapists, social work and administrators and receptionists. Currently just 34% of the population with medical cards have access to these services.

This proposal is based on making these services available to the whole population at an annual cost of €265.6 million, delivered during the first five years of the plan. The proposal is based on boosting staffing ratios to those indicated in the Primary Care Strategy (2001) updated to take into account population growth for cadres which do not currently have sufficient numbers including specialist nurses, public health nurses, therapists and care staff. (Baseline Human Resources WTE data was provided by HSE Workforce Planning, Analytics & Informatics). Unit costs were identified from HSE payroll (with costs ranging between €33,000-€56,000) to allow the estimation of the cost implications of expanding the primary care workforce (by 1,917 healthcare assistants, 2021 nurses and 1,296 occupational therapists, physiotherapists and social workers).

¹³¹ Department of Health, 2016, Ipsos MRBI, *Healthy Ireland Survey 2016* <http://health.gov.ie/wp-content/uploads/2016/10/Healthy-Ireland-Survey-2016-Summary-Findings.pdf>

¹³² Nolan, A, Ma, Y, Moore P (2016) *Changes in Public Healthcare Entitlement and Healthcare Utilisation among the Older Population in Ireland, ESRI/TILDA;* <https://www.esri.ie/publications/changes-in-public-healthcare-entitlement-and-healthcare-utilisation-among-the-older-population-in-ireland/>

¹³³ *Research Consortium led by Centre for Health Policy and Management. Trinity College Dublin, prepared for Department of Health. A Model of Demand for and Supply of General Practitioner and Practice Nurse Services in the Republic of Ireland. A Handbook. 2012. Department of Health*

4. Social Care Expansion

4.1 Universal Palliative Care – €49.8 Million Over the First Five Years of the Plan

Estimates from the National Clinical Programme for Palliative Care submitted to the Department of Health in 2016 show that an additional €49.8m is needed to deliver universal palliative care.

This includes €41 million for adult specialist palliative care and €8.8 million for children's palliative care (including State funding for the LauraLynn hospice, community and home care programmes). Data was provided by the HSE following a specific information request by the Committee on the Future of Healthcare

4.2 Increasing Homecare Provision – €120 Million in the First Five Years of the Plan

The 2017 budget allocation for home care is €403 million (HSE submission following a specific information request by the Committee on the Future of Healthcare). Wave 1 TILDA data found 26% of unmet need for homecare services for people over 50 years of age¹³⁴. Estimating a 30% increase in provision would cost €120 million. This is proposed to be delivered in the first five years of the plan (A 50% increase in services to cater for higher levels of unmet need would cost €205 million). The Committee also recognises the need for further work to be done on costing nursing home provision, having regard to the recommendation in Section 3 of this report on ending over reliance on market mechanisms for provision of such care.

4.3 Social Care – Additional Services for People With Disabilities – €290 Million Over Ten Years

It was not possible with available data in the timeframe of the committee's work to do a detailed assessment of the projected costs of providing timely access to quality services for people with disabilities. The Committee is aware that this is an area of high need where current services are not meeting demand and where there are high out of pocket payments which cause impoverishing and catastrophic out of pocket payments.

While many of the measures outlined in this plan will positively impact on people with disabilities, such as reducing and abolishing drug charges, better access to diagnostics, primary and hospital care without charge, the management of chronic diseases and mental healthcare in the community, more homecare, people with disabilities often have additional needs that must be met. Of particular importance to services for people with disabilities is increased personal

¹³⁴ Murphy, C., Kamiya, Y., Savva, G., Timonen, V. (2012) *Profile of Community-Dwelling Older People with Disability and their Caregivers in Ireland*. Dublin: Trinity College Dublin, TILDA (The Irish Longitudinal Study on Ageing) <https://tilda.tcd.ie/assets/pdf/Carer%20Report.pdf>

choice of services, rights based access to services and empowering people with disabilities to live independently.

The additional funding allocated in the Committee’s plan is €290 million over a ten year period. How this is best targeted for services for people with disabilities should be determined by the Implementation Office in conjunction with people with disabilities, their families and service providers. The targeting of such spend should draw on relevant research where the healthcare costs of people with disabilities causes financial hardship and impoverishment.

5. Mental Healthcare

The expansion of access to counselling in primary care is specified above in the primary care section. The below budget lines are the additional staffing requirement for fully functioning multi disciplinary mental health teams as laid out in A Vision for Change adjusted for population growth. Figures are those submitted by the Mental Health Directorate in the HSE to the OCFH.

5.1 Child and Adolescent Mental Health Teams – €45.7 Million – Delivered by Year 5

5.2 Adult Community Mental Health Teams – €44.5 Million – Delivered by Year 5.

5.3 Old Age Psychiatry – €18.8 Million – Delivered by Year 5

5.4 Child And Adolescent Liaison – €4 Million – Delivered by Year 5

5.5 Intellectually Disability MH Services – 120 Additional Staff, Costing €8.5 Million – Delivered by Year 5

6. Dentistry Expansion

Reinstate pre economic crisis budget to Dental Treatment Services Scheme – €17 million in Year 1

The Dental Treatment Service Scheme (which provides some dental care for people with medical cards) was cut by €17 million during austerity, even though many more people were dependent on the scheme. As the scheme now operates, virtually no treatments except extractions and emergencies are carried out and orthodontic services have been severely diminished. This scheme should be reinstated at pre crisis levels in year one, until a more comprehensive package of care is put in place for the whole population. (Data from Primary Care Reimbursement Scheme Annual Reports).

7. Expanding Public Hospital Activity

7.1 Expanding Public Activity in Public Hospitals – €649 Million from Years 2 to 6 of the Plan.

The revenue paid to public hospitals by private insurance companies is costed at €649 million for 2016 (HSE December 2016 Performance Report). The Committee proposes replacing this income over a five year period starting in Year 2.

7.2 Increase Numbers of Public Hospital Consultants – €119 Million Between Years 4 and 10

€119 million is allocated to expand additional consultants in public hospitals. Other consultants are costed in other parts of this plan eg in palliative and mental health services. The costings are derived from taking a mid-scale public only salary for 593 consultants

Appendix 4: Waiting list Management

eHealth Waiting List Solution & Evidence on Successful Waiting List Management

A summary of the digital solutions for waiting list management are:

- *Patient portal – a web site that enables patients to view their own referrals and status and position within the waiting list*
- *Reminder service – a service to remind patients about their upcoming hospital appointments via text to reduce Did Not Attends. This will allow for cancellations of appointments through this route to be reassigned ensuring that the current capacity of appointments is maximised*
- *Integrated Referral Management System – This system will enable the collation of information digitally allowing management and analysis of the referral and triage processes as well providing coordination of care between primary and secondary care*
- *Digital Discharge Solution – This enables electronic collection of all information relating to that patient's episode of care, resulting in a more efficient, safer and traceable discharge of the patient.*
- *A single integrated hospital waiting list management system*

Enforcing Maximum Waiting Time Guarantees in England, Finland and Portugal

Table 10

Countries	Policies
England	<ol style="list-style-type: none"> 1. Hospitals are required to provide in-patient services to 90% and outpatient services to 95% of patients waiting before 18 weeks. A breach of the 18 week guarantee results in a reduction of up to 5% of revenues for the relevant specialty 2. Strong political oversight from the Prime Minister's Delivery Unit 3. Senior health administrators are at risk of losing their jobs if targets are not met 4. Good performance results in increased freedom for hospitals 5. 'NHS Choices' is a website that allows patients to access a number of metrics about specific hospitals, including wait times
Finland	<ol style="list-style-type: none"> 1. Increased attention on healthcare issues at the national level 2. A general improvement in transparency and accountability 3. Scrutiny of hospitals that do not meet wait time targets and threat of fines. 4. Increased use of performance measurements 5. Patient empowerment and increased freedom to pick the hospital where one gets treatment
Portugal	<ol style="list-style-type: none"> 6. When a patient on a waiting list has reached 75% of the maximum allowed wait time, they are given a voucher that allows them to seek treatment outside the hospital they were originally waiting for treatment at. 7. The patient can be treated privately or publically – it is their choice. Vouchers are restricted only to the procedure a patient is waiting for. 8. Payment by the Portuguese NHS is the same irrespective of provider – private or public 9. Hospitals have an incentive to not lose patients they have incurred costs for before the patient was placed on the waiting list. 10. Public hospitals must meet productivity goals or they will incur financial penalties. 11. Patients can look up their estimated wait time through a website

Sources: OECD 2013, Siciliani et al 2014, Besley et al 2009, Wilcox et al 2007

Appendix 5: Terms of Reference of the Committee

That, Notwithstanding Anything in Standing Orders, Dáil Éireann: Recognising:

- *the severe pressures on the Irish health service, the unacceptable waiting times that arise for public patients, and the poor outcomes relative to cost;*
- *the need for consensus at political level on the health service funding model based on population health needs;*
- *the need to establish a universal single tier service where patients are treated on the basis of health need rather than on ability to pay;*
- *that to maintain health and wellbeing and build a better health service, we need to examine some of the operating assumptions on which health policy and health services are based;*
- *that the best health outcomes and value for money can be achieved by re-orientating the model of care towards primary and community care where the majority of people's health needs can be met locally; and*
- *the Oireachtas intention to develop and adopt a 10 year plan for our health services, based on political consensus, that can deliver these changes,*

Orders That:

- (a) *a special all-party Committee, which shall be called the Committee on the Future of Healthcare, shall be established, to devise cross-party agreement on a single long-term vision for health care and direction of health policy in Ireland;*
- (b) *the Committee shall be made up of fourteen Members of the Dáil, of which four Members shall be appointed by the Government, three Members by Fianna Fáil, two Members by Sinn Féin, one member by the Labour Party, one member by Independents4Change, one member by the Anti-Austerity Alliance – People Before Profit, one member by the Rural Alliance and one member by the Social Democrats – Green Party group, and four shall constitute a quorum; Members may be substituted as provided under Standing Order 95(2);*
- (c) *notwithstanding the provisions of Standing Order 93, the Committee shall elect one of its Members to be Chairman, who shall have one vote;*
- (d) *the Ceann Comhairle shall announce the names of the Members appointed under paragraph (b) for the information of the Dáil on the first sitting day following their appointment;*

- (e) *the Committee shall have the powers defined in Standing Order 85 (other than paragraphs (3), (4) and (6) thereof);*
- (f) *the Committee shall examine existing and forecast demand on health services, including the changing demographics in the Irish population;*
- (g) *the Committee shall examine and recommend how to progress a changed model of healthcare that advocates the principles of prevention and early intervention, self-management and primary care services as well as integrated care;*
- (h) *the Committee shall examine different funding models for the health service and make recommendations on the funding models that are best suited to Ireland and have these models fully costed;*
- (i) *the Committee shall examine and make recommendations on how best to re-orientate the health service on a phased basis towards integrated, primary and community care, consistent with highest quality of patient safety, in as short a time-frame as possible;*
- (j) *the Committee shall be mandated to hold hearings in public with expert witnesses; invite and accept written submissions; draw up a report(s); make findings; and/or suggest recommendations if the membership so agrees in unison or in majority/minority format;*
- (k) *the Committee shall produce an interim report, containing also its proposed work schedule, to be debated at a meeting of the Dáil no less than one week, and no more than two months, after its establishment;*
- (l) *the Committee shall, by 31 May 2017, present a final report to the Ceann Comhairle for earliest possible discussion in the House; and*
- (m) *the Committee shall meet as frequently as appropriate to fulfil its remit.*



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