The future of healthcare in Ireland

Position paper on the health crisis and the government’s plans for healthcare

Prepared for IMPACT

Dr Jane Pillinger, Independent Researcher and Policy Advisor

November 2012

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Preface

This report sets out IMPACT’s vision for a high quality public healthcare system, as well as its doubts about the structural changes currently underway, which are an understandable response to the failed HSE experiment. It advocates a different approach to the reform of health service structures that is more likely to deliver equity, access and quality in our public health services. The report also calls for a transparent information and consultation process, which will bring service users and staff into the debate about changes that could shape our health services for a generation or more.

IMPACT is Ireland’s largest public service trade union. Around half our members - over 30,000 – work in health and social care professions, and health service administrative, management and technical grades. Health staff are committed to efficient, effective and high-quality healthcare. But they have been demoralised by successive reorganisations and strategies that have failed to fundamentally reform our health services – as well as an approach to funding that has not delivered promised improvements to our health services. Like patients and other service-users, staff see the impact of this dysfunctional system, and the impact on the most vulnerable, first-hand.

Methodology
The report was informed by consultations, including focus group research, with IMPACT members in the health services, including HSE managers. Our consultations confirmed the urgent need for fundamental change to address the structural and funding problems in the healthcare system. IMPACT members are concerned that Government’s plans for the funding and structure of our health services are poorly conceived, with unrealistic timeframes and budgets inadequate for successful implementation. They are being implemented within a system that, to say the least, is short of resources and is not functioning well. There is also a huge information deficit about the changes and their potential implications, and a fundamental lack of consultation with communities, service users and staff. Politicians and top health service managers seldom talk to their stakeholders – and virtually never listen – on issues that have huge implications for all our futures. All this makes it difficult to envisage how the Government’s approach will meet its stated aim of improving access, equity and quality for the growing numbers of people who depend on the public health service.

Service shortcomings
We probably hear the word ‘crisis’ too much, but there certainly is a crisis in Ireland’s healthcare system. The health system remains unable to meet the health needs of the population because of historical underfunding (notwithstanding a short ‘blip’ in the economic boom years), perennial and growing HSE deficits, long waiting times for many services, the long-standing and inequitable two-tier system, creeping privatisation and outsourcing, a deterioration in quality in many services, and cuts resulting from the troika-imposed budgetary policy. These are exacerbated by demographic changes and the increasing cost of new medical technologies The Croke Park agreement has been crucial in managing cuts in resources and staffing. Nevertheless, they inevitably have a negative impact on services and staff morale.

Long-standing commitments to fund and develop core areas like primary health care and mental health services have not been implemented. Constant crisis management prevents the necessary planning for future service needs and, just as importantly, draws
attention away from the potential impact and of current government plans for healthcare reorganisation.

**Universal health insurance**

Section 2 of the report looks at what the government plans for universal health insurance (UHI). The preference for a competing private insurance model will incur substantial costs to the government. The government believes the phased introduction of UHI can create a one-tier universal healthcare system, with free access to GP care and hospital care by 2016, and operating on the principle that the ‘money follows the patient’. IMPACT supports the idea of UHI but does not believe it can deliver the Government’s aims without the right funding and operational model.

The Government’s model of competing private sector insurers has not been properly tested. Delays in its implementation suggest that Government plans for UHI have been poorly thought out. If implemented, the model is unlikely to deliver equity, value-for-money, quality or universal access. Quite the opposite: lessons from the Netherlands show that a profit-driven commercial model led to an inequitable and inefficient system of funding, different tiers of entitlement, rising hospital deficits, and even bankrupt hospitals.

Current budgetary restraints are not a justification for adopting the wrong model for a generation or more of public health services. The World Health Organization has rated the French and Japanese social insurance models as being best practice models for positive health outcomes, and for the delivery of effective and equitable healthcare. We believe these models should be explored further rather than opting for a model that is failing.

**Hospital trusts and health service governance**

Section 3 of the report considers the Government’s proposed governance model. Again, IMPACT has serious concerns about aspects of the model, including the creation of new independent hospital trusts. We very much doubt that it will improve integration between hospital and community care services. We believe it is likely to lead to more privatisation, with adverse implications for future costs, quality and accountability. The creation of independent hospital trusts has begun without sufficient discussion of the overall model or specific details like the organisation and management of clinical care programmes or the budgets and staffing levels of individual trusts.

There is little clarity about which services will fall into the individual directorates (in primary care, mental health, social insurance models as being best practice models for positive health outcomes, and for the delivery of effective and equitable healthcare. We believe these models should be explored further rather than opting for a model that is failing.

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There is little clarity about which services will fall into the individual directorates (in primary care, mental health, health and wellbeing, hospitals, and social care) that will replace existing HSE structures. We have not been told how these directorates will interact with each other and, most importantly, how clients with multiple needs will be served. We do not know how ongoing structural and funding shortcomings, including the need for a more systematic and planned approach to determining entitlements, staffing levels and staff-population ratios are to be resolved.

IMPACT members have welcomed the creation of the Family and Child Support Agency but, again, we have serious concerns about the capacity of the agency to deliver what has been promised, as well as the staffing levels necessary to meet new regulations on child protection.
Given the potential shortcomings in both the government’s model and the implementation of its plans, the lack of public information and consultation represents a fundamental democratic deficit. Communities, service users and staff want to be consulted about change – and can contribute to achieving popular and successful reforms. That is why IMPACT is calling for systematic consultation, including through ‘town hall’ meetings in our communities.

Recommendations

• Health policy and its implementation must be underpinned by commitments to social solidarity, respect, trust, universality, accessibility, quality and value-for-money, including the role of healthcare in reducing broader inequalities in society.

• An independent assessment of appropriate staff-patient ratios across all services should be carried out. Current ratios should be measured against these to identify the shortfalls.

• A single payer social insurance model, along the lines of those used in France, Germany and Nordic countries should be considered and evaluated in detail before the Government’s white paper on financing UHI is issued. The ‘competing insurers’ model should not be adopted before all the options have been evaluated in terms of medium and long-term value-for-money, quality, equity and access to services.

• The Government should instigate active consultation measures, including ‘town hall’ meetings, to elicit the views and priorities of different communities and service users, and to harvest the skills and experience of health staff and professions. These meetings should set out the government’s plans for UHI and governance structures with information about all the models examined by the Government.

• New governance and funding structures should not be implemented until existing underlying problems and priorities are addressed. Central to this is to shift the balance of funding to primary care services, preventative care services and mental health services. Crucially this means investing in a public healthcare system and ending the drive towards more privatisation.

• More attention needs to be given to systems for financial management, accountability, quality assurance, shared services and integration and coordination across the healthcare system, including for ICT systems.

• No matter what budgetary constraints exist, health service funding should be put on a multi-annual basis to improve and facilitate proper planning.

• A more systematic approach to collecting data on service use and demand, including in the community and voluntary sector, is essential to service planning and should be implemented as a priority.

• Full consultation over the staffing and industrial relations implication of changes in health structures and funding should be undertaken with the appropriate unions.

• The Therapy Advisory Group, along the lines of the Medical Council and Nursing and Midwifery Units, should be reinstated to ensure that all health professionals have an effective role in workforce planning and redeployment.

Louise O’Donnell, Head of Health and Welfare, IMPACT
Section 1: Introduction

1.1 Background and context

Unprecedented funding cuts¹, a growing HSE deficit that is predicted to rise to €500 million by the end of 2012, continued long waiting times, a highly inequitable two-tier system and a deterioration in the quality of care, have left the healthcare system unable to meet the health needs of the population. At the same time the cost of care is rising because of advances in medical technology, an ageing population and an increasing incidence of chronic health problems. Cuts are taking place within an already unequal and poor functioning healthcare system, typified by lack of transparency, and discriminatory and arbitrary decision-making.

Many of the underlying problems in the healthcare system existed before the cuts were imposed. Decades of underfunding, prior to the boom years, resulted in very low level of hospital beds, staffing levels for primary care and mental health services, and infrastructure for hospitals and primary care centres². The injection of additional resources for health services, between 1997 and 2008, represented a catch-up from a very low funding base. During this time the government failed to implement structural reforms and key healthcare strategies to create a universal and high quality public healthcare system, and systematically tackle the inequitable two-tier structure.

The 2011 Programme for Government set out ambitious and radical plans for healthcare. There are two main elements to this:

• Introduction of Universal Health Insurance (UHI), with the ambition to create a single-tier service with access to healthcare based on need, not the ability to pay. UHI will fund free access to GP/primary care and hospital care on the basis of the principle that the ‘money follows the patient’. (Discussed in Section 2)

• Replacing the HSE with a new governance structure based six new Directorates, which will operate on an interim basis until a new Integrated Care Agency is established. Hospitals will be formed into independent hospital trusts and a new Child and Family Agency will be created outside of the HSE. (Discussed in Section 3)

Pressure to improve the safety and quality of care through adherence to quality standards are also being implemented by HIQA on Safer Better Healthcare.

¹ Between 2008 and 2012 cuts in the health budget amounted to more than €1.8 billion (€1.75 billion in 2010 and 2011 and 2012 of €750m). The health budget stood at €12,237,369 million in 2012, with further cuts planned for 2013. The HSE deficit was €374 million at the end of September 2012; this led to the HSE imposing a €130 million cut in the HSE budget for the remainder of 2012.

² The public health service, funded through central taxation, grew four-fold from €4 billion in 1997 to €16 billion in 2008 – going some way to make up for decades of under funding. Health spending increased between 2000 and 2009 at rate of 8.4% per year, but by 2010 had decreased by 7.6% after significant public expenditure cuts were imposed as part of the IMF-EU bailout to reduced Ireland’s budget deficit.
While IMPACT members acknowledge that the government is bound by external budgetary constraints imposed by the Troika, there are key issues that need to be addressed in the healthcare system. It is also important to acknowledge the important contribution of the Croke Park agreement in delivering substantial savings for the HSE, amounting to €400 million in savings in the first two years. Without these savings, which have been made through greater flexibility, redeployment, reduced premium payments and sick leave, services would be even more stretched than they are at the moment.

Government plans for further staffing cuts raise fundamental questions about how essential healthcare services will be provided in the future. Calls for further pay cuts for public service workers, have no sound economic logic either. Pay cuts will result in lower purchasing power and further economic decline.

Consultations with IMPACT members, staff and managers in the HSE\(^3\), carried out to inform this paper, confirm the urgent need for fundamental change to address the structural and funding problems that underlie the healthcare system.

IMPACT members are concerned that the implications of the government’s plans have been ill-conceived, with unrealistic timeframes and inadequate budgets for implementation. These changes are being implemented within a system that is not functioning and that is already short of resources. As a result, it is hard to envisage how the government’s agenda to improve access to healthcare can be introduced in the light of growing deficits and cuts in services. Implementation of the government’s plans has been slow and there have been few public announcements, information or consultations with local communities, service users, patient organisations, professional associations, staff or healthcare unions. A recurring issue raised during consultation with IMPACT members was their demoralisation because successive reorganisations, health strategies and funding commitments have not materialised. They see first hand the impact of the dysfunctional system and the cuts on the most vulnerable populations.

### Views from IMPACT members about government’s plans

“There is skepticism about the government’s plans, despite a political commitment to increase resources for primary care.”

“IMPACT members working in the health sector have little or no knowledge of what is contained in the government’s health reforms.”

“If expectations are managed and services planned the concept that the ‘money follows the patient’ is welcomed, but only if there are sufficient resources. But what happens when the money runs out?”

“There is no information about how Universal Health Insurance will be organised and be funded. The danger is that if it is to be funded from the same pot of money there will be no change in services.”

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\(^3\) Four focus groups with IMPACT members, and individual interviews with IMPACT members and managers in hospitals, primary care and mental health services around the country were held in July and August 2012. In addition, an IMPACT health forum attended by over 200 IMPACT members, took place on 13 June 2012.
“There is no honesty or information about the priorities for funding and service delivery under the government’s programme.”

“There is a danger that hospitals will give lower priority in the future to the contribution of therapy staff. The lack of recognition of the value they bring to health and social care staff is likely to diminish. Indications are that the therapy staff will not be at the decision-making table.”

“IMPACT should be pressing the HSE and the Minister for a more effective system of communication of what is happening regarding the reform process.”

1.2 The underlying problems in the healthcare system

Problems exist in a healthcare system that is failing to plan services to meet the needs of the population. Unless these problems are dealt with, it is unlikely that the government’s current plans to reorganise healthcare will result in a more accountable and quality healthcare system.

There are many reported cases of poor quality services, from delays in diagnosis and abuses arising from a two-tier healthcare system (Burke 2009), to the criticisms by the Ombudsman Emily O’Reilly that the Department of Health and the HSE are responsible for a large number of cases of neglect and inequality in the healthcare system, poor quality services and deficits in accountability. Fergus O’Ferrall (2011 and 2012), amongst others, has spoken about the erosion of citizenship in the Irish Republic in relation to healthcare reforms where arbitrary and discriminatory decisions deprive citizens of access to much needed services such as home help services, and the payment of subsidies under the Nursing Home Support Scheme.

The problems in the healthcare system have been identified in endless reports, expert groups and policy initiatives. Even before the onset of the cuts, the strategic priorities set out in the 2001 Health Strategy Quality & Fairness A Health System for You were not been implemented, including the goals of ‘fair access’, defining ‘eligibility for health and personal social services’ and in promoting ‘patient-centred care’. Lack of resources and failure to shift resources into community and primary care have led to a void in implementing the far-reaching proposals for change under the mental health strategy Vision for Change (2006) and the Primary Care Strategy (2001). It has been difficult, for example, to implement chronic disease management programmes in primary care because of inadequate prioritisation of resources.

The economic crisis also has led to a higher incidence of ill-health, widening inequalities and a growing dependence on the public healthcare system, as larger numbers of people experience unemployment and reduced incomes. Cuts in services are leading to wider health inequalities and poorer access to services. This is particularly affecting people living in poverty and disadvantaged communities. As Sara Burke and Sinéad Pentony argue in their report on inequalities in health for the think tank TASC, little has been done to address inequalities in health between high-income and low-income groups, which have worsened since the economic crisis:
Regressive budgetary measures over the last three years have had a disproportionate impact on low-income groups. These measures will contribute directly to higher levels of poverty and deprivation – and thus to increased health inequalities. (2011, p.v)

In addition to rising costs associated with a higher number of medical cardholders, there has been no additional funding to take account of demographic change and the rising incidence of ill health. Increasing costs exist because there are more complex health problems, a higher burden of ill health, increasing health and social care needs, an increase in mental ill health, demographic ageing and as well as a baby boom. An ageing population puts extra pressures on healthcare and it is projected that by 2041, 1.4 million people will be over the age of 65 years. There is a 3% predicted annual growth in incidence of cancer. In addition, emergency admissions to acute hospitals were 6.7% (14,015) above the target set under the HSE’s National Service Plan.

Poor coordination of hospital and community care further reduces the quality of care. An HSE report for the Public Accounts Committee (26 September 2012) shows that over 1,532 inpatient beds (of the total of 11,200 hospital beds) are affected by delayed discharge because of a lack of services in the community or because beds have closed. Further problems arise because staffing levels and skill mix in residential units are no longer adequate to meet the higher dependency/increased acuity needs of older people.

The growth of for-profit healthcare has taken place at a time when public hospitals and primary care have been starved of resources. Driven by the property boom in Ireland, there was an unprecedented and unplanned boom in the building of private hospitals and primary care centres - hospitals were built in the grounds of hotels and primary care centres were built on sites that included shopping centres – all for profit. Co-location of private hospitals on public hospital land and tax incentives for private hospital developments have been ended. However, the Fair Deal scheme has facilitated an expanding private care market. The private sector now provides 75% of all residential care for older people. There are approximately 28,500 long-term care beds, of which about 6,500 are public and 21,500 private, representing an increase of 14,000 private beds in the last 10 years ago. This is a result of the neglect of the public sector, tax allowances for the building of private nursing homes and declining levels of funding for public provision, including capital investment for building new homes and maintaining existing homes.

For years trade unions have opposed private market strategies to fund public services. The global economic crisis raises further questions about this model of funding. In particular, the credit crisis has reduced the possibility for private funding of public-private partnerships, since the reduction in both the capacity to borrow and the cost of borrowing have led many private companies pulling out of these partnerships. Trade unions believe that future capital building of healthcare premises, including primary care centres, on this model, may be counter-productive.

The effect of the cuts on staff morale: the experience of IMPACT members

“Cuts in HSE services are hitting deeply, there have been ‘cuts upon cuts’. Pressures on staff mean that staff are near breaking point – high expectations and unrealistic demands are being made of staff.”
“Cuts are demoralising as staff are committed and devoted to their work. Staff are often dealing with people with very challenging behaviour, and the cuts will increase the vulnerability of these service users. In particular, worsening staff-patient ratios will mean that people will become more challenging because a high quality service cannot be maintained.”

“Staff morale is sinking below floor level. Services are squeezed to breaking point and the system is in chaos, but staff are expected to do more with ‘crazy’ targets in place for staff to meet.”

IMPACT members welcome the measures currently being introduced by the government to increase efficiency and reduce waiting times. A similar priority needs to be given to addressing long waiting lists for community-based services under the SDU.

Finally, the problems of planning and the arbitrary nature of the moratorium on staffing calls into question the capacity of the HSE to meet its goals. It is therefore essential that the government look systematically at current staffing levels across the HSE, including skill-mix and staff-patient/population ratios, and identify any shortfalls in order to address geographic areas and services where there are critical shortage of staff.

1.3 IMPACT’s vision of a quality and equal public healthcare system

Consultations with IMPACT members show a huge commitment to creating a quality public healthcare system. The following gives a summary of the key points raised by IMPACT members during the consultations for this paper. They emphasise the key principles that should underpin a public healthcare system based on **social solidarity, respect, trust, universality, accessibility and quality**:

- A quality public healthcare system must guarantee an equitable funding model for universal access to services, based on the principles of social solidarity, respect, trust, universality, accessibility and quality. There is a need for appropriate staffing levels, decent work and training and development, and an organisation that is able to deliver effective and timely care.

- Universal access to healthcare should aim to redistribute resources, enabling disabled people, for example, to participate fully in society and for older people to live independently in their own homes. As well as universal access to hospital and primary care services, there should also be universal provision of core social services, including residential and home based care of older people and childcare.

- A core purpose of the healthcare system should be to redistribute resources to the poorest and most disadvantaged people and communities, and through this address inequalities in health and guarantee quality healthcare services for everyone in the population.

- Workers and service users must be at the centre of the development of quality public healthcare services. This requires transparent decision-making, information and consultation, worker participation and strong collective bargaining.
• Trade unions have a central role to play in ensuring that staff providing health services are involved in and participate in helping to shape our future healthcare system. Workers can and want to bring innovation and creativity into the delivery of services and in with their expertise and experience can help develop alternative models of service delivery.

• A high quality workforce, where workers are valued and have rights to training and education and decent working conditions, is essential for the implementation of the government’s health plans. This includes the importance of valuing and recognising the contribution of all healthcare staff, including allied healthcare professionals who, unlike other health professionals, have no consultative status within the Department of Health.

• The public healthcare services should contribute to social justice and the dignity and equality of everyone. Healthcare services should be universal, equitable, accountable and user-focused. This should be the starting point to inform and guide all changes in the organisation, delivery and funding of healthcare.

The health service is currently under-resourced. The current budgetary situation means that this will continue and that services will be affected. However, it is imperative that the government starts to plan systems and structures that can deliver on the vision of a high quality healthcare system in the future and as the economy grows.

While there is little support among IMPACT members for the austerity programme currently being imposed in Ireland, they are aware of that access to funding for health and social services depends on government cooperation with the Troika programme. IMPACT members are, therefore, committed to working with the HSE to make improvements in care and introduce cost savings.

Staff have risen to the challenge to improve the quality of services through changes in working practices and redeployment. Examples of this are the introduction of clinical and chronic care programmes, improved standards of care and quality and safety, better auditing of clinical outcomes, and multi-disciplinary team working in primary care and mental health. A key concern, however, is that cuts should be proportionate, planned to have minimum impact on service delivery, and carried out in a systematic, rather than arbitrary, way. IMPACT members welcome the opportunity to contribute to a better quality healthcare system and to have their views listened to.

Using the experience of healthcare staff: views from IMPACT members

“There are some good practice developments that have led to cost savings and these should be promoted nationally. For example, the recycling of equipment is working very well in some areas and could be further developed if better ICT systems were in place.”

“We have ideas that we can feed into the system. But our views are not listened to.”

“Measures to improve the management, efficiency and cost-effectiveness of health services are welcomed, but it is important that this does not compromise the quality of care or the working conditions of health staff.”
1.4 The need for an alternative budgetary strategy

Underlying this paper is the need for an alternative budgetary strategy. This raises a broader question about the negative impact of the government's austerity strategy on economic growth. Taking more staff out of the system takes money out of the economy, dampening down the possibility for economic growth. Health services play an essential role in creating social inclusion, equality and social cohesion (OECD 2011a). Health services play a key role at a time of economic crisis in mitigating the health and social consequences of higher unemployment and economic distress.

The pressures facing the public sector, and particularly the health sector, in Ireland are not unique. The economic crisis has forced the public sector in many countries into a crisis fuelled by significant cuts in expenditure, jobs and wages. A recent ILO study (Vaughan-Whitehead 2012) on the impact of cuts in the public sector shows a common pattern across many countries typified by quantitative adjustments leading to expenditure cuts, cuts in employment and a trend to outsourcing, privatisation and rationalisation of the public sector. While these adjustments are having a devastating effect on pay and working conditions, more worrying is the long-term threat to the public sector and the future of collective bargaining. This needs to be underpinned in an approach that goes beyond immediate austerity measures and to a discussion about how fiscal measures can be used to promote economic growth, equality and social cohesion, and quality healthcare services.

Uniform cuts across the public sector have led to widening inequality, with many of the lowest paid women workers experiencing the greatest hardship. These cuts have also undermined the important role that the public sector has played as a model employer, typified by collective bargaining and employee participation, and good pay and working conditions. Collective bargaining can be an important instrument to reduce wage inequality, which in turn promotes growth. According to the ILO, widening wage inequalities in the UK and the USA are directly attributed to a decline in union membership and in the numbers covered by collective bargaining agreements. In contrast countries that have high levels of political support for collective bargaining, such as in Denmark, Finland, France, the Netherlands and Sweden, there is a much smaller gap with regards to wage inequality. This is also the case in relation to productivity and performance where changes in work organisation or working time are negotiated with workers and their representatives.

In Ireland there are growing calls for the government to implement an alternative budgetary strategy that increases domestic demand and purchasing power, and reduces income inequalities and unemployment (NERI 2012, ICTU 2012). Noble prize winning economist and former IMF chief economist Joseph Stiglitz (2012) is amongst a growing number of economists who argue that cutting spending, reducing taxes and reducing the role of government destroys domestic demand and jobs, and widens inequality. In his earlier report for the United Nations (2010) he suggested that sustainable recovery needs to be democratic, equitable and inclusive. The Nevin Economic Research Institute (NERI 2012) has reviewed the evidence and found that, “Loss of income, jobs and continuing erosion of purchasing power is depressing demand” (p. i). On top of this
Austerity budgets have dragged down domestic demand and income levels, which has delayed recovery. In 2012 private sector employment fell by 0.3% but adjusted public sector employment fell by a significant 5.1%. Further cuts of €3.5 billion, planned in December’s budget, will further reduce GNP and domestic demand.

There is also growing international evidence that austerity is not a solution to the economic crisis. This has led to a shift in thinking across Europe about the need for a coordinated fiscal stimulus for Europe. Recent commentary by the conservative Lex column of the Financial Times concluded that the impact of arbitrary and savage cuts in Ireland means that the "cure is as likely as is the disease to kill the patient." In October 2012 the IMF said that austerity measures are not working alone and need to be balanced with measures to stimulate “balanced and sustainable growth.” With worse economic forecasts than projected for 2012, the IMF found that countries that have engaged in austerity measures and spending cuts have done more economic and social damage than expected.

NERI estimates that a cut of €1 billion in public spending would reduce GDP by 0.6% in one year and a cut of €1 billion in capital spending would lower GDP by up to 0.3%. Reduced revenue will be the knock on effects of lower employment levels in the public sector. There will be a loss of revenue from income tax, USC and PRSI arising from higher unemployment and lower incomes, lower VAT and excise receipts arising from lower consumption, and other revenue losses from reduced domestic demand (NERI 2012). As well as recommending maintenance of the capital investment programme, NERI proposes that Budget 2013 shift fiscal adjustment from public expenditure cuts to revenue raising. This would provide an increase for government revenue by one percentage above the planned level, to 36.5%. This would be achieved through a narrowing of tax reliefs and credits for household with incomes in excess of €100,000 annually. In addition, NERI suggests that a continuous review of public expenditure should be carried out with a view to reducing waste and redirecting savings to priority areas such as mental health.

According to ICTU (2012) an imaginative and innovative approach to promoting investment could reduce both the deficit and the national debt, and stimulate economic recovery. ICTU’s proposals are based on an increase investment in GDP by 2% each year, or €3 billion, for three years, in addition to the commitments made under the Public Capital Programme. This would be funded through a combination of public, private, European and international funds, including pension funds. Jobs are key to this and this strategy is expected to create 30,000 jobs per annum. In the health sector the building of 30 primary health care centres could create an estimated 2671 jobs, while the construction of the National Children’s Hospital could create 2750 jobs.

An alternative budgetary strategy, as proposed above, needs to be seriously considered by the government. This would provide an opportunity to resolve many of the underlying problems in healthcare. It should open the doors for a fundamental rethink about the values that underpin our healthcare system, the contribution that health makes to the public good and allow for innovation and creativity to flourish. Most importantly it would enable Ireland to implement reforms for a world-class, public universal health care system that is capable of addressing inequalities in health and in meeting the healthcare needs of future generations.
The government’s current austerity strategy in health places huge constraints on the realisation of the government’s planned changes in the funding and governance of health care. The achievement of a single tier universal healthcare system to be funded by Universal Health Insurance and the replacement of the HSE by a new directorate structure, all have resource implications. Similarly implementation of these structural changes, through a privatized model of healthcare funding, should not inhibit the potential to meet the ambitions of a quality public healthcare system when economic circumstances improve.
Section 2: Universal Health Insurance

Summary

Universal healthcare is welcomed by IMPACT members, but will only work if the right funding model is put in place. If implemented through a social insurance model and a public ethos of ‘social solidarity’ it will put an end to the deeply inequitable two-tier healthcare system.

The government’s intention is to introduce Universal Health Insurance (UHI) through a competitive market model of insurance. This is planned to be the source of funding for one-tier universal healthcare on the principle that the ‘money follows the patient’. UHI is to be introduced on a phased basis for free access to GP and hospital care by 2016.

The government plans to fund UHI through a competing private sector insurance model are deeply flawed. The implications of this model and its implementation in Ireland have not been fully analysed. Lessons from the Netherlands show that a profit driven commercial model leads to an inequitable and inefficient system of funding, different tiers of entitlement and rising hospital deficits.

Delays in implementing the government’s plans for UHI indicate that the system has been poorly thought out or costed. Funding constraints arising from current austerity measures will make it difficulty to implement UHI.

An alternative is recommended, based on a single payer social insurance model, along the lines of suggestions made by a growing number of social justice organisations in Ireland. A social insurance model would provide an equitable one-tier funding model capable of providing equality of access and a ‘right to health’ in Ireland.

The government is urged to consider the social insurance model prior to issuing its planned White Paper on Financing UHI. In the light of the need to plan for an equitable model of healthcare financing, the government is urged to consult widely with the public, trade unions, professional associations, service users, community organisations and patients’ organisations.

It is vitally important to have the best model for a high quality, accessible and affordable universal healthcare system that will meet the healthcare needs of the population in the future. This means costing out the implementation of UHI, putting in place a system of risk equalisation and ensuring that there are sufficient resources from taxation to provide UHI for young people, older people, people with disabilities and long-term sickness and people who are unemployed.

The introduction of UHI will incur substantial costs to the government. However, introducing UHI through a commercial insurance model should not be seen as a cheap option. Neither should this be a reason for adopting the wrong model. Implementing the wrong model will have ramifications for the healthcare of future generations. A realistic timetable for a phased introduction should be planned for. This should set out in a transparent way the costs of setting up and implementing a social insurance model.
2.1 Introduction

The first pillar of the government’s plans is the introduction of Universal Health Insurance. The Programme for Government says that ‘this government is the first in the history of the State that is committed to developing a universal, single tier health services, which guarantees access to medical care based on need, not income’. The Programme for National Recovery (2011) states that:

The Universal Health Insurance system will be designed according to the European principle of social: access will be according to need and payment will be according to ability to pay. The principle of social solidarity will underpin all relevant legislation.

Universal Health Insurance (UHI) aims to create an integrated system of primary and hospital care by replacing the current two-tier structure with a one-tier structure by 2016. In 2016 the integration of care will be the responsibility of an Integrated Care Agency, under the aegis of the Minister for Health. UHI will require that workers and employers pay into a UHI Fund, yet to be determined, and risk equalisation will be ensure that health insurers cannot refuse any person because of their age, disability of health need. UHI will provide the system for hospital funding and access to free GP in the future on the basis that ‘money follows the patient’. The objective is that patients are not seen as a cost, but a source of income. The government will also subsidise the system by paying premiums for people on low income and partially subsidising payments for people in middle incomes.

The current inequitable two-tier healthcare system

Ireland’s two-tier healthcare system, which results in public patients having to wait longer for healthcare and endure longer waiting lists, is unfair and inequitable. The inefficiencies in the system mean that resources are not always directed to the people and the areas where they are most needed. The result is that those that can afford healthcare can be fast-tracked through the system, while poorer people experience discrimination in access to healthcare. One of the most inequitable elements of the two-tier system, unique to Ireland, is that people with insurance get faster access to the public healthcare system.

According to Amnesty International (2011) medical card holders are three times more likely to be on in-patient hospital waiting lists and nearly 50,000 people living in consistent poverty do not have a medical card. One in five people are denied or delayed access to healthcare due to cost. In study by O’Reilly et al (2007) around 18.9% of patients with medical problems did not consult a doctor because of cost; this is likely to be much higher in the current economic crisis with much anecdotal evidence showing the impact of reduced household income on access to GP care. People are less likely to visit their GP and access primary care services in the Republic of Ireland, compared Northern Ireland, where access to GPs is free (MacGregor et al. 2001). In the Republic GP fees lock care into a GP delivery model, preventing an alternative and cost-effective model of care provided by primary care service providers.
One of the problems with the current system of primary care is that over 60% of the population currently pays GP fees. According to the Report of the Expert Group on Resource Allocation and Financing in the Health Sector (2010) “Payment for healthcare at the point of use conflicts with the goal of developing continuity of care...User fees are regressive, posing a greater burden on patients with lower incomes.” However, GP fees add only 2% of overall health funding and prevent delegation to lower cost care and primary care services. The high costs of GP care has resulted in higher usage of accident and emergency services and in the long-term more expensive hospital care. Removing GP fees has the potential to improve access to primary care services and early diagnosis.

2.2 The timeframe to introduce UHI

The government plans to introduce UHI on a phased basis. Starting in 2012 access to free GP care was to be introduced for claimants of free drugs under the Long Term Illness (LTI) scheme, for which €15m funding was provided in Budget 2012. However, the implementation of this first phase has already been stalled and implementing legislation had still not been issued by the autumn of 2012. There is no information about the implementation of the second phase, planned for 2013, or whether access to subsidised care for all patients accessing GP and primary care services will be implemented in the third phase by 2015. There are remaining doubts whether it will be possible to meet the target to introduced free GP care for everyone by 2016. When implemented all patients will be required to register with a primary care team and GP fees will be replaced with annual capitation fees.

An Implementation Group in the Department of Health is overseeing the development of proposals for UHI, including the services and functions to be covered under UHI. However, there is very little information about progress made to date. Indications are that there will be a competing market for insurers and the current VHI will remain in public ownership in order for it to provide a public option in the UHI system.

It is planned that UHI will be extended to hospital care by 2016. This will be established through a Hospital Insurance Fund, which will subsidise or pay insurance premiums for those who qualify for subsidy. It is also questionable whether the plans to introduce UHI for all patients to public and private hospitals will also be implemented by 2016. To work in practice the Hospital Insurance Fund will need to implement a system of community rating and risk equalisation so that public hospitals can also be paid for services that are not covered by insurance such as EDs and ambulance services. Controls will also need to be put in place to prevent independently governed hospital trusts, individually or in cartels, increasing the costs of care, which cannot be reimbursed through insurance. Similarly, controls on insurance premiums will also need to be put in place to avoid the situation that has arisen in the Netherlands, where hospitals have run into deficit or have closed down because of insufficient funding generated from private insurance companies.

A White Paper on Financing UHI, planned during the government’s first term, has not been published. This will form the basis for a Universal Insurance Act, which will set out a pricing system and funding mechanism to guarantee what will be covered under the UHI and will require competing insurers to provide the same package of services. One of the dangers is that if private insurance companies compete to sell insurance on the
basis of the quickest and cheapest access to healthcare possible, that the quality of healthcare provided will be compromised to save costs. This raises important questions about why a competing market is necessary for UHI, and why a social insurance model, as exists in many European countries cannot be introduced.

The shift from the current taxation funding model to a system based on UHI has huge administrative, organisational and funding implications, and not least vested interests that will need to be dealt with. For a commissioning model to work there will be a need for a new agreement on GP contracts, waiting lists will need to be reduced to zero, as well as a radical reorganisation of services, investment in ICT and new management systems. Getting the model right is essential if the vision of quality, accessibility and affordability in healthcare are to be met.

2.3 Getting the model right

Models of healthcare financing

There are four models of healthcare financing. Some countries have a mix of different health financing models, while others rely on one model. In Ireland, there is a mix of tax based financing, private insurance and out-of-pocket expenses.

| Tax based model |
|-----------------|--------------------------------------------------|
| The tax based funding model for universal health care is often known as the ‘Beveridge Model’, based on the system which established the UK’s National Health Service. Healthcare is provided and financed by the government through national taxation. The government is the sole payer and controls are in place for charges levied by doctors. In most cases hospitals are publicly owned. This system is also in place in many of the Scandinavian countries in a modified form, and in Cuba and New Zealand. Currently the public healthcare system in Ireland, including medical cards, is funded through the tax-based model. |

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<th>Social insurance model</th>
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<td>The origins of social insurance were established by Bismarck in Germany in the 19th century, often known as the ‘Bismarck Model’. Healthcare is funded through a social insurance model organised through social insurance funds that are financed jointly by employers, employees and in some cases the state. Many of the social insurance funds established across Europe grew out of the solidarity movement led by trade unions to provide health and welfare services for workers and their families through ‘sickness funds’. Social insurance funds or ‘sickness funds’ are universal in coverage, and healthcare is financed and administered on a not-for-profit basis. In many cases, the funds are managed by employer and worker representatives, under government regulation covering standards, coverage, contributions, risk equalisation and costs. This helps to give a focus and voice to patients on the quality of care. The costs of healthcare for the non-working population and subsidised costs for people on low incomes are covered by the government. In some countries there are multiple funds that administer social insurance and costs are controlled and regulated by the government. In this model hospitals are often privately owned but regulated and funded by the State. The social insurance model exists in Germany, France, Belgium, Japan, Switzerland and the Netherlands. In some countries, including the Netherlands, social insurance is organised through competing commercial insurance companies. In others, including France,</td>
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Germany and Belgium social insurance funds are organised through non-profit social insurance funds, managed by workers and employers. The World Health Organization has rated the French and Japanese social insurance models as being best practice models for positive health outcomes, and for the delivery of effective and equitable healthcare.

**The National Health Insurance Model**
This system has elements of both of the above models, with healthcare provided by private-sector providers and financed through government-run insurance programmes. These programmes are universal in coverage and not-for-profit, and are based on a single payer model. A single payer model has advantages in driving down costs, for example, from pharmaceutical companies and by controlling costs by imposing limits on the medical services that will be paid for. The National Health Insurance model is found in Canada and Australia, and has been introduced in some recently industrialised countries such as Taiwan and South Korea. In Canada, the Canada Health Act, introduced a publicly funded health care system funded by health insurance plans and delivered by public and private providers. The Act sets out criteria and conditions for the delivery and funding of healthcare by provincial governments. An annual increase in funding of 6% is set in legislation. It provides a universal, comprehensive and rights based healthcare system.

**Private Health Insurance model**
In this model healthcare is provided through private health insurance, in what is largely a private market for healthcare. This is most typical in the USA, but elements of this exist in many countries, including Ireland.

In addition to these four models many developing countries, which have insufficient funding to provide government financed universal healthcare systems, rely on out-of-pocket expenses to fund healthcare. In some countries, including Ireland, certain elements of healthcare are paid for through out-of-pocket expenses. Ireland is unique amongst comparable countries in its absence of universal system for financing GP care.

**Overview of the Dutch model**
In the Netherlands healthcare is financed through a system of compulsory private health insurance, provided by competing private insurance companies who purchase care from hospitals and care providers. This is the model preferred by the government.

In 2006 National Health Insurance legislation introduced a system of managed competition of health insurance, resulting in a merger of private insurance and the public sickness funds into one system. Managed competition is defined as a system in which consumers have free choice of health insurers, health insurers contract care providers, and competition is regulated by government to ensure the public goals of universal access to affordable care of good quality. In effect, insurance companies compete for clients, while healthcare providers compete with each other for the best services for the insurance companies. The average annual premium in 2009 was €1,065. Contributions are income related and have risen over time to 6.9% for the first €32,369 of annual taxable income. There has been a 40% increase in contributions over the last four years and certain packages of care have been removed from insurance coverage in order to
reduce costs further. Additional funding is provided by the government to compensate insurance companies for higher risk patients or children under the age of 18 years.

The basic package of healthcare covered by the insurance companies is regulated by the Dutch state regulator, NZa. Complementary insurance can be taken out for care and treatments not covered by the national insurance scheme, for example, for dental care or physiotherapy. There are concerns that more services will move from the national to the complementary insurance as costs rise.

Most Dutch hospitals are not for profit Trusts and in many cases hospitals have merged in order to influence their power in negotiations with the insurer. However, the anticipation that market competition would control costs has not materialized, rather several hospitals have run into deficit and several hospitals had to be bailed out by the government after they faced bankruptcy. One of the positive aspects of the 2006 Act has been better regulation of generic drug prices, with costs falling by between 76% and 93%.

Healthcare unions in the Netherlands are unhappy with the system; it has created a three-tier healthcare system, with differential levels of access to services offering varying levels of entitlements. Spirally costs had led to some hospitals and care companies going into deficit and entitlements being reduced. The Dutch healthcare unions argue that the danger of organising health insurance through a private and competitive market results in costs being driving down to maximise profit, rather than opening up healthcare for all.

The relevance of the Dutch model in Ireland

IMPACT members believe that the Dutch system has many problems and should not be replicated in Ireland.

At IMPACT’s Health Forum, held on 13 June 2012, Louise O'Donnell warned the Minister of Health to learn from the lessons abroad:

“Government plans to introduce UHI and hospital clusters run by trusts could become expensive failures if lessons from abroad are ignored….the Dutch model of UHI has created an under-resourced three-tier health service. The system has not provided a universal and equitable service, where up to half a million people are uninsured or unable to pay insurance payments. In parallel there those that can afford to have private health insurance. The impact of this is that more than half of Dutch hospitals, which are funded through UHI, have faced bankruptcy, while others have closed.

First, there are substantial costs in setting up the system. The Netherlands had a historically had a well-funded healthcare system. Prior to introducing the system in 2006 considerable resources, amounting to €5 billion, was injected into the system to reduce waiting lists. Additional resources were also put in place to establish the system and recruit an additional 500 tax collection staff. However, by 2010 approximately 136,000 Dutch people, many of whom were of working age, were not insured for medical costs.

Second, are the problems inherent in a commercially driven system induces demand for services. One of the problems with Dutch model is that is has resulted in supplier-
induced demand; more procedures and tests are carried out because they are profit driven. This is inherent in a system that moves from an ethos of public service to one based on financial incentives. In the Netherlands there is evidence that the drive for lower costs has increased demand for services, induced by providers. There may also be implications for smaller hospitals or hospitals in rural areas as decisions about commissioning healthcare will be in the hands of insurance companies.

In an Irish context there are advantages to a system of UHI where the ‘money follows the patient’ by improving access to healthcare in the first instance. However, there may be additional pressures on hospitals to discharge patients early or to limit the time given to health promoting interventions in primary care. Although the Dutch system has led to shorter waiting times and quicker access to consultations and elective procedures, it has also resulted in early discharge of patients, with the country now ranked second in Europe where patients are most likely to be hospitalised due to a complication after discharge (OECD 2012). It is anticipated that Irish scheme will lead to shorter hospital waiting times and waiting lists, because the money will be with the patient, but could result in earlier discharge from hospital and may increase waiting times for GP and primary care services. However, what happens if the money runs out and there is no money following the patient or if certain entitlements are withdrawn from insurance coverage?

The Adelaide Hospital Society’s (2010) has warned against a private health insurance model:

The evidence to date suggests that private health insurance companies do not yield greater efficiency and cost control. Rather they add to costs and layers of administration for both providers and governments: fractured payment systems mean multiple claims databases and tend to subvert quality improvement efforts while adding to costs. (2010: 6).

Competition between insurance companies is likely to create additional financial and administrative costs and problems with risk equalisation. Organising UHI through a private insurance model is risky if there is no guarantee against rising insurance costs and/or reducing the procedures and treatments that are covered under insurance. In 2011, private health insurance costs in Ireland went up between 15% and 45%; there may be similar dangers associated with UHI.

Third, managed competition in the Netherlands resulted in the introduction of a state regulatory body. Having a strong and well-resourced regulatory body would be essential in Ireland and would require investment in IT systems to ensure that patient information is readily available on-line. Similarly, IT systems will be needed to ensure that there is an integrated system in place for patient information and records.

Fourth, there are also questions about how the government will deal with insurance companies who have underpriced their products or hospital trusts that go into deficit. There are concerns in the Netherlands that private sector interests are undermining the Dutch tradition of social solidarity and that financing healthcare through the private market undermines the core public values of quality, affordability and accessibility.
This differs from the approach taken in Germany where the insurance system covers 100% of the population who have access to universal healthcare, based on need rather than ability to pay. There is a mix of public and private insurers and also public and private providers. Contributions are income related in the public system and the law sets out rules of fairness and transparency. All public and private providers operate within the same legal framework and the rights of service users are governed by the Social Code. The system works efficiently, there is timely access to care and there are no formal waiting lists.

2.4 The merits of a social insurance model for Ireland

An effective and equitable social model of insurance should be put in place for UHI, with rights under UHI enshrined in legislation, as recommended by TASC, Amnesty International and the Adelaide Hospital Society. Plans for UHI, based on the Dutch model of universal healthcare, will not produce the outcome of a truly universal and accessible health service. Equitable universal healthcare programmes in other countries appear not to have been considered by the Minister of Health as viable alternatives. The problems inherent in the market-led Dutch social insurance system and alternatives to this model need to be more thoroughly reviewed by the government.

In this light the social insurance model needs further examination for its relevance to the Irish healthcare system and for the merits that the model has in improving health outcomes, reducing health inequalities and in providing the ‘right to health’ (Cummiskey 2008, Burke and Pentony 2011, O’Ferral 2012).

Policy papers commissioned by the Adelaide Hospital Society give evidence-based options for an equitable model for universal healthcare through a social insurance model (Thomas et al. 2006, 2008 and 2010). As Thomas et al. (2008) argue in their paper for the Adelaide Society options for a social insurance, including a ‘Rolls Royce’ option for a comprehensive social insurance system, which upgrades access to healthcare, deals with capacity problems and provide universal access to hospital and primary care services. This would require a €2 billion increase in running costs (at 2006 prices), representing an increase from 7.5% to 8.9% of GDP in health expenditure, which they argue is still low compared to countries such as France and Germany that fund healthcare through social insurance. Introducing UHI will be complex and will need to be phased in over time. They argue that a phased approach should be implemented beginning with free primary care to children, then families on average and lower incomes and finally the whole population. Similarly, hospital insurance should be phased in starting with all families on average or lower incomes or those in employment who have no insurance or medical card, followed by medical cardholders who do not have insurance, and finally the whole population.

It is timely for the government to examine the social insurance model of health financing and to examine research and evidence-based policy proposals on this model. In particular, the Adelaide Hospital Society’s (2010) policy paper on UHI sets out a useful blueprint for an equitable model of social health insurance based on ethics of dignity, equality and social solidarity. A New Covenant in public services is proposed based on a planned and phased system and with a focus on equity and human rights. It is recommended that a Social Health Insurance Authority be established to provide the design and strategic framework for social health insurance, with wide public consultation.
about the ‘basked or goods’ to be covered by social insurance. A single payer system is also recommended, based on a not-for-profit Social Health Insurance Fund, covering both primary and hospital care. This would provide the incentive for greater efficiencies, cost savings and integrated care, including better care at lower costs.

It may be unrealistic to expect social insurance to be funded entirely from a declining working population. In Germany, for example, an ageing population and increasing costs of healthcare means the government now contributes resources directly to help finance the costs of social insurance. Other more innovative systems of income generation should be considered, for example, as backed by trade unions across Europe through a Financial Transaction Tax (based on a tax on foreign exchange transactions in order to finance budget deficits and avoid further austerity measures). The World Health Organization, for example, has also proposed innovative forms of income generation through taxes on tobacco and alcohol that are used for health expenditure. As well, the WHO suggest that in most healthcare systems 20-40% of resources are wasted because of inefficiency, including overspending and over-servicing through unnecessary procedures being carried out, resulting from fee-for-service payments to health practitioners, overpriced drugs or inefficient procurement of medicines or equipment (WHO 2010). Efficiencies in the planning of services that take account of health needs and matching them with appropriate services, are also important to promoting cost-savings, efficiency and quality (WHO 2012). Finally, there needs to be a new social contract, that commits citizens and the State to a progressive taxation system to complement social insurance and generate the additional resources required to implement healthcare strategies and priorities.

2.5 Conclusions and recommendations

Getting the model of healthcare financing right from the start will be important to achieving a high performing and equitable healthcare system. Equally important is the need for transparency and public trust in a health system that is fraught with problems of accountability. The principle of universal health care, based on equal access for all needs to be developed in line with a funding model that will genuinely provide universal and equal access to health services. The social insurance model, rather than a model based on competition between private insurance companies, would be more likely to achieve this. IMPACT members have highlighted some of the inherent problems with the model of UHI proposed by the Minister, including a lack of public engagement on the issue. IMPACT members believe that if the correct model of UHI it introduced this will help to shift the model of care from GP-led care to multi-disciplinary teams. This will be important to preventing health problems and expensive hospital care. Removing financial barriers to healthcare is good for people’s health and has the potential to reduce the longer-term costs of hospital care.

Recommendations:

• The funding model for healthcare envisaged by the government under single-tier UHI model should guarantee universal access, equity, quality, affordability, value for money, and efficiency.

• The government is urged to examine and consider the merits of a single payer, social insurance model that guarantees rights to UHI for everyone. It is essential that
this be carried out prior to the publication of the White Paper on Financing Universal Health Insurance.

- A single social insurance fund should be established and funded through employer and employee social health insurance. The social insurance fund should be governed with representation from union, employer and patient/service user bodies. This should be supplemented with general taxation to ensure that all health commitments are funded in full and everyone in the population, regardless of their ability to pay, has equal access to healthcare.

- A comprehensive package of services covered by UHI should be set out in legislation and should cover entitlements to home care services, hospital care, rehabilitation, mental health services and health promotion services. The Adelaide Hospital Society’s proposal for an initial ‘basket’ of guaranteed services to include primary care, medicines and acute hospital care and treatment provide a good example of the minimum services that should be included as part of UHI.

- There is a need for information on how UHI will operate in a primary care context and for clear proposals about the future funding of primary care services.

- Entitlements to UHI should be set down in legislation on the fundamental ‘right to health’, as recommended by Amnesty International, and as enshrined in the Universal Declaration of Human Rights and Article 12 of the International Covenant on Economic, Social and Cultural Rights.

- The Minister for Health is called on to carry out a public consultation exercise on UHI with the public, service users, patients’ organisations, staff, professional bodies and trade unions.
Section 3: The new governance model

Summary

The government’s plans for a new governance model for health are discussed in this section. This includes the development of a new Directorate under the Department of Health.

This new structure is to be funded on the basis of the principle that ‘the money follows the patient’, which the government plans to be funded through Universal Health Insurance. As the discussion in Section 2 on Universal Health Insurance showed, IMPACT members do not believe that the commercial insurance model, advocated by the government, will not create an equitable quality universal healthcare system.

IMPACT does not believe that the government’s plans to create new independent hospital trusts will lead to a better system of healthcare and integration between hospital and community care services. The government’s plans have the potential to open the doors to further privatisation in healthcare.

The first stage of creating independent hospital trusts has begun. However, there has been little discussion about the budget and staff ceiling for each trust, the organisation and management of clinical care programmes and whether area-based hospital trusts are the right model.

The creation of the new Family and Child Support Agency is one area of the government’s reforms that is welcomed by IMPACT members. However, adequate staffing levels are needed to meet new regulations on child protection.

Other planned changes through Directorates in primary care, mental health and social care have not been implemented yet. IMPACT members are very concerned about the legacy of continuing underfunding and poor planning in these areas.

There are also important structural and funding issues, including a more systematic and planned approach to determining service user entitlements, adequate staffing levels and staff-population ratios, which need to be resolved in advance of further changes.

Overriding many of these problems is that lack of public information and consultation about the government’s plans. IMPACT members want to be consulted and involved in any change and call on the government to initiate an informed public debate about its plans.
3.1 Introduction

This section gives an overview of the government’s plans for a new governance model and highlights the views of HSE managers and IMPACT members about the changes and their concerns about how they will create a genuine and lasting impact on healthcare. What will the new governance and organisational structure look like? How will it function as a whole? What will need to be done to ensure that it meets IMPACT’s vision of a quality public healthcare service?

3.2 Overview of the new governance structure

The new governance model was introduced in 2012 to replace the current HSE Board / Chief Executive structure of the HSE. This is to be replaced by a new Directorate made up of a Director General and six Directorates organised along service lines (primary care, mental health, hospitals, health & wellbeing and social care, and a new Children and Families Agency).

These provisions are set out in the Health Service Executive (Governance) Bill 2012, published on 18 July 2012. According to the Minister of Health, James, O’Reilly: “this new Directorate structure in the HSE will allow us to redesign the system to put the needs of the patient front and centre.” The Director and six Directorates will be accountable to the Minister and while the HSE is still in place the Minister has stated that he will specify priorities and performance targets for the HSE.

The transitional structure, headed up by the Minister of Health can be seen in Chart 1.

![Chart 1: The new HSE governance structure](chart.png)

Source: Department of Health
The new Directorate structure will be responsible, on an interim basis, for financial, service and structural changes, including overseeing a purchaser-provider split in the health system. The old HSE Board stepped down in March 2011 and a new interim Board has been appointed. The plan is that the HSE will be replaced by a new Integrated Care Agency by 2014, under the egis of the Department of Health. The Minister of Health has taken over responsibility for the HSE, but confusions remain about who is in charge, how decisions are to be made and who has the ultimate responsible for the delivery of services. There is no clarity about how services and clinical care programmes will be coordinated under the new Directorate structure, which will operate as a transitional structure, and how it will be carried forward under the new Integrated Care Agency by 2014.

**Problems and confusions inherent in the new governance structure**

IMPACT members have highlighted the risk that separate directorates will lack coordination and integration, and that the transitional structure will fail to deliver. IMPACT members also are concerned that service users may slip between services if there is poor integration across the Directorates, for example, where a person has a dual diagnosis and require services from one or more directorate. There are also uncertainties about whether the structure will facilitate better integration between hospital and primary care services.

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**The new governance structure: Views of HSE managers**

“One of the problems with the new governance structure is that it reinforces ringfencing of funding into specific ‘care’ groups that people don't necessarily fit into or for whom services are not coordinated. If a person has an intellectual disability and a mental health difficulty there is no service that takes account of their dual disability – they are either cared for under disability services or under mental health services.”

“The buck is passed from one service to another; this will be worse in the future as everyone will be fighting for resources between one directorate and another.”

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The remainder of this section looks at the implications of the new governance structure for hospitals, primary care and community based health services. It draws on the experiences of IMPACT members and managers in the HSE, and highlights what needs to be done to ensure that the government’s plans lead to a genuine and lasting impact on the quality and accessibility of healthcare in Ireland.

**3.3 The role of hospitals and hospital trusts**

**Overview of the government’s proposals for hospital trusts**

Under the new governance structure public hospitals will no longer be managed by the HSE, but will become independent, not-for-profit trusts. CEOs and managers will be accountable to their Boards. Boards will include representatives of local communities and staff, and will be responsible for corporate and clinical governance structures, systems for quality and safety of care and staffing. Each trust will have a single budget and a single ceiling on staff. The Minister has indicated that the Boards must be open
and transparent to the public, including the holding of an Annual General Meeting in public from 2013. Arrangements should be made to ensure that staff and patient advocates can raise concerns about patient care and safety. The Minister of Health has said that this will ensure local accountability and for the community, health staff and managers to have a voice in governance and planning.

UHI, it is proposed, will provide the source of income for hospital trusts by 2016. As the Programme for Government states:

> The system should be both fair and efficient. While value for money is vital, the ‘not for profit’ ethos must remain at the heart of the Irish health system, with the State acting as guarantor for high standards and quality. In addition, although public hospitals will become independent trusts with local representation, the land and assets will remain in the ownership of the State.

This marks a significant shift from the centralisation of healthcare financing and delivery. Public hospitals will continue to be owned by the State, but will operate as semi-state companies, independently governed and managed by local hospital trusts. The government’s objective is that groupings of hospitals into trusts will lead to greater efficiencies, cuts in waiting times and reduced pressure on front line staff. Groups or networks of hospitals in a geographic area will work together to improve access to treatments for patients. The logic of this is that three hospitals working together in an area will be able to provide better care than one hospital.

Hospital managers interviewed for this policy paper were of the view that hospital networks are a positive way forward, providing opportunities for more shared services and coordination of outpatient appointments across a network. However, there is a concern that there are huge variations between hospitals in the proposed networks, which may benefit some hospitals and not others. In the current climate of planning inertia, the moratorium on staffing and the lack of a systematic approach to implementing budget cuts, some hospital managers question the logic of creating a new hospital structure, without these underlying issues resolved. Some see the system as becoming overly complicated. As one hospital manager said, “It is convoluted. There are so many people we report to but no one overall decision-maker.” Another said, “We no longer know who the boss is, there are no clear lines of accountability.”

The trust model will create a purchaser (insurance company) – provide (hospital) split. The rationale is that hospitals will be paid on the basis of the care they provide on the principle that the ‘money follows the patient’. Insurance companies will negotiate directly with hospitals.

Hospital networks are not new in Ireland. However, the government’s programme anticipates a very different structure through the formation of area-based networks, and eventually independent, self-governing trusts. Some hospital managers question the logic of the hospital network groupings, particularly because some hospital groupings have already been established outside of the HSE or are under discussion. The hospital
groupings that have been established outside of the HSE have tended to be along specialty lines rather than groupings of larger and smaller hospitals.  

The first hospital merger under the government’s programme took place in the West in January 2012. The group includes University Hospital Galway, Merlin Park Hospital, Roscommon General Hospital, and Portiuncula Hospital in Ballinasloe. All the four hospitals have a single budget, governance structure and employment ceiling. Plans are current in place for the merger of six hospitals in the Mid-West (Mid-West acute hospital network) covering Limerick Regional, St John’s Hospital, Ennis General, Nenagh General, the Maternity Hospital, Limerick, and Croom Orthopaedic. Other plans are in place to join St James’s Hospital with Tullamore and Portlaoise Hospitals and to join Beaumont and Connolly Hospitals. A final list of hospital networks will be published early in 2013 and negotiations are ongoing with all hospitals across the country.

Under discussion is whether each network can include one large teaching/academic hospital, providing a centre of excellence within the network. However, this may not be possible for all trusts. For example, proposed merger of Sligo and Letterkenny hospitals into a single Trust may diminish the reputation of the network, and its ability to attract the best staff, as there is no obvious teaching/academic hospital to link with. This situation and the geographic proximity of Donegal to Northern Ireland, has also led to proposals for cross-border mergers between hospitals in the Republic of Ireland and Northern Ireland. The implications for staff will also have to be discussed further as trusts are formed. This may be relevant if some trusts make decisions to locate specific services in one hospital or if a larger hospital in the group takes on specialist services.

A further concern is that groupings of hospital in trusts could have implications for smaller hospitals, with the potential for them to be closed in order to implement efficiency savings. This has been of concern to smaller hospitals in the hospital network in the West. However, if managed effectively, if the money is to truly follow the patient and if services are to be provided as close to patients as possible, and linked into primary care services for routine healthcare, this situation can be avoided.

Although trusts will be independent, the government still plans to impose a staff ceiling on each trust. Problems may arise if trusts seek to use their budgets to attract new hospital managers and directors on higher salaries than currently exists. This may result in reductions in staffing levels for middle management or administrative/clerical level

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4 For example, Cork University Hospital Group has a network of three hospitals (Cork University Hospital, Mallow General Hospital and St Mary’s Orthopaedic Hospital); while St Vincent’s also coordinates services of two smaller hospitals in their area (St. Columcille’s Hospital, Loughlinstown and St. Michael’s Hospital, Dun Laoghaire). Other hospital mergers are currently under discussion outside of the HSE. In Dublin, one merger between the Mater Hospital, the Children’s University Hospital and Cappagh National Orthopaedic Hospital is being discussed, as is a second grouping involving Beaumont Hospital, Connolly Hospital in Blanchardstown and Our Lady of Lourdes Hospital in Drogheda. There are also long-standing plans to establish the Dublin Academic Medical Centre (DAMC), involving the merger of the Mater Hospital and St Vincent’s University Hospital into a single hospital structure, with University College Dublin. A Dublin North East Neonatal Network has also been launched, including Rotunda Hospital in Dublin, Our Lady of Lourdes Hospital in Drogheda and Cavan General Hospital. The regional network aims to improve the quality of maternity services, particularly in relation to premature delivery.
positions, in favour of higher paid, higher level appointments. It will be imperative to make sure that future staffing levels and skill-mix of doctors, nurses, allied health professionals, managerial and admin staff are led by effective patient care, rather than by financial imperatives. It will also be important that this does not undermine collective agreed wages, terms and conditions of employment and the move towards standardised systems for workforce planning and human resources across the HSE.

Putting in place robust systems for management and governance is particularly relevant in the light of the implementation of the 76 recommendations made by HIQA in their 2012 report on Tallaght Hospital. An Oversight Group, chaired by the Chief Medical Officer in the Department of Health has been established to oversee the implementation of the recommendations across all hospitals. These cover governance, improving quality and coordination of care locally, as well as the interim accountability arrangements to manage the introduction of hospital trusts.

**Hospital trusts in the UK**

Hospital trusts were first introduced in the UK under the Thatcher government on the basis that trusts would improve efficiency and facilitate competition through an internal market system and a purchaser-provider split. Privatising the NHS was politically out of the question at the time and the Trust structure has remained in place since then. In 2003, all hospitals were required to become reformed foundation trusts by 2014. By 2012, 144 Foundation trusts had been created in England. This has given hospitals greater control and flexibility in managing finances, to invest surpluses in hospital equipment and services and to retain surpluses to reinvest. The governance structure was reformed to enable staff, patients and local people to become governors and board members. However, many hospitals have been beset with budgetary difficulties and have sought mergers with other hospitals and have imposed staffing reductions. Staff have remained employees of the NHS with the same pension rights and conditions under the national agreement *Agenda for Change*. However, Foundation Trusts have the freedom to set their own pay and conditions of employment and some are already seeking advice on how they can step outside of *Agenda for Change* completely, threatening collectively agreed pay, terms and conditions of employment.

Reforms introduced in 2012 by the Cameron government have, however, fundamentally altered the way that services are provided in England. This has resulted in the in the abolition of Strategic Health Authorities and Primary Care Trusts, decision-making about the commissioning of services vested into the hands of consortia of GPs and an opening up healthcare to private care providers. According to the public sector trade union UNISON, the Health and Social Care Act 2012, covering England, introduced a major challenge to the public healthcare system by opening up the system to privatisation. It was introduced in spite of opposition from professional organisations and unions. It opens up the NHS to private providers and also lifts the cap on the number of private patients NHS hospitals can treat. The concern is that this will lead to a two-tier health service, with NHS trusts prioritising the cash that comes from private patients over medical need.

This has resulted in plans to break-up the NHS through the sale of parts of the NHS to the private sector and into private companies. UNISON believes that this will have implications for staff terms and conditions of employment, job security and the quality of
healthcare. The principle that the ‘money follow the patient’ has been core to the NHS model. The logic is that if hospitals compete for services they will create greater efficiencies and attract services from commissioning bodies. However, this has not worked in all areas, particularly where there has been a concentration of hospitals and in urban areas or a limited supply of hospitals in rural areas. In practice, the internal market is irrelevant if there is one large hospital in one area.

Speaking at IMPACT’s health forum on 13 June 2012, Christina McAnea, Head of Health in the public sector union, UNISON, said, “…this has opened the door to privatisation and will result in deteriorating patient care, the closure of hospitals that are unable to complete and longer waiting times.” She went on to say that, “There are now very severe threats to national pay and conditions, through the introduction of the concept of ‘market facing’ pay. This is undermining national standards on training and development, and leading to cuts in services and staffing levels.”

In the England hospitals that have fallen into debt can be taken into administration and private healthcare providers can be invited to take over the running of hospitals. This particular situation arises became of the failed Private Finance Initiative which has led to unsustainable debts and the high cost of servicing repayments to private companies. UNISON has argued that the best option is to ensure that debt ridden hospitals continue to be run by the NHS and that they should be assisted by the government to avoid privatisation. There is also some initial evidence to show that hospital competition in the UK has reduced quality, and hospitals located in more competitive areas have higher death rates (Cooper et al. 2010).

In Northern Ireland the situation is different from England. Changes in the trust model over time have resulted in a streamlining of the trusts and services operating within clinical networks, such as cancer services and critical care, and on the basis that integrated services could be purchased across the whole healthcare system. The system is now made up of five trusts and one ambulance trust, one commissioning authority (the Health & Social Care Board), one public health agency, one business support trust and a regulation and quality improvement authority. Some commentators believe that trusts worked better when hospitals and community services were integrated into one legal entity, thereby improving coordination across hospital and community services.

**IMPACT’s Concerns about hospital trusts and the lessons for Ireland**

“IMPACT has many concerns over the detail of how these ambitions are to be realised, particularly in the current spending climate. And we have many questions about the funding models currently under consideration by the Government.” She also reiterated IMPACT’s concern that safeguards need to be put in place to avoid any move towards trusts becoming a model for future privatisation.”

Louise O’Donnell, Head of Health in IMPACT, speaking at IMPACT’s Health Forum on 13 June 2012:

The lessons for Ireland are that even with universal healthcare, the trust system creates a model for privatisation. In the UK this has taken place in a system where universality is enshrined in the NHS Constitution. Although the Minister of Health is publicly committed
to a public healthcare system, independent trusts could easily be privatised or be further developed under a private sector model in the future, particularly because of the perverse system that exists in Ireland of private care within public hospitals. Will hospital trusts that are stripped of cash in the future prioritise the provision of private beds and private care over public beds and public care?

The plans for independent hospital trusts require a significant change in the culture of health service delivery and in the management of healthcare. Experience from the UK suggests that hospital trusts have not solved all problems in the delivery of healthcare, with many hospitals beset with budgetary problems and geographical inequalities in the provision of care. This change of culture needs to be firmly rooted in a public service ethos of universalism, accessibility, availability and equality of service provision.

It is imperative that the new structures guarantee improved access to services and avoid a situation where each hospital trust become a mini-HSE with the same endemic problems that have beset the HSE. To date there is no information about the level of the budget and the staff ceiling to be set for each hospital trust. To be implemented systematically and fairly, this will require an assessment of staff-to-population ratios and staffing skill-mix, while also taking into account factors such as deprivation and health needs within each trust area. Basing this on historic budgets and staffing levels will be counter-productive. A systematic approach to workforce planning, staffing levels and skill-mix in hospital trusts is needed to create a hospital structure that genuinely reflects the needs of the population.

It will be important that there is overall Ministerial responsibility for ensuring that no hospital is allowed to close under UHI and the proposed Hospital Insurance Fund provides assistance where needed, and particularly in rural areas where there may be less opportunities for economies to be made in the provision of services. Further measures will also need to be put in place to ensure that the higher costs of public hospitals, for example, regarding provision of EDs and training of healthcare staff, can be compensated for in order to avoid an unequal system developing between public and private care.

The experience from the Netherlands shows that universal health insurance introduced in 2006 was insufficient to keep hospitals out of deficit. This makes it all the more critical that the model of universal health insurance is robust enough to ensure that the funding really does follow the patient and that it meets with the Minister’s stated objective of social solidarity. It is for this reason that IMPACT and other organisations in Ireland prefer a social insurance model (as discussed above).

Introducing competition between hospitals to enhance efficiencies and patient care remains unproven. Unions in the UK have repeatedly argued that competition is not essential to the creation of high quality services. Competition distorts the operation of an equitable public healthcare system, provides disincentives to treat expensive or chronic health conditions, and consequently creates inefficiencies. Evidence from the UK shows that rather than improving the quality of care, competition has reduced the quality of services. The countries that have equitable, accessible and universal health systems do not base their systems on competition, but on a public service ethos that drives up standards and accountability, with sufficient resources to fund good quality care.
There are many questions that still have to be resolved. What will happen if the trusts are unable to put in place effective management structures that improve efficiencies and performance? What happens if hospitals go into debt or if staffing levels are not maintained? If debts are incurred will this impact on staffing levels and levels of service provision? The track record to date of hospitals running up huge deficits because of inadequate funding does not bode well for the future. How will health services or insurance companies commission and buy services from the trusts? How will the principle of the ‘money following the patient’ be implemented if pricing structures are not fully thought out and hospitals have insufficient budgets to deliver care? What happens if efficiencies are not implemented by hospitals and budgets run dry?

3.4 Primary care services

Under the new governance structure there will be a separate Directorate for primary care and the appointment of a national Director for primary care.

The Programme for Government sets out the government’s commitment to a new model of primary care, including ring-fenced funding for primary care. This, it says, will lead to changes to GP payments, based on capitation, GP participation in primary care teams and a new GP contract requiring them to work closely with nurses for patients with chronic illnesses. The Clinical Care Programme will shift management of chronic diseases from hospitals to the community. A Diabetes programme is planned to commence in 2012, and will be followed by clinical care programmes covering stroke, heart failure, asthma, chronic obstructive pulmonary disease, dermatology/rheumatology and care of older people.

Primary care is essential to addressing chronic diseases, which are the major cause of death and illness and amount to three-quarters of current healthcare expenditure. However, primary care is not functioning in the way that it should and the Primary Care Strategy, Primary Care - A New Direction introduced as long ago as 2001, has still not been implemented.

The Programme for Government states that priority will be given to locating resources and building primary care centres in areas of urban and rural deprivation. On this basis the HSE has carried out an assessment of the areas of greatest need, using a tried and tested deprivation index, with a priority list in 20 locations. In September 2012 the Minister of Health changed the list, adding fifteen non-priority locations, including two primary care centres in his constituency. This calls into questions whether the priority to locate primary care resources in areas of greatest need, based on the Deprivation Index, will materialise. As Minister of State for Primary Care Róisín Shortall stated in the Dáil Éireann Debate on 19-20 September 2012:

> Decisions on where primary care centres are located must be transparent and objective, based on health need and no other consideration. Primary care centres, just like schools, are essential public infrastructure and should be provided on the same basis.

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5 Irish Times: [http://m.irishtimes.com/newspaper/frontpage/2012/0921/1224324234058.html](http://m.irishtimes.com/newspaper/frontpage/2012/0921/1224324234058.html)
6 Irish Times: [http://m.irishtimes.com/newspaper/frontpage/2012/0921/1224324234058.html](http://m.irishtimes.com/newspaper/frontpage/2012/0921/1224324234058.html)
When she resigned on 26 September 2012 she stated that, “The public have a right to expect that decisions on health infrastructure and staffing will be made in the public interest based on health need and not driven by other concerns.”

**IMPACT’s concerns about primary care**

Healthcare expenditure cuts and the growing deficit raise the question of whether it will be possible to deliver care in the most appropriate and lowest cost setting and on the basis that primary care will meet 90-95% of health needs. IMPACT members and managers in the HSE are of the view that the focus of healthcare expenditure must be shifted into primary care and that commitments on funding to increase the numbers of primary care staff must be prioritised. Some managers believe that another reorganisation will be counter-productive unless a change in culture takes place and fundamental problems in the healthcare system are dealt with.

**Primary care and community services: views from IMPACT members about the government’s plans**

“There is still a lot that needs to be done to bed down the healthcare system. Another set of reforms is seen as counter-productive, unless critical structural issues are dealt with.”

“PCCC never really did get bedded down in the system and now we are moving away from that structure. PCCC wasn't working, then the ISA came along, and all that happened was that deckchairs were moved around.”

“There are huge changes that need to be made in custom and practice, and it is important for staff to change practices so that services are more service user orientated. This can’t be done if there is so much change and uncertainty, staff are demoralised.”

“Across the HSE there are huge variations in levels of service provision and entitlements to services. Part of the problem is that local arrangements have evolved over time.”

Be it lack of political commitment or a failure to fund primary care services, many Primary Care Teams have not been established and many are barely functioning because of staff shortages and inadequate resources. However, the scale of the cuts and the HSE’s rising budget deficit put into question the ringfencing of primary care funding, including the plans for 255 Primary Care Team posts (Public Health Nurses, Registered General Nurses, Physiotherapists, Occupational Therapists and Speech and Language Therapists, and an additional 17 Clinical Nurse Specialists to support the Integrated Care Diabetes Programme). Even if these levels of staffing were to be implemented in full, it will barely recoup the loss of staff in primary care teams, which led to unfilled 350 vacancies in 2011 that could not be filled because of the imposition of the moratorium on staffing.

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One of the biggest challenges for the government, highlighted by HSE managers and IMPACT members, is the need to shift the model of care from acute hospitals to community and primary care. Addressing historic underfunding of primary care requires the government to give an urgent priority to refocusing the health budget to primary care. Early diagnosis, prevention of ill health and health promotion will provide value for money and cost savings in the long run. However, it is essential that primary care be funded to do this, with fully staffed primary care teams and modern primary care centres. At a time of scarce resources it is essential that primary care centres are located in the areas of greatest need. The government’s commitment to recruiting 300 frontline primary care staff, for which a funding was allocated in the 2012 budget, must be carried out in full. There must also be a commitment to reduce waiting lists for primary care services, and the same priority given to these as is given to hospital waiting lists by the SDU.

While many managers who were consulted about their views welcome being part of a national system of standards, quality and risk management, the health crisis means that there is no local accountability or planning for services in primary care. As one manager said, “We are part of a national system and things are being standardised, but it is a race to the bottom, so if we are doing well because we are managing our resources and then someone isn’t replaced, this is demoralising for staff.” The legacy of poor planning and differential levels of services from one part of the country to another, led one senior manager in Cork to say that, “Cork has managed well with funding for home help services but has poor old age psychiatric services. Now we are being expected to standardise our services; if we go up to the best level it is unaffordable, what will happen is that we are all pulled down to a lower level – equality at the bottom.”

Primary care and community services: views from IMPACT members

“The continuing focus on hospitals needs to change. This requires a fundamental shift in the organisation of services.”

“Primary care teams are severely short of staff. The team I am in is supposed to be ‘functioning’ but we are down on 2.5 staff; another team is not functioning because only half of the staff were in place on the team.”

“Negative experiences could be avoided if there was better planning and coordination, with services organised on the basis of clinical decisions. In some cases General Managers have overridden clinical decisions because of the budget cuts, irrespective of a person’s need. The effect is that services are not fitting around the person; rather it is the reverse.”

“Therapy staff welcome the implementation of the HSE’s clinical care programmes, which are having a positive impact on the standards of care across the country. However, this best practice approach is undermined by inadequate staffing levels in the community and hinders an effective response to the increase in chronic health problems and an ageing population. Further problems have arisen because planned clinical posts, for example, in physiotherapy have not been filled.”

“Problems occur when teams are ‘virtual’ with no core primary care centre to work from. This is an important priority.”
“Difficulties have occurred for primary care teams when social work staff are pulled from teams with no consultation, usually because of critical shortages of staff in child protection. The system is reactive and there is no capacity plan.”

“There are no primary care services to refer people to in the community. Who can we refer to? There are not services. Teams are depleted of staff.”

“There needs to be a clarity of professional roles within primary care teams; often the boundaries between the roles of nurses and social workers are blurred, and there need to be clear demarcations of the roles of physiotherapists and occupational therapists.”

“The deficit of funding in primary care arises partly because hospitals take up the majority of the HSE budget. Services in the community are a low priority and the ‘crumbs’ of the healthcare system.”

“There needs to be a planned approach to staffing levels in primary care, including after care services for young people leaving care. It is vital that there is transparency in services, particularly since the Roscommon case revealed the failures in the system.”

“Priorities need to be put in place for the representation of psychology services in primary care teams and networks.”

“IMPACT should be pressing for a uniform approach to staffing levels, staff-patient ratios and service entitlements across the HSE to avoid the current regional inequalities in provision. This should frame the reconfiguration of services.”

“IMPACT should send a strong message to its members that it will be necessary to have a uniform approach to negotiations. This will require IMPACT to have a systematic approach to agreements, a clear position on staffing levels etc. and to use these as a basis for national negotiations. This should be a priority for the Vocational Groups in the coming months, who should develop a clear national position base on local information.”

It is important to establish and uniform approach to outline clear entitlements to primary care services under UHI. In particular, UHI should go beyond free GP care to include access to all primary care services in order to promote multi-disciplinary team working. Similarly, the arbitrary effect of the moratorium has led unequal distribution of primary care services and staffing across the country. This needs to be addressed through a systematic approach to staffing levels, for example, through the setting of staff-population ratios tailored to levels of deprivation and health need.

3.5 Mental health services

A new Mental Health Directorate will be created under the planned new governance structure. The government’s plans for mental health services are in line with A Vision for Change, the Report of the Expert Group on Mental Health (2006), is a 10-year strategy for a modern mental health system, with a focus on a recovery model and multidisciplinary community based services.
The government has said that it has ring-fenced €35 million in funding to implement A Vision for Change and recruit additional psychologists and counsellors to community mental health teams in order to promote early intervention and to detect and treat people who are at risk of mental ill health and suicide. However, this is unlikely now to be implemented, at least in 2012, as cuts in services and the need to reduce the HSE’s budget deficit have taken priority.

**IMPACT’s concerns about mental health services**

There are huge societal costs for the estimated 25% of the population who will experience mental health difficulty at some point in their lives. It is estimated that 2% of GDP (€38 billion) is lost annually because of poor mental health. Years of neglect and under-funding of mental health services, have resulted in repeated calls for better systems of community based mental health services by the Mental Health Commission, the Inspector of Mental Health Services, mental health organisations and trade unions. Ireland fails to meet international best practice developments and has an over-reliance on a medical model of care. Vision for Change has been poorly implemented and the recommended spending on mental health of 8.4% of the health budget has never been reached. In 2009 spending was 6.4% of the annual health budget and declined further to 5.3% of the budget in 2010. Overall spending declined to €770 million in 2009, from 1.1 billion in 2008. This compares badly with international levels of spending on mental health. Some countries spend as much as 20% of their health budget on mental health; in England mental health is 12% and in Scotland it is 18% of the health budget.

IMPACT members working in mental health services speak of the problems inherent in a system that prioritises in-patient and medication-based treatment over a therapeutic approach, mental health promotion and prevention in a community based care setting. The lack of specialist mental health services, for example, for children and adolescents, older people or people with disabilities is a significant concern. In particular, the practice of placing children and adolescents in adult psychiatric wards is condemned.

**Mental health: views of IMPACT members**

“Acute shortages exist in mental health teams, most of which are well below the planned staffing levels. The situation in child and adolescent mental health services is even worse.”

“There is no systematic approach to equity of service either based on geographic areas or on the basis of population demographics. A lower priority is given to early intervention and there are massive differences across the country in access to early intervention.”

“Mental health teams should include representation from social care staff, who contribute to front line mental health services.”

“IMPACT welcomes the priority given to mental health by the government through the creation of a new Directorate for mental health that will be responsible for planning, managing and delivering mental health services in the future.”
“A modern mental health services available in primary care settings should be provided through universal health insurance.”

“Prior to the cuts we had insufficient staff [for CMHTs] and now we are further depleted; however, I am optimistic that the ringfencing of the additional allied health professionals, particularly in psychology and social work, will enable us to start implementing Vision for Change.”

“The reality on the ground now is that there is no longer a specialist service for service users experiencing dementia and depression, which has to be picked up by already overstretched CMHTs.”

“There is a huge strain on existing resources; it is counterproductive as there is now a higher rate of admissions incurring further costs on the HSE, which could have been prevented if the team was functioning.”

“Investing in A Vision for Change, for a recovery model, community based services and implementing the Suicide Prevention Strategy requires significant additional resources for psychologists, counselors and community mental health teams in the primary care setting.”

3.6 Social care services

Unlike mental health services, services for older people and people with disabilities will not have their own Directorate, but fall under the new Directorate on Social Care.

The Programme for Government stated that investment in the supply of more and better care for older people in the community and in residential settings will be a priority and that additional funding would be provided each year for the care of older people. The reality is that the reverse has happened. Although Fair Deal is a demand led scheme, its budget has been capped, resulting in the suspension in 2011 because it ran out of money.

Publicly funded and provided residential homes for older people have closed because there is insufficient money for their upkeep. The spin off of the most recent cuts in home help hours and home care packages will put further pressures on the system. Services for people with physical and sensory disability and people with intellectual disabilities have similarly been under-funded, despite the introduction of the Disability Act.

IMPACT’s concerns about older people’s services

Services for older people have been beset with problems in the past and there continues to be underfunding of home based care services that enable people to live independently in their own homes for as long as possible. These services are increasingly being provided by private care companies.

The government’s call for a review of the financing of nursing home care is a welcome development. However, there is a need for there to be a secure and equitable system of financing for community and long-term care, which supports older people to stay in their
own homes for as along as possible, including the piloting of person-centred budgeting (NESC 2012). There needs to be a shift in the resource base so that care is incentivised in a community as a well as a residential setting. There are also concerns that the expansion of Fair Deal has led to a huge growth of the private care sector, resulting from a lack of priority for resources in the public sector.

Unless sufficient resources are given to care in the community and to supporting family carers, a serious crisis in care will arise in 2012 and beyond. The Minister needs to look at the experiences of other European countries who have reduced dependence on residential care places through integrated support for older people to remain in their own homes for as long as possible.

Older people’s services: Views from managers

“Poor planning for future service needs is the most obvious in older people’s services. Many of these problems are related to the slow throughput from acute hospital beds to long-term residential care or services in the community. When older people are discharged from hospital there is often little longer term planning for their care needs.”

“Home care packages are often viewed as being a short-term solution, while the reality is that people will need them for the rest of their lives. There is a fundamental problem with discharge, some people with complex needs require a lot of support in the community and for a significant period of time and may need lifelong supports.”

“Inadequate staffing and poor planning have led to horrendous experiences, mainly because of poor planning following discharge from hospital. Older people are a risk of falls because of inadequate home care services and there is no follow up for patients who have had a stroke.”

IMPACT’S concerns about disability services

“IMPACT members working in disability services in the voluntary sector and the HSE have seen first hand the impact of cuts on a decline in the quality of services. It is now harder to give a person-centred service.”

IMPACT members working in the disability sector spoke of the additional pressures on them to deliver a social model of care and supported independent living for people with disabilities, with fewer resources and staff. They questioned whether sufficient priority has been given to disability services as no separate directorate has been established under the new structure. Disability service providers in the community have seen an average cut in their budgets of 7% and staffing levels are inadequate to provide for higher care needs, person-centred services for an ageing population and care for the most vulnerable people with disabilities.

“It is a problem that there is no separate Directorate for disability services and puts into question the government’s commitment in this area and whether this would impact on funding levels in the future.”
IMPACT members working in a voluntary disability service, who participated in a focus group, called on the Minister of Health to visit the centre and take a close look at what care workers and social workers do in their day-to-day work roles. They believe that the government’s programme must provide adequate resources to enable disability services to function effectively in line with standards of care. Growing pressure on staff to deliver services with fewer staff and lower budgets is having a negative effect on the quality of services and leads to staff being stressed and demoralised. They also stated that they would appreciate more communication and opportunities to improve the service and to give structured inputs in the future of the service. One member of staff suggested that all staff should be asked ‘what do you need – how can you improve the quality of your service’.

Disability services: views from IMPACT members

“Best practice approaches developed in pilot projects should be mainstreamed if they work. For example the differential response model in the North Dublin pilot (with Daughters of Charity) is an example of an approach, although it may be difficult to apply at the local level.”

“There has been a huge programme of change in the sector, marked by a shift in staffing from residential care to group homes. The HSE failed to see that staffing ratios would need to increase when services moved from institutional to community settings.”

“Service users have had to be supported in moving into the community. Staff have had to change their working practices and roles. However, staffing levels have been insufficient to meet the care needs of people in a community setting and all group homes are short of staff.”

“There is no doubt that higher care needs and a cut in the budget has led to poorer quality services; service users with higher support needs and challenging behaviour are prioritised and services users with lower needs lose out.”

“These extra pressures are affecting staff morale and levels of stress and sick leave have increased. Staff feel demoralised that they cannot give a higher level of support for children. Additional problems arise because referrals to services do not materialise because there are no services in the community.”

“Staff believe that personal outcome measures cannot be met and that they are no longer able to meet quality criteria. There are risks that clients will not be safe in the future, a pressures on staffing mean that accidents are more likely to happen.”

“The needs of service users to have an independent quality of life should drive the service, but this is not possible within current HSE budgets.”

“Community living has been a very positive development as it enhances the independence and autonomy of people with disabilities. However, it is demoralising to see a decline in the quality of the services provided.”
3.7 Children and families

The creation of a new Child and Family Support Agency is one aspect of the new governance structure that is progressing quickly. The Programme for Government makes a commitment to:

Fundamentally reform the delivery of child protection services by removing child welfare and protection from the HSE and creating a dedicated Child Welfare and Protection Agency, reforming the model of service delivery and improving accountability to the Dáil.

A Task Force on Child and Family Support Agency reported in July 2012 and set out best practices in child welfare and family support, and advised the Department of Children and Youth Affairs on the transition programme to establish the new Agency. The heads of bill to establish the Agency are also being drawn up.

The establishment of the new Agency based on an integrated model for child and family support. Speaking at the publication of the report of the Taskforce Minister Fitzgerald said that the new Agency represents a significant shift in child welfare in the history of the State, “We are going to move from a position where child and family welfare was barely a priority, to a position where it will be the sole focus of a single dedicated State agency, overseen by a single dedicated government Department.” The Child and Family Support Agency will be headed up by a CEO and managed by regional managers. It will merge staff and functions from existing HSE child protection and welfare and services and from the Family Support Agency. Commitments were made in the 2012 budget for the recruitment of sixty additional social workers, which have not yet materialised.

A new Service Delivery Framework is currently being discussed. This will differentiate between child welfare and protection cases and introduce new multi-agency teams, community-based models for early intervention and family support, the streamlining of local services, a single assessment method for referrals and a new child protection reporting system. This will be important to ensuring the full implementation of HIQA’s Child Protection and Welfare Standards, which received Ministerial approval in July 2012, the Children First National Guidance for the Protection and Welfare of Children 2011 and new child protection legislation that puts the Children First guidelines onto a statutory footing, in line with the recommendations from the Ryan Report’s Implementation Plan.

The National working group on children and families is planning the moving of core staff into the new Agency. The new Agency is an opportunity for the first time to plan a streamlined approach to child and family services; but there are doubts if this can be achieved with insufficient staffing levels. This is a time to properly focus on and plan a uniform approach to services, and to give focus on early intervention. The HSE is planning an audit of personnel working in children and family services. IMPACT members are of the view that they should be given access to the data and participate in an active dialogue with regional managers about staffing levels in the new Agency.
IMPACT’s concerns about the new Agency

In the ongoing discussions about the new agency it will be imperative that the resources and staffing are put in place. In January 2013 more than 4,000 social work, social care and administration jobs will transfer to the new Agency. It is important that the HSE engages in full consultation with staff and IMPACT about the transfer of staff, staff roles and responsibilities and staffing levels.

The new Agency: Views of IMPACT members

“We welcome the opportunities for better coordination of services, but confusions remain and there are fears that the terms and conditions of staff will be diluted in the new agency.”

“There is no evidence that the commitment to employ an additional 60 social workers has been carried out. In practice no new jobs have been created, rather the posts have been used to cover people on career breaks or sick leave. New graduates are only getting jobs in the voluntary sector.”

“Despite the shortfall in social workers in the HSE there are many trained social workers who are ready to take up positions, but are still on the HSE’s panel. Their only opportunity for employment are temporary positions to fill gaps in services.”

“Social care should be seen as a profession in its own right, where they can work as an independent profession in a team.”

“Social care workers have no career structure and want to have the opportunity to use their experience in other areas. In particular, staff who work with challenging clients, whose jobs are traumatic and stressful, should be given the opportunity to move into other jobs, otherwise ‘burn out’ and stress will force them to leave.”

IMPACT has signed a cooperation agreement for full cooperation with the changes on the basis of adequate resources to meet the government’s commitment to improve services for children and families and improve the quality of child protection services. Significant additional resources are needed to ensure that there are enough social workers to provide a robust system of child protection in Ireland. The introduction of new legislation on child protection and the mandatory reporting on child abuse, as well as the implementation of the HIQA National Standards for the Protection and Welfare of Children, will require further resources to enable staff to meet the new statutory requirements and responsibilities.

The new Agency offers great potential for better child and family services and an integrated structure for child protection. However, social workers and social care staff work in very stressful working environment and staffing levels are grossly inadequate to provide robust child protection services. One of the problems highlighted by IMPACT members is the need for adequate staffing levels to deal with the challenges ahead in meeting child protection guidelines. Social workers and social care workers spoke of the difficulties in maintaining standards and quality. There has been no back up and no agency staff since the moratorium. As one IMPACT member said, “staffing must be
resolved, as it is a fact that the numbers don't add up, because staff are categorised into jobs that they are not doing."

There are a lot of confusions about the new Agency and who will be transferred. Staff working in child and adolescent mental health services do not know if they will be in mental health services or the new agency. There are questions about how services will be integrated and coordinated under the new structure and a danger that this will result in ‘silos’ and poorer integration across services. As one IMPACT member stated, “Service users do not fit into these boxes and there are many crossovers between services.” IMPACT members working in social work and childcare, who participated in the focus groups, stated that they want to contribute to providing better solutions to providing care and services.

Consultation with staff: views of IMPACT members

“The HSE should be pro-actively consulting with staff and there should be a renewed focus on early intervention. It is important to use our ideas and learning from our experiences on the ground.”

“Use staff knowledge to build plans and strategies for the future and use our expertise.”

“We urge the Minister for Children to also prioritise services for families in the community, with a focus on early intervention.”

IMPACT members have highlighted the need to improve resources for social care, including an urgent need for out-of-hours and weekend services from social worker and social care services, so that the most vulnerable and at risk children can be protected. IMPACT members working in childcare say that effective staffing levels are needed for children living in care so that vulnerable young people in care can be properly supported. And aftercare services are urgently needed for young people leaving care. Similarly, greater efforts need to be given to prevention and early intervention. In practice social workers are working in crisis management; with better staffing levels this emphasis could be given to their work.

Creation of the new agency: views from IMPACT members working in children and family services

“There are many deficits in services that need to be addressed in the new agency. One is how to provide after care for children coming out of care services. There is an absence of services for vulnerable young people (18-23 years) because of the absence of an after-care system. In practice many young people are kept in the care system longer than necessary because there is no after care or no after care staff – this creates blockages in the system.”

“Social workers and social care workers carry out very important roles in primary care teams and respond to families in crisis – however, they have insufficient resources and staffing levels to work on prevention. Part of the problem is that primary care teams do not have services for after-care.”

“There has been an increasing level of contracting out of services to private childcare providers, resulting in creeping privatisation in the sector...In one service in Meath there
is no longer a public service for high support disability care. Is it honest to say that the private sector can provide a service cheaper, when the quality of service is compromised?"

“There is no strategy or plans on the ground for early intervention, this is the ‘elephant in the room’ and results in ‘fire fighting’. Although there are some initiatives in place [e.g. Atlantic funded project and the Springboard project] these are not part of an overall strategy.”

“The early intervention team in Dublin 15 is barely functioning, and currently only has two staff.”

“One of the problems is that there is a lack of strategy guiding the work of social care workers, for example, in working with challenging clients and in anger management. There are no national guidelines in critical areas, such as restraint.”

### 3.8 Allied health professionals

This section looks at the specific issues raised by health professionals about their role under the new governance structure. Health professionals, many of whom are members of IMPACT, make a vital contribution to preventing long-term illness and disability through rehabilitation. However, allied health professionals have stated that their expertise and contribution to a modern healthcare system are not taken into account in health policy making and in the strategic planning of services.

Allied health professionals are not represented in an advisory capacity in the Department of Health, as exists for other professional groups. This means that there is no access to workforce planning or for these services to be assessed under the Health Intelligence Unit. Similarly they have no clinical representation at service level and at the regional level under the regional ISA structure.

Allied health professionals consulted with spoke of the importance of having this representation and recognition under the new directorate structure. They are left outside of the health system and their professional insights about how to improve services are ignored.

#### Contributing to policy and decision-making: views of allied health professionals

“Allied health professionals are experts able to bring changes into the planning and delivery of services in social care; their roles should be utilised and planned more strategically to enable them to have maximum impact in preventing unnecessary and expensive hospital admissions and in preventing ill-health.”

“IMPACT has an important role to press for and facilitate the representation of allied health staff at the decision-making table, in primary care, in hospitals and at a strategic level as an advisory group in the Department of Health. This is important if allied health staff are to be valued and can contribute unique insights about the reconfiguration of healthcare.”
This problem arises because of the predominance of the medical/nursing model in health and the prioritising of resources in the hospital sector. This continues to be reinforced by the Department of Health and underpins the current programme in health. Good practice exists in Scotland where Allied Health Professionals are viewed as ‘agents of change in health and social care’ under The National Delivery Plan for the Allied Health Professions in Scotland, 2012–2015. This structure should be replicated in Ireland because it brings Allied Health Professionals in the centre of service delivery. A similar system exists in New Zealand, where front-line therapy staff had budgets that they managed. This facilitated better service provision, planning and outcomes, as well as better accountability and auditing.

<table>
<thead>
<tr>
<th>Changes needed in the healthcare system: views of Allied Health Professionals</th>
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<tr>
<td>“Chronic care programmes, while welcomed as an approach to improved service delivery, need to be reconfigured so that they include representation from and improved contribution from therapy staff. Currently these programmes are dominated by a medical/nursing approach.”</td>
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<tr>
<td>“Occupational Therapists play a key role in discharge planning in acute and mental health services. However, there is an understaffing of all therapy grades in primary care teams. Skill-mix in rehabilitation teams is nursing-led, further reducing the role that Occupational Therapists can play in a coordinated approach to rehabilitation.”</td>
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<td>“Problems arise from poor procedures on hospital discharge planning and a lack of resources to provide follow-up care and rehabilitation in the community. Therapy staff are unable to meet the requirements of care packages because there are not the resources, which increases the risk of re-admission to hospital care.”</td>
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<td>“A lack of resources for continuing professional development means that allied health professionals are unable to keep abreast of new developments and attend conferences.”</td>
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<td>“There is a legacy of a lack of funding for equipment, aids and appliances to enable people to live independently in the community.”</td>
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<tr>
<td>“IMPACT needs to stress the importance of implementing staffing levels for specialist posts under clinical programmes. IMPACT should present a positive case about the contribution that therapy staff make to quality of care and the need for their contribution to be recognised as part of the reconfiguration of services.”</td>
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3.9 ICT systems and administration

The new governance structure has specific implications for ICT systems and for administration.

**ICT systems**

The current government’s proposals present an opportunity to look strategically at healthcare ICT systems and to develop a centralised data and administrative system, with a unique digital identifier for each patient. This could lead to major cost efficiencies.
and better coordination and integration. This would fit well with a single-payer financing model and as recommended by The Adelaide Hospital Society (2010) could be implemented through a digital card held by each patient.

**ICT systems: views from managers and IMPACT members**

“Weak ICT systems and poor access to technology are creating major problems for staff and managers working in primary and community services. This is made worse as the system is already overstretched. While managers accept the need to reduce staff, this can only be done if better use if made of web based solutions and cloud computing.”

“ICT systems need to be implemented so that each patient can have a unique identity. This would prevent silos developing and promote better coordination across services.”

“ICT systems are deficient and we cannot run a modern health services with such depleted and ineffective systems. There is no integrated ICT systems to enable us to work in multi-disciplinary teams and to integrate hospital and community services. Many health workers still do not have access to a computer.”

“There is no systematic approach to data collection across services in both the HSE and the voluntary sector. This means that data that is collected is not assessed; and staffing levels and staffing requirements are not addressed. Improved ICT systems could resolve this.”

“The healthcare system needs to plan for development of modern and integrated ICT systems. This requires clarity about business, reporting and ICT requirements. Integrated patient systems across hospital and community/primary care services, a unique patient identifier and greater utilisation of technology by staff in the community, are all needed if there are to be costs savings, better planning of services, coordination and higher quality of services in the long-run.”

“Staff training in ICT, at operational and management levels, needs to be rolled-out across the HSE so that staff and managers are ICT competent. Training will also help to reduce staff uncertainties about using ICT, which is particularly relevant for older staff.”

**Administration**

Many of IMPACTs members working in healthcare carry out administrative and bureaucratic positions (the ‘backroom’ people) and are not visible to the public. These services are crucial for the efficiency of services; cutting these services results in referral letters and other administrative functions being delayed or curtailed. Hospital and primary care managers who participated in IMPACT’s consultations also spoke about the devastating impact of cuts in admin services on the functioning of the healthcare system.

**The views of admin staff and managers**

“The morale of staff is rock bottom. There are not enough clerical officers for admissions and yet we have this pressure to reach targets. There are competing issues in the HSE.”
“Even when new hospital consultant appointments are made, there are no resources for administrative back up or referral to allied health support to enable them to provide a service. The significant reduction in administrative staff has led to serious problems.”

“One of the biggest failures has been the inability to recruit admin staff; this is at a time when we are overrun with managers and more specialist functions at the national level, but there is not a priority in providing services. We need admin staff to enable a clinic to be run efficiently and that’s not happening because of the moratorium.”

“There is less administrative back-up for allied health professionals, this means that they are experiencing a heavier burden of administrative work, for example, in making and following up on appointments for people who do not show; that is often not recognised.”

IMPACT members and HSE managers who were consulted with spoke about the importance of a functioning and well-resourced administration for an efficient quality healthcare system. However, the moratorium on staffing has led to a significant reduction in admin staff in the HSE. In addition, IMPACT members believe that the Croke Park agreement has undermined any possibilities for regrading, promotion or changes in terms and conditions of employment. Some staff are carrying out managerial posts that they are not compensated for. In a focus group held with admin staff working in the PCRC, staff highlighted different contractual arrangements in areas such as working hours, leave and grading because of their historic terms and conditions of employment. In the current structure there are no job specifications or grading structure and no opportunities for promotion. Some staff spoke of the need to revisit the grading structure and for an independent job evaluation so that terms and conditions can be standardised and harmonised.

PCRS staff did not know how the government’s programme would impact on them. There will be implications from the introduction of UHI, although no information has been given about this to staff. Concern was expressed about the possibility that private insurers would run UHI and that the PCRS staff jobs would go.

**Views from IMPACT members working in PCRS**

Admin staff working the in the PCRS recounted their experiences of moving to a centralised service for the processing of medical cards. This, they believe, provides lessons for future reorganisation of administrative or service functions in the future. As one IMPACT member said, “the lessons of poor change management should be learnt in the current climate of reorganisation.”

“Although we are invisible to the public, in the PCRS each admin staff member deals with up to 100 inquiries a day. The service we provide is essential to keeping the healthcare system working.”

“There are benefits for a centralised admin service, this results in efficiencies and better administration. The old HSE system was dysfunctional and disorganised. A more streamlined service enables a faster processing of medical cards and payments, which is important given that the number of medical cards has increased in recent years.”
“We are short of 60 staff whose jobs have not been filled. This has impacted on staff being able to take unpaid leave or flexible working time. This is despite the fact that staff are currently processing a much higher number of applications from people who are in economic difficulty or unemployed.”

“The most important lesson is that good communication, transparent information and consultation are essential to any planned changes in work roles or the reorganisation of services. However, there was poor communication during the change process; very little information given about local and national level changes. The system was dysfunctional and lacked coherence.”

“The old system was very demoralising for staff. It is important to bring staff with you. Staff are your investment and if you keep people with you this will allay fears and worries.”

“Ongoing information and consultation is important. Although consultations do take place, staff do not feel listened to. Staff have ideas that can help to improve the quality and efficiency of the services, but we don't get the chance to feed in these ideas.”

3.10 Conclusions and recommendations

There is major confusion about the government’s plans for the transition from the HSE to new governance structures. It is still unclear how the new hospital trusts will function and there is little detailed information available on this. Although plans are in place to create hospital trusts and the new Children and Family Support Agency, there is no clarity in relation to the rest of the health sector, which it is planned will deal with 90-95% of health needs.

There are merits to having better integration of services across the healthcare system, through networks of hospitals and in improving coordination between hospitals and the community. However, it is essential that the major problems inherent in the healthcare system are addressed before any further changes are implemented. The warnings of IMPACT members are that the new governance structure will be another set of costly changes on top of previously failed programmes of reorganisation.

IMPACT’s vision of a quality healthcare system outlined in section 1, based on the principles of principle of social solidarity, respect, trust, universality, accessibility and quality, should underpin the healthcare system. Creating a quality healthcare system in the future requires careful planning and wide consultation. Addressing the underlying problems in the healthcare system, redirecting resources to areas of critical need, addressing geographic inequalities in service provision and entitlements, engaging in more systematic planning of resources and staffing, are all essential to this.
Recommendations:

• IMPACT members believe that it is imperative that there is a focus on the provision of quality healthcare services, not just the governance and organisational structure around the services.

• While acknowledging that the imposition of austerity measures will lead to fewer resources, IMPACT members recommend that staff be involved in discussions about improving the quality of services. More emphasis needs to be given to improving the planning of services locally, which can result in cost savings in the long-run.

• It is essential that there is clarity and transparency during the implementation of the new governance structure. Information is needed in a timely way so that unions can consult their membership and also engage in discussions about the staffing implications of the new structure.

• There is a need for transparency and evidence that shows that moving to hospital trusts will provide a better quality health care system and resolve the current difficulties. The experience of trusts in England suggests that hospital trusts have not resolved the problem of deficits and have opened the door to privatisation. The experience in the Netherlands, where insurance companies are involved, is that some hospitals have run into deficit, have gone bankrupt or have closed.

• The Minister should outline how the new directorates structure will work and how primary care, mental health and other services will be organised and funded once the directorates are established. There is also a need for incentives put in place to ensure that there is coordination across each directorate and between hospital and primary care services under the interim directorate structure.

• The challenges arising from population growth, the ageing of the population, increase in mental ill health and increased preventable disease incidence must be addressed as priorities. The provision of primary care services and community based mental health services, delivered close to where people live in the community can save money in the long run by preventing long-term illness, expensive hospital stays and a higher burden of ill-health.

• Well-resourced and equitable access to primary care must be a priority if the huge increase in preventable and treatable chronic illnesses can be addressed. Within the health capital budget, the immediate priority must be primary care centres, step-down and long-term care facilities, and community care facilities such as day centres for older people. Funding these services should an overriding priority.

• Similarly, mental health services need to be fully funded in line with Vision for Change, with a budget to ensure that community mental health teams are fully functioning and equipped to address the rise in incidence of mental ill health.

• The role and contribution of allied health professionals must in the future be at the centre of the healthcare system. This includes their participation in strategic decision-making and as an advisory group in the Department of Health. Their role in
preventing long-term ill health and disability are vital to population health and creating value-for-money.

- Critical issues such as integrated ICT systems and sufficient administration to ensure that the healthcare system functions effectively urgently need addressing.
Section 4: Creating a quality healthcare system for the future

4.1 Conclusions

The economic crisis has had an unprecedented impact on the economy, on public services and on the economic and social development of Ireland. Growing poverty, unemployment, underemployment and inequality are affecting the health and well-being of the population and leading to widening income inequalities and inequalities in health. At a time of crisis health services should be playing a vital role in redistribution, tackling health inequalities and in supporting the most disadvantaged service users. It is an ideal time to rethink our approach to providing health services in order to create a modern, equitable and universal public health service.

This paper suggests that government’s reforms have been ill thought out, they have not been fully costed and have not been implemented in line with their plans as set out in the Programme for Government. Rather than rushing into ill-conceived reforms, this is now time to create a long-term vision for Universal Health Insurance, the priorities for services and for an effective governance structure for healthcare that genuinely integrates hospital and primary care services.

While many IMPACT members know that budgetary cuts are inevitable. They are clear that the financial crisis is an opportunity to revisit fundamental questions about the values underpinning our healthcare system and the future delivery, organisation and funding of healthcare. This is also an ideal opportunity for establishing the priorities and funding needed for a fully functioning primary care and community mental health services.

Alongside this is a need for an alternative budgetary strategy as outlined by ICTU, NERI and others and for a government strategy to implement economic reforms to stimulate the economy and create good quality jobs.

In particular, IMPACT members are concerned about the privatisation agenda of the government and believe that privatisation should not be a short-term solution to resolving some of the major problems within the healthcare system. Neo-liberal policies and cuts in budgets have opened the doors to privatisation, particularly in residential and community based older people’s services, in childcare services and in other areas of public provision. For example, the Fair Deal scheme and the contracting out of home based care for older people has enabled private providers to flourish, undermining the public system. Implementing UHI through competing private insurance companies, similarly places the funding of healthcare into a privatised funding model.

IMPACT members are concerned that with less money, staff and hospital beds there is a serious risk that the government’s plans will fail. Many are concerned that reduced budgets and inadequate staffing levels will impact on patient safety and the quality of care. IMPACT members believe that the core purpose of a public healthcare system should be to provide equitable access to health as a fundamental right. However, inequalities in health have widened through increasing charges for medical care, such as higher fees for presenting at emergency departments, increased prescription charges for
medical card holders, all of which impact on the poorest people in the community who need the services the most.

An overriding message from IMPACT members is that the lessons of past attempts to reorganise healthcare, particularly in establishing the HSE, need to be learnt. Many IMPACT members have little confidence that the government’s plans will result in a better quality healthcare system given the past failures to implement reorganisation and follow through on the commitments in successive health strategies. The HSE has not lived up to its promises to improve patient care, value for money and the management of healthcare, and has failed to deliver on integration between hospital and community care and enhancing patient-centred care. In practice, there has been a duplication of services, inadequate decision-making and little change in how services are delivered. Top heavy and centralised management structure and poor decision-making have prevailed, leading to a waste of resources and deterioration in the quality of care. There has been a slow pace of change in meeting strategic goals and strategies, for example, in primary care and mental health, leading to further staff demoralisation. Healthcare staff have spoken about the negative effect that the cuts are having on the capacity of the healthcare system to plan to meet the growing and complex health needs of the population. There are inadequate resources and staffing shortages in administration, primary care and mental health. Their on-the-ground experiences paint a picture of a healthcare system in serious crisis.

IMPACT members want guarantees that the latest plans for reorganisation will not result in a similar legacy of poor implementation, oversight and deteriorating access to healthcare. They believe that there are a whole raft of issues that need to be thought out in advance of the reorganisation of services and funding. Feedback from IMPACT members across the country is that there are no clear lines of accountability, decision-making is not taking place locally and local plans are often overridden by national priorities to cut costs. Involving and informing IMPACT members in discussions about changes in services are essential to allaying fears and uncertainties.

One issue of concern for trade unions is whether independent trusts and a new system for primary care will lead to changes in national collective bargaining in the health sector. In the UK Foundation Trusts have seriously threatening national bargaining in favour of local bargaining, undermining collectively agreed wages, terms and conditions of employment.

IMPACT members believe that the media and the public do not always appreciate the problems faced by healthcare workers and the stress they experience in an overstretched healthcare system. They say that more needs to be done to create a national culture of social solidarity and to value the contribution that healthcare can make to economic growth and equality. Core to this is ensuring that healthcare staff, along with their unions and service users, have a say in changing mindsets and in creating a world-class, high quality, universal healthcare system.

Creating a modern, equitable and universal healthcare system needs careful planning and wide public consultation. This is important to building public trust and confidence in the healthcare system, and to building democracy. There has been limited consultation with local communities, service users, patient organisations, professional associations
and healthcare unions. This undermines the government’s commitment to openness, transparency and consultation.

4.2 Recommendations

In addition to the specific recommendations made about Universal Health Insurance (Section 2) and the government’s plans for a new governance structure (Section 3), the following overarching recommendations are made.

Addressing budget cuts

• The current budgetary crisis should not determine the future funding model and organisational structure for health services.

• In acknowledging that the HSE is bound by external budgetary constraints imposed by the Troika, it is essential that any future cuts are proportionate, based on effective and transparent criteria, realistic priorities and carried out in a planned and systematic way.

• The government is urged to seriously examine the impact of further budget cuts in health on domestic demand, and to consider an alternative budgetary strategy that boosts demand and economic growth, and protects employment, incomes and services.

Addressing the underlying problems in the healthcare system

• Plans to introduce UHI and a new governance structure should not go ahead until the underlying problems in the health system are addressed. Central to this is to shift the balance of funding to primary care services, preventative care services and mental health services. Crucially this means investing in a public healthcare system and ending the drive towards more privatisation.

• High quality healthcare requires better management and planning of resources and a more equitable allocation of budget cuts. Urgent priority needs to be given to addressing the under-funding of primary care and mental health services and for implementing funding commitments for staffing levels in primary care and mental health.

• Attention needs to be given to systems for financial management and accountability, systems for guaranteeing quality, mechanisms for integration and coordination across the healthcare system, shared services and integrated ICT systems.

• There needs to be more systematic approaches to collecting data on the number of service users receiving services directly from the HSE and from the voluntary sector. If this were carried out it would be possible to have a systematic and real approach to planning resources and allocating staffing levels for services.
Safeguards need to be put in place, including spelling out the fundamental ‘right to health’ in legislation and in the Constitution that guarantee universality and equality. Uniform entitlements to services should be laid out in the Health Act.

Multi-annual funding should replace the current annual budgetary allocations in the HSE. Ideally there should be a three-year budgetary cycle. This would enable healthcare planners to take a longer view about the planning of services.

The need for an informed public debate on the future of healthcare

- This is an ideal opportunity to have an informed public debate about the vision of the type of healthcare system Ireland needs for the future. This should be user-focused and should set out a vision and plan for a healthcare system as the country moves out of the economic crisis. Economic policies should be planned in the long term to enable the vision to be realised in practice.

- The public debate should promote the widest participation from all groups in society, including those living in the most disadvantaged communities, service users, patients’ organisations, staff, professional bodies and trade unions.

- The public should have an opportunity make their views known about the government’s plans for healthcare. This should take place through town hall meetings across the country with the Minister of Health. These meetings should set out the government’s plans for hospital, community and primary care services. It should also set out what Universal Health Insurance will mean in an Irish context, the evidence for the model chosen by the Minister and what other models have been examined.

- The debate should be underpinned by a commitment to create a vision of the healthcare system needed in Ireland, based on the principle of social solidarity, respect, trust, universality, accessibility and quality. This should take into account the role that healthcare in reducing inequalities and in contributing to the country’s economic and social development, and in so doing address broader issues of redistribution.

- It is now eleven years since the health strategy was written. Since then major economic and social changes have taken place in Ireland and disease and illness profiles have changed. It may now be time to consider a new national health strategy that takes account of the views of all stakeholders.

Consultation with unions

- Union consultation should be promoted at an early stage to ensure that the industrial relations implications of any reorganisation of services, and any implications for workplace changes and staffing roles are addressed. Unions bring the insights of their members into the picture and have a key role to play in ensuring that the public health system is protected in the future.

- Any changes in staffing levels, reorganisation or redeployment of staff should be carried out with the full consultation with staff and unions locally, regionally and
nationally.

- The Minister should honor his commitment to ongoing national consultations with unions on the new structures being implemented, staffing roles and inter-disciplinary working, as agreed at the meeting held between the Minister of Health and IMPACT, the INMO, SIPTU and the IMO, in May 2012.

- The government needs to set out clearly and in discussion with IMPACT and other unions, the reconfiguring of services or specialisms within hospital trusts and in the new approach to primary care. There is also a need for a systematic approach to addressing staffing levels in relation to the employment ceiling for each hospital trust and in guaranteeing adequate staffing levels for primary care and mental health services.

**Representation of staff and professional organisations in operational and strategic decision-making**

- Decision-making should be informed by the perspectives of staff at an operational level and professional organisations at a strategic level, who should be given the opportunity to contribute their insights and perspectives about the provision of quality healthcare services at operational and strategic levels.

- Staff and professional organisations should be fully consulted about any changes in the organisation and delivery of services. An open dialogue should be created with staff and professional organisations about the future of healthcare so that prevention, health promotion and primary care are at the centre of the healthcare system.

- There should be a reinstatement of the Therapy Advisory Group so that allied health staff have a role in workforce planning and redeployment. There should be a similar body established as exists for nurses and doctors, under the Nursing and Midwifery Units and the Medical Council.

**Staffing levels**

- While acknowledging the current economic constraints, there is a need to look systematically at staff-patient ratios – this is important to optimising the best quality patient care in the future. The HSE should begin a process of determining best-practice staff-patient ratios, which should guide service planning and staffing levels in the future. Systems for determining skill-mix and staff-patient ratios also need to be implemented.

- A national headcount of all categories and grades of staff should be carried out. A study should be undertaken on outpatient waiting times, workforce and caseload levels of allied health professionals, and to compare these levels with other OECD countries.

- Systems, norms and guidelines need to be put in place to accurately calculate staffing levels for allied health professionals and admin staff in order to plan for short-term and long-term developments in services.
• Information and data about the allied health professional workforce needs to be credible and comparable so that senior managers can make better-informed decisions about staffing levels. There should be targets set for staff-patient/population ratios for the supply of therapy staff as exists in other countries.

Preparing for changing job functions and work organisation

• Change should be informed by employee participation and ongoing skills development of staff, particularly if job functions change. Cooperation should be encouraged where changes in work roles and responsibilities take place, and through changes in work organisation, for example, multi-disciplinary working.

• Improved skills and development opportunities are necessary to enable workers to carry out more complex tasks required from changing models of service delivery. Essential to this is that staff have employment security and decent working conditions, with pay and benefits that reflect the value of the work carried out.
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