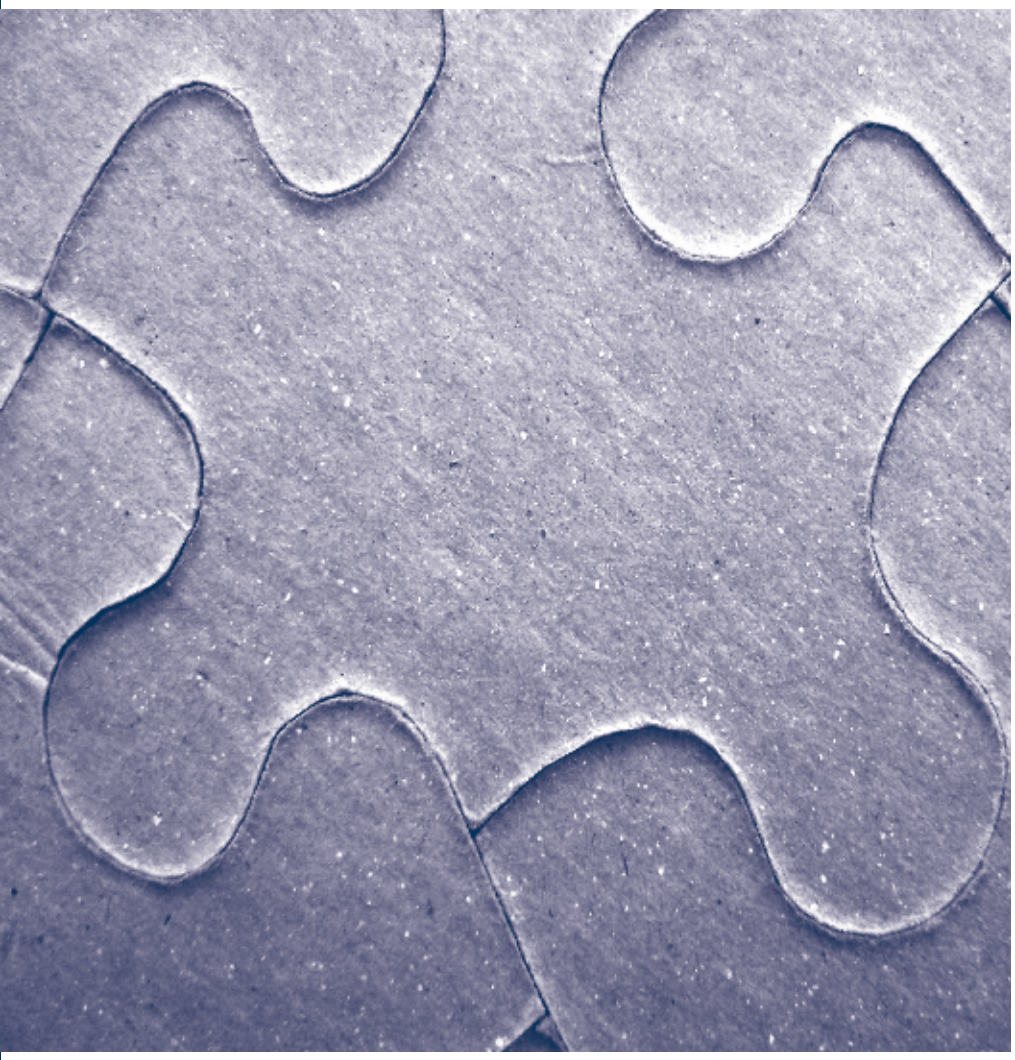
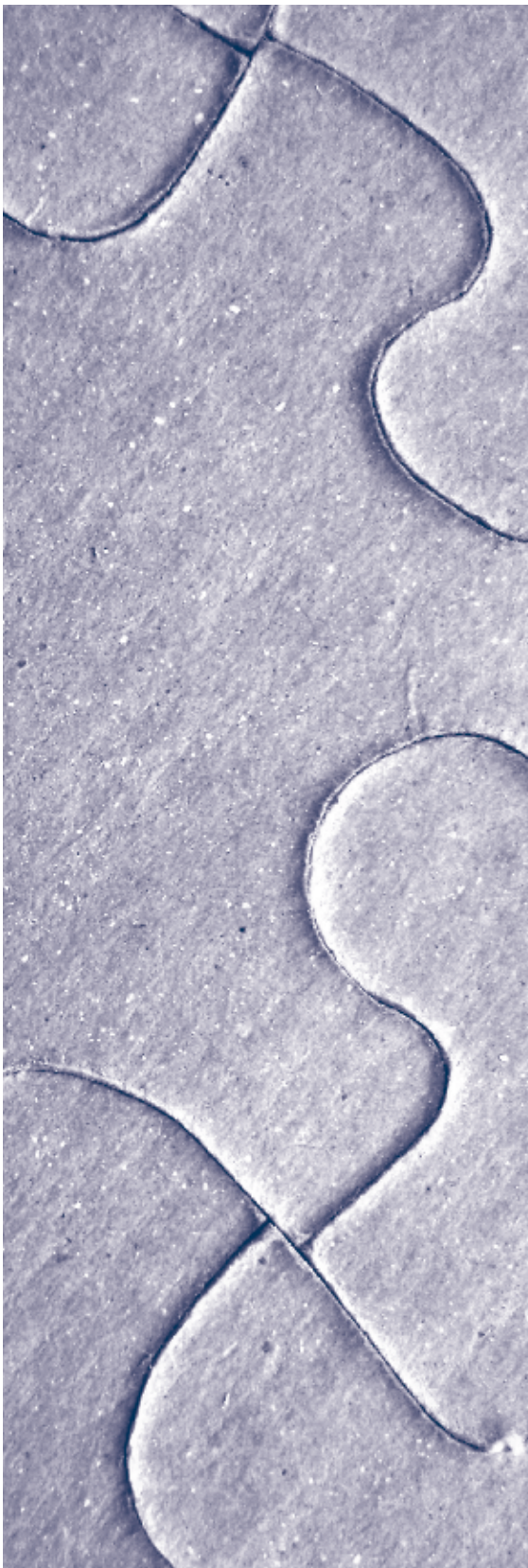
An Roinn Sláinte agus Leanaí
DEPARTMENT OF HEALTH AND CHILDREN

July 2010





Report of the Expert Group on Resource Allocation and Financing in the Health Sector

REPORT OF THE EXPERT GROUP ON RESOURCE ALLOCATION AND FINANCING IN THE HEALTH SECTOR

JULY 2010

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Published by Government Publications, Dublin

Price: €10

ISBN 0-7557-7638-2

MINISTER'S FOREWORD

I am pleased to receive this Report from the Expert Group on Resource Allocation and Financing in the Health Sector which sets out a comprehensive and detailed set of recommendations on how we might, in the future, better allocate the resources made available to our health services.

I firmly believe that one of the most important drivers of change is the way we allocate resources. When I established the Expert Group last April I asked them to examine how the existing system of resource allocation could be improved to support better the aims of the health reform programme and deliver better, more equitable health care provision for all our citizens.

I also asked the Group to look at the way we finance the health system particularly if, in the course of its deliberations, the financing system was shown to influence the best allocation of a given level of resource.

These are highly complex areas where there are no simple answers. As this examination took place against a background of ongoing organisational change in our health services and significant pressures on the public finances the task this Group were asked to undertake was a difficult one. I am particularly grateful therefore to Prof. Frances Ruane and all the members of the Group for their dedication, commitment and hard work over the past 14 months.

Mary Harney TD
Minister for Health and Children

CHAIRPERSON'S FOREWORD

Health-care systems face rapidly changing contexts and escalating costs. Demography, new technologies, changing life styles and rising expectations are contributing to the increasing demands on health-care systems in all developed countries. While health-care benefits from new innovations, the relative costs have risen with the growth in real incomes. A key challenge for many countries is how to finance health care in a way that is equitable, affordable and promotes good health.

While Ireland is a highly developed country by many criteria (growth rates, participation in higher education, per capita GNP), it performs less well in terms of health care, despite significant progress over the past decade. This may be partly due to its particular blend of public and private health care providers and the absence of an overarching framework that optimises the contributions of each component of the system. It may also be due to the fact that many aspects of the present resource allocation system promote fragmentation rather than integration.

The absence of a coherent framework adversely affects accountability, efficiency, governance and clinical care. The Group took as its starting point the high-level principles/values expressed in current health policies which place the users of services (patients and other recipients of care) as the central focus of health policy, and which aim to ensure that services are delivered in the most appropriate and safe setting.

A fully-integrated, coherent health-care system which brings together primary care, community/continuing care and acute hospital services, is recognised internationally as optimal in terms of both safety and cost. For Ireland to achieve this standard requires greater clarity on governance, national policy implementation, national standards setting, local service delivery, and regulation. It will also be important to distinguish between policy development and priority setting.

Resources must be allocated so that the different health system components collaborate, provide complementary services and incentivise co-operation. The system of financing should be fair and provide incentives to have health-care needs met in the safest and most cost-effective setting.

The Group adopted an evidence-based and holistic approach. This was supported by the unique mix of skills among group members, covering economics, health-system management, health-care delivery, business practice, and community care.

One challenge for the Group was the absence of readily accessible data on the current resource allocation systems, particularly in the community care sector.

The Group is confident that the approach recommended will deliver quality and financial benefits over time. The long-overdue introduction of a unique health identifier, together with commitment to greater transparency in resource deployment, is a precondition for the successful implementation of our recommendations. This transparency should also be reflected in the roll-out of care protocols, greater focus on ethics and standards set out by the reformed Medical Council, and better use of health information to ensure accountability.

Health-care reform is continuous and will always be a 'work in progress', with the pace of reform reflecting available resources and the constantly changing environment. Consequently, this Report does not describe a perfect health-care system, but rather presents proposals that will support immediate and medium-term improvements aimed at enhancing the health and well-being of our population. Our proposals are for a systematic and consistent improvement over time, rather than simply ad hoc solutions to short-term crises. We are convinced that, as long as the relevant stakeholders can be persuaded to operate in the national interest, it is possible to make relatively rapid and significant improvements to the Irish health system.

It has been a privilege, as well as a pleasure, for me to chair this Group. I am grateful to the Minister for giving us this challenge and for urging us to bring our independent expertise to bear on the issues. I believe that our analysis together with the implementation of our recommendations will see our health-care system improve systematically over time. I want to thank most sincerely all who have been involved in our consultation process, the members of the Group for their contributions over fourteen months, and the officials for their contributions throughout.

Finally I want to pay a special tribute to the ESRI researchers for their dedication and commitment to the project. Their painstaking research provided us with the evidence we needed to develop our ideas and to consider the range of options open to us. Their impressive output is published as a separate volume, which I believe will provide an important resource of independent research for anyone who wants to understand resource allocation and financing issues in our health-care system.

Prof Frances Ruane
Chairperson
July 2010

Table of Contents

Executive Summary

Resource allocation mechanisms are ways of ensuring that the goals of policy are achieved on the ground. They set out how and where decisions need to be made, over what domains they should operate, and what incentives need to be put in place in order to make sure that the goals are achieved. Financing mechanisms are designed to ensure that access to health care is based on need and not on ability to pay.

The three key messages in this report are:

(i) Ireland needs a system of integrated planning for all aspects of health care, covering national policy setting and local delivery, standards of care and clinical pathways, capital and current spending, and public and private delivery in the primary, hospital, and community and continuing care sectors.

(ii) Our current medical card system could be developed in a manner which would increase systematically equity of access, and promote the use of safe and cost-effective care. The pace of development depends on the rate at which resources can be made available.

(iii) It is possible to improve resource allocation within and across the primary, hospital and community/continuing care sectors, supporting cost effectiveness and improved quality of care. Central to this is that the incentives of both patients and providers are in line with stated health-care objectives.

Context

1. Like most other developed countries, Ireland is grappling with the challenges of providing health care for its population at a cost that it can afford. In this report we show how these challenges are set in a context where

- the population is rising and ageing
- individual expectations in relation to health-care provision continue to grow
- better living conditions and more effective medical interventions mean that individuals are living longer
- successful ageing means living with and managing a number of chronic illnesses that will be the norm
- developments in medicine mean that people with chronic illnesses who previously needed to be cared for in institutions can now be treated in primary and community care settings
- managing chronic illnesses means that people need to be involved in the management of their own health alongside health professionals.

2. The response to these issues across developed countries has been to
   - develop new models of integrated care which match the changed landscape, specifically by integrating care across the primary, hospital and community settings focussing on prevention and successfully managing chronic disease
   - engender a new era of clinical leadership that understands the importance of performance, quality and cost effectiveness
   - develop multidisciplinary teams in all care settings, targeting funding to those providers who can provide the safest care in the most cost effective manner
   - align the incentives of providers and users of care so that care and financial incentives are more compatible, so that reimbursement rates for providers and payment rates for users should lead them to the best care outcomes possible with given resources
   - ensure that the services are paid for in fair and equitable ways, and that people are not deterred by cost from seeking effective care.

3. Against this background and taking into account the policy documents that have issued over the past decade, the Minister asked the Expert Group
   - to analyse the strengths and weaknesses of the current resource allocation arrangements for health and personal social services[1]
   - to recommend appropriate changes in these arrangements which would support and incentivise the achievement of the core objectives of the health reform programme
   - in the light of its work, to take a view on the most appropriate financing mechanism for the Irish health service
   - to base its examination and recommendations on the existing quantum of public funding for health.[2]

4. Throughout its analysis the Group combined its own experience with an evidence-based approach drawing on research that reviewed the relevant international literature and the health care systems in eight jurisdictions.[3] It also benefited from over sixty submissions made by interested stakeholders in the health care system.

[1] Throughout the Report, for convenience, the term 'health care' or 'care' is used to cover 'health and personal social services'.

[2] The Group has interpreted this to mean the total quantum of public funds that go to support health care, directly through the health vote and indirectly through tax incentives.

[3] This research was undertaken on behalf of the Group by the Economic and Social Research Institute.

Findings

5. In relation to the arrangements for current resource allocation arrangements for health care, the Group found that the system of resource allocation, as resulting from the combined roles of the Department of Health and Children (DoHC) and the Health Service Executive (HSE) is not as coherent as it could be. Specifically, there is no framework which allows decisions to be taken in an integrated way that links systematically with the overarching principles of the Irish health care system and aligns resources with goals. For example:
   - the planning of current and capital expenditure is not integrated
   - the planning of public provision of care takes no systematic account of private provision
   - the planning of care provision does not have adequate population health information to support equitable and efficient care delivery.

6. Furthermore, the Group found that many of the reimbursement systems for providers and the payment systems for users of health care currently used by the HSE create incentives which run contrary to the direction suggested by key health policies. For example:
   - The primary care strategy promotes the transfer of activities into the primary and community care settings, yet many individuals pay less for their care if they attend hospital out-patient departments rather than their GPs or other care providers in the community.
   - The professionals and competencies required to manage and treat chronic disease tend to be concentrated in hospitals rather than in the community, thus making it difficult for individuals to have their health needs met outside a hospital setting.
   - Cost-effective management of chronic diseases promotes the use of multi-disciplinary teams to deliver care, much of which should be community based, yet there is no governance or funding system in place to develop the primary and community care systems to meet this important demand.
   - Safe and cost-effective care is a key goal for the hospital system, yet current funding systems do not reward either, and the absence of resources in the community means that length of stay in hospital is often longer than it should be.
   - Disease prevention is known to be an effective tool to promote health and well-being, yet there is scant reward for activities that achieve this.
   - While there are aspirations for the 'money to follow the patient/user' in the health budget, there is no structure in which this can take place and the potential for individualised care solutions in many parts of the health-care system have yet to be developed.

   Consequently, there continues to be over-reliance on hospitals as a source of services for users, and inefficient resource allocation leads to poor value for money for the total health envelope.

7. In relation to the financing of the health-care system, the Group found that the current financing system lacks transparency, gives rise to serious inequities in access to care, and results in numerous anomalies in terms of incentives for users of care. For example:

- Over two thirds of the population pay for GP and many community-based services on a pay-as-you-go basis, which takes no account of their ability to pay.
- Individuals who can afford private health insurance gain access to some hospital services faster than those with equivalent health needs but who do not have insurance.
- High pay-as-you-go GP charges are known to deter use of care, increasing the risk of later detection of medical problems, with the likelihood of higher costs in terms of health care in the longer term.
- There are widespread anomalies in the current Long Term Illness system; some important diseases are covered, but equally serious ones are not.

8. In relation to the sustainability of the health-care system, the Group noted that recent actions have shown the potential for cost reductions, for example in the use of drugs. The Group noted that there is considerable potential for further cost savings and that, were the efficiency of all Irish hospitals to move to the level of the most efficient hospital, significant resources could be saved. Furthermore, additional resources could be saved over time if the levels of efficiency of Irish hospitals were to move to the best international norms.

9. Consequently, in terms of the stated objectives of policy, changes could be made to the current system which would do more to

- promote equity and fairness
- support quality of service
- generate clear accountability
- facilitate a greater focus on the patient.

10. The Group is aware of some very positive developments that have taken place in the period since it was established in April 2009. The Group strongly supports the integration of the two pillars (Acute Hospitals and the Primary, Continuing and Community Care (PCCC)) within the HSE as a move which is consistent with delivering integrated care. However, the three areas, hospital care, primary care and continuing and community care should be structured into decision making at every level - the DoHC, HSE Corporate and HSE at local level. The Group recognises that a major challenge ahead is the development of new governance structures in the primary and continuing and community care sectors. Integration also means that hospitals need to be configured in such a way as to allow them to play appropriate roles in care delivery across the country. The Group is also aware of the potential arising from the Croke Park agreement to reallocate resources in such a way as to ensure that care at primary and community level can replace care in the hospital sector where this is appropriate.

Resource Allocation Mechanisms

11. The Group concluded that changes are required in the operation of the present system if progress is to be made in meeting the aims of current health care policy. In relation to resource allocation, what is missing is a structure in which decisions can be made which support policy objectives in relation to high quality, easily accessible and safe care that is delivered cost-effectively. Given that the issues are systemic, i.e. they need to run throughout the system at the policy, implementation and delivery level, the Group suggests that the process of decision making must become more transparent at every level. The Group favours greater clarity in relation to governance, with the DoHC responsible for policy and strategy and HSE responsible for national implementation of policy though its local offices, which are in a position to meet local needs most appropriately. The Group believes that, at each level, the concept of integrated care should be mainstreamed so that the connection of policies to actions is strengthened. All of the Group's recommendations in relation to resource allocation are connected to five guiding principles, which it has identified on the basis of its review of Irish health policy documents and international best practice.[4] These principles are as follows:

P1 *There should be a transparent resource allocation model based on population health need.*

This effectively means that the Department of Health and Children should adopt a coherent approach to integrated planning of the health care sector in Ireland, which would cover both public and private providers, and integrate both capital and current funding decisions. It also means shifting resources so that they are systematically linked to current population health need.

P2 *The resource allocation model should support local implementation of national priorities based on nationally-set clinical accountability and governance standards.*

This effectively means that there must be local implementation of standards which are set by and supervised by HSE Corporate. It is important to note that this proposal of a geographically distributed system is NOT a return to the old health board system.

P3 *The resource allocation model should support the delivery of safe, sustainable, cost-effective, evidence-based care in the most appropriate setting, whether public or private.*

This means that the resources must systematically follow the requirements of the new integrated model of care which promotes greater quality and safety, so that what is planned is resourced and resources are not provided without planning, i.e. where there is a coherent national plan in place and framework for local implementation.

[4] There are two further Guiding Principles in relation to financing and sustainability.

P4 *The resource allocation model should promote the integration of care within and across the hospital, primary and community/continuing care sectors at local level.*

This means that resources must support integrated care so that users can get the best combination of health care to support them on clearly defined pathways. It points to the need for planned development of governance and infrastructure in the primary care and community/continuing care sectors.

P5 *Financial incentives should align as far as possible across all actors (including users and providers) in the system, consistent with promoting health and well-being and in line with nationally-determined priorities.*

This means that the HSE should develop new contracts which transparently fund health-care providers on a prospective basis, and reward quality of care and cost-efficiency throughout the system. The is effectively mainstreaming the approach currently being taken in the National Treatment Purchase Fund (NTPF), where there is a split between purchasers of care (on behalf of users on waiting lists) and providers of care. This will require a change in governance, to ensure that the HSE is not conflicted in relation to its own hospitals. In effect, over time, the system will move in the direction pioneered by the NTPF over the past decade, and when it is in place there will be no need for a specific programme for waiting lists *per se*.

In association with these five guiding principles, over 20 specific actions are proposed with related timelines for implementation and delivery. These recommendations are set out in Chapter 5 of the Report.

Financing Mechanisms

12. In relation to financing, the Group concluded that reform of the present system is necessary on the grounds that it is not equitable and that it does not encourage appropriate behaviours. The Group took the view that such reform could take place either through a social health insurance system or by the development of the mainly tax-funded system currently in place. What matters crucially is the effectiveness of the system which is put in place and not whether it is financed by taxation or social insurance. The Group identified the main characteristics of a quality health-care financing system as:

- Equity and fairness, i.e. those who can afford to pay more, should pay more
- Transparency, i.e. everyone should be able to understand the system and know what they are entitled to receive
- Promotion of good attitudes to care, e.g. encourage patients to be registered with a GP, and to seek help when needed (requiring pre-payment[5] for at least some services)
- Consistency with policy objectives (e.g. promotion of integrated care)
- Sustainability (e.g. promotion of treatment of chronic disease within the community).

[5] Pre-payment means that the cost of care is not paid at the time of use, and the cost to individuals does not depend on how much they use. Typical systems of pre-payment are insurance (both private and social) and services funded through taxation. Pre-payment is important when needs are uncertain or where it is important not to deter people from using services (e.g. checking or monitoring blood pressure).

13. In its Report, the Group shows the merits of taking a framework approach to eligibility that would help to progress these objectives. Since in-patient hospital care is free, the illustrative framework concentrates on eligibility for services in the community, and the focus in the first instance is on GP services and Drug Payments (DP). The illustrative framework allows for this to be done progressively in a rational and systematic way, with the pace of restructuring dependent on the availability of resources. In essence, the framework shows how the current complex arrangements in relation to medical cards, GP Visit cards, DP cards, long-term illness cards, etc., could be replaced by a single integrated stepped system (involving four different levels of primary care card). Each card type would provide the card holder with a level of support that reflects both their income and health status, i.e. a graduated co-payment system. In effect, individuals currently above the medical card threshold would receive graduated subsidies towards the cost of both their GP visits and drugs, and the balance of the cost would be met by co-payments that would be fixed or capped.[6] For example, a person a little above the current GP Visit card level or a person at high risk of a stroke or heart attack might pay a maximum user fee of €30 for a GP visit, and only 60 per cent of the standard price for drugs, and a person who has had a stroke or heart attack might pay €20 out of pocket when seeing a GP and 40 per cent of the standard drug prices.

14. The essence of the illustrative framework is that subsidies should focus on improving access to care by those on lower incomes (but above current thresholds) and on those with diseases that require continuing treatment (or people at high risk of such diseases where early interventions are needed). Since the subsidies would be progressive, people would not face a large increase in costs when their incomes rise slightly. The framework details are discussed in the Report. In line with its Terms of Reference, the Group considers how such a framework might be developed within the current quantum of resources going to support the health-care system. It identified that there are significant potential savings if all Irish health care providers were as efficient as the most efficient Irish providers. It also suggests that direct subsidies that would help meet policy objectives would be a better use of public resources than the current tax relief on medical expenses and private medical insurance.[7]

[6] Co-payment means the share of the cost of services paid by the user at the time of use.

[7] The Department of Finance notes that various significant tax expenditures have been restricted or terminated in recent years. All revenues raised by such tax base broadening measures have been absorbed into general government revenues. There is no direct link between tax expenditures and expenditure programmes, allocations for which are determined as part of the annual Estimates process.

15. In relation to financing, the Group proposed one Guiding principle, namely,

P6 *The methods of financing health care should be as effective and equitable as possible.*

This means having a coherent system of financing that supports the most efficient use of services across the whole health-care system and removes current inequitable and inefficient barriers to appropriate care. This involves reducing payment or co-payment rates at point of use and supporting the transfer of health care out of hospitals and into the primary and community care settings. Lower co-payments can be achieved over time either by the orderly development of the existing medical card system or by the development of a social health insurance system. Potential resources to fund more equitable and effective care must be found within the current quantum of resources supporting health care by efficiency savings and more targeted use of existing resources.

Sustainability

16. The Group's final guiding principle relates to the need for the system to be sustainable.

P7 *All aspects of the health-care system should be as sustainable as possible.*

17. This means having an information system that brings together all the costs of health care into a transparent setting, and that major costs should be continuously subject to careful analysis and value for money audits so that Ireland's cost base for health care can be brought into line with relevant comparator countries. This should parallel audits in relation to safety that are currently being developed.

Implementation Challenges

18. The Group noted the potential benefits to the Irish health-care system of having a resource allocation system that can underpin and support the actions being pursued to improve safety and quality of care throughout the system, and how this links up with the payment systems used to finance care. For example, where clinical protocols are currently being rolled out to support better care for those with chronic diseases, the effectiveness of these protocols will be limited if there is not a systematic approach to providing resources to support them. By this the Group means moving resources out of hospitals and into the community in the context of developing the appropriate infrastructure and governance. This requires good management of budgets and the creation of appropriate incentives to support the protocols. While there might be agreement at a high level to changing practices and changing incentives, there are consequential changes for the rest of the system which need to be tackled if possible barriers to implementation are to be addressed before they emerge. The Report lists the major barriers to implementation that might arise. Such potential barriers include the weak state of development of governance and the inadequacies of certain organisational structures. There is also need for greater flexibility on the part of health-care providers, both individuals and institutions. The Group recommends that, in the implementation process, particular attention be directed to considering these issues in full, as a failure to do so could undermine the essential goals of safety, quality, effectiveness and sustainability.

19. The Report's recommendations are set out in Chapter 5.

CHAPTER 1 | Introduction

Chapter 1

Introduction

1.1 Context

The Irish health service, in common with those in most advanced countries, is in the process of change and reform. The central focus for most of the reforms is improving safety and quality for potential and actual users of care by focusing on illness prevention and on better management of chronic illness, which now account for a major share of total health-care costs in developed countries.[8] Both of these objectives require a major change in the way care is integrated across the system, ranging from the most basic public health measures (e.g. encouraging smoking cessation) to the most advanced surgical techniques (e.g. organ transplantation).

Integration makes it easier for individuals to access the right services in the right setting. In an integrated health-care system patients get the majority of their care through community based facilities, using acute hospital services only where necessary. For real integration to be effective

- providers of care in the community must have shared responsibility for patient care with specialised services, thus guaranteeing continuity of care for the patient
- potential users should expect regular and reliable communication from the different care providers
- potential users must not face long delays when they do need to attend hospitals
- the historic system that has a built-in distinction between hospitals and community care must disappear
- any new system will require multidisciplinary team-based behaviour, underpinned by transparency and accountability.

Ireland has begun the long process of moving to integrated care, recognising that, without further integration within the health-care system, the objectives of having a fair, high quality and cost-effective system cannot be met. There have been significant positive developments in recent times but much more needs to be done.

A further area of change internationally relates to methods used to finance health care that are equitable and sustainable. In many countries, there are debates on whether and to what extent public health care should be financed through social health insurance or taxation and what individual entitlements to health care should be. These debates in turn are linked with financial sustainability and with the need for health-care delivery that is safe and effective. In Ireland there has been some public debate on this issue, but little discussion on what characteristics such a

[8] Box 1.1 on page 5 sets out different types of chronic diseases with examples.

system might have, irrespective of whether it is financed through taxation or social health insurance.

To make further progress in terms of integrated health care and sustainable financing, Ireland needs

- a resource allocation system that promotes the delivery of safe and cost-effective services and
- a financing system that promotes care in the right setting without financial barriers for users to effective services.

The resource allocation system must reinforce efficient management of resources and good clinical practice. It provides a vital support to existing Value for Money (VFM) programmes and efficiency measures and to the process of rolling out clinical protocols. A fairer and more rational financing system should also support good clinical practice and reduce disparities in the access to care that are unrelated to need.

On 23 March 2009, the Government agreed to a proposal from the Minister for Health and Children, Ms Mary Harney, T.D., to establish an Expert Group to examine how the existing system of resource allocation in and financing of Irish health care could be improved to support better the Irish health-care policy priorities.

The remit of the Group was to include all 'health and social care' covered under the health budget. This is a wider definition than the international norm (e.g. OECD) for health care. The Group has used this wider definition throughout the Report, so that when the term 'heath care' is used, it should be interpreted to include those parts of social care that come under the auspices of the Department of Health and Children (DoHC) and the Health Service Executive (HSE). In line with this, the term 'user' should be seen to cover 'patient' in a health-care context. Throughout the Report the term there is reference to 'acute hospitals'; from time to time these are referred to simply as 'hospitals' but it will be evident from the context that these are 'acute hospitals'.

Box 1.1: What is a chronic disease?

A chronic disease is an illness that is long lasting or recurrent. The term chronic refers to the course of the disease or its rate of onset and development. It is understood that there are several distinct but often related forms of illness that can be considered under this definition.

1. A disease with an acute presentation, complex initial treatment and ongoing surveillance with or without recurrence. Many cancers can be considered under this definition.
2. A disease with an acute onset and relative periods of stability, but with acute exacerbations often requiring complex care. Examples include epilepsy, asthma and diabetes.
3. A disease with a sub-acute onset, with a slowly progressive course, with periods of relative stability, but with chronic ongoing dysfunction. Examples include dementia and chronic multiple sclerosis.
4. A disease that remains hidden or non-symptomatic and that may be detected on routine screening which requires ongoing surveillance and treatment. Examples include hypertension and hypercholesterolemia.

This Report presents the findings of the Expert Group. The evidence that has underpinned the work of the Group is set out in 'Resource Allocation, Financing and Sustainability in Health Care: Evidence for the Expert Group on Resource Allocation and Financing in the Health Sector'. This document was prepared by researchers at the Economic and Social Research Institute (ESRI) and throughout the Report there are cross-references to it. It is referred to as the 'Evidence Report, ESRI (2010)'.

Section 1.2 of the Report lists the members of the Group and sets out its terms of reference. Section 1.3 outlines the principles and goals of health care in Ireland, which the Group used to establish its guiding principles for resource allocation and financing of the Irish health-care system. Section 1.4 describes the methodology the Group adopted in carrying out its work, and Section 1.5 provides an outline of the remaining chapters of the Report.

1.2 Membership and Terms of Reference

On 01 April 2009, the Minister for Health and Children announced the establishment of the Expert Group on Resource Allocation and Financing under the chairmanship of Professor Frances Ruane, Director, ESRI. The Group was asked to report to the Minister for Health and Children and the Minister for Finance by April 2010.

The composition of the Group was designed to include the key disciplines required to develop a framework for resource allocation in health care: medicine and social care, economics and management. This reflects the need for clinical/care, economic and managerial and economic drivers to reinforce each other, and the danger that if not jointly considered, they actually undermine each other.

The membership of the Group is as follows:

Chair – Professor Frances Ruane, Director, ESRI

Mr. Brendan Broderick, CEO Sisters of Charity of Jesus and Mary, Moore Abbey

Mr. Ian Carter, CEO, St. James's University Hospital

Dr. Colin Doherty, Consultant Neurologist, St. James's University Hospital

Mr. Derry Gray, Partner in Charge of Consulting, BDO Simpson Xavier

Professor Arnold Hill, Professor of Surgery at RCSI and Beaumont Hospital

Ms. Nuala Hunt, Board of Governors, National Maternity Hospital

Professor Peter Kearney, Consultant Cardiologist, Cork University Hospital

Mr. Thomas G. Lynch, Chairman and CEO Amarin Corporation plc.

Mr. Pat Lyons, CEO, Bon Secours Health System

Professor Andrew Murphy, Department of General Practice, NUI Galway

Professor Charles Normand, Edward Kennedy Professor of Health Policy and Management, University of Dublin, Trinity College

Mr. Manus O'Riordan, Head of Research, SIPTU

Professor Rowena Pecchenino, Head Department of Economics, Finance and Accounting, NUI Maynooth

Ms. Patricia Purtill, Principal Officer, Sectoral Policy Division, Department of Finance[9]

Ms. Patricia Sullivan, General Manager, Waterford Regional Hospital

Mr. Dermot Smyth, Assistant Secretary, Department of Health and Children

Mr. Liam Woods, National Director of Finance, Health Service Executive

Secretariat to the Expert Group was provided by the Resource Allocation Review Unit of the Department of Health and Children.

[9] Patsy Purtill joined the Group in August 2009 following a request from the Department of Finance for representation. She was subsequently replaced on the group by Mr. David Moloney, Assistant Secretary, Department of Finance, who attended the 9th and 10th plenary meetings and by Ms. Judith Brady, Principal Officer, who attended for the 11th and 12th meetings. Mr. Paddy Howard, Department of Finance, supported the work of the Group on financing throughout the process.

The Minister asked the Expert Group:

- to analyse the strengths and weaknesses of the current resource allocation arrangements for health and personal social services
- to recommend appropriate changes in these arrangements which would support and incentivise the achievement of the core objectives of the health reform programme
- in the light of its work, to take a view on the most appropriate financing mechanism for the Irish health service
- to base its examination and recommendations on the existing quantum of public funding for health.[10]

1.3 Health-Care Principles and Goals in Ireland

As outlined in its Terms of Reference, the work of the Expert Group has been aligned with the goals of the health-care reform programme, which derive in turn from the overall vision and principles set out in our current national health-care strategy. In looking at any health-care system, the starting point is to explore what the health-care system is seeking to achieve.[11] It is therefore important to reiterate the national health-care principles and goals here, identifying how they relate to international policy statements.[12]

At the international level, three core values for health care have been adopted by the World Health Organization. The first is to achieve better health in the population, the second is to ensure fairness in contributions to health-care financing, and the third is to ensure that the health-care system is responsive to people's needs and expectations (e.g. respect, dignity, autonomy, confidentiality of information, etc.). Some further important objectives have also been identified at the international level. These include: equitable use and provision of services relative to people's needs, transparency and accountability, quality and efficiency in service delivery, efficient administration of the health financing system, and participation (i.e. direct involvement of individuals in health decision-making processes). Similar values have been adopted at the European level and these include: universal coverage, high quality health care, equity, and solidarity in financing, as articulated in the Tallinn Charter.[13]

[10] From a government expenditure perspective, the quantum of public funds represents the gross spending of the relevant department, i.e., the Vote. From an economics perspective, it means the public funds that go to support health care, directly through the health vote and indirectly through tax incentives.

[11] In the literature on health policy statements, many of the terms around health policy principles, values, objectives, goals and others are often used interchangeably. In the Irish context, the national strategy adopts a hierarchical use of the terms, from the vision and principles at the top, to goals, to specific objectives and from there to actions. We interpret the overall vision and principles as providing the broad, overarching, conceptual aims of the sector and act as general signposts for how the sector should behave (principles) to achieve what it is striving towards (vision). We interpret the goals as translating the general principles into more tangible statements of what needs to be achieved. The objectives state in more detail what needs to be done to meet those goals, and these give rise to specific actions that can be monitored and assessed.

[12] However, it should be noted that arriving at a coherent set of policy principles and goals is not straightforward and there are particular complications around the principle of equity which are discussed in more detail in Evidence Report, ESRI (2010), Chapter 1.

[13] See WHO Europe, 2008.

In Ireland, the key values for the health-care system are outlined in the *Quality and Fairness – A Health System for You*, published by DoHC in 2001. We note that the strategy takes a whole-systems approach and clearly sets out that its remit covers both health and social well-being, and also encompasses not just public providers, but private providers of health-care services, and any other people/institutions with a role to play in health care.

Its overarching vision for the Irish health-care system is:

'*A health system that supports and empowers you, your family and community to achieve your full health potential; A health system that is there when you need it, that is fair, and that you can trust; A health system that encourages you to have your say, listens to you, and ensures that your views are taken into account.*'

Four guiding principles support this overall vision:

- Equity and fairness
- Quality of service (best-practice, evidence-based care)
- Clear accountability (financial, professional and organisational)
- People-centredness (responsive to needs of individuals, co-ordinated delivery of care, and individual participation in decision-making).

A set of four national goals has been identified to pursue this vision and these guiding principles, and the same vision and goals guide the 'Health Service Reform Programme' set out in 2006.[14] The health policy objectives outlined in the Terms of Reference for the Expert Group are consistent with and effectively include the four goals outlined in the national strategy, while adding a fifth goal, namely, to ensure financial sustainability.[15] With regard to the work of the Expert Group, it is important to clarify the above principles and goals as they apply in the context of financing and resource allocation in the health-care system.

[14] The goals are: (i) to achieve better health for everyone by placing health at the centre of public policy, promoting health and well-being, reducing health inequalities and targeting specific quality of life issues (e.g. improved quality of life for older people, improved chronic disease management, improved rehabilitation for people with disabilities, etc.); (ii) to increase fair access in the system, involving clearly defining and broadening the scope of eligibility in the system and ensuring equitable access for all patients; (iii) to ensure that health-care delivery is responsive and appropriate, by placing the patient at the centre of care planning, delivering appropriate care in the appropriate setting, and ensuring that the system has the capacity to delivery timely and appropriate services; and (iv) to achieve high performance in the system by using national standards and protocols for quality care and evidence-based decision-making. See The Health Service Reform Programme, Department of Health and Children. Available at www.healthreform.ie/background/purpose.html

[15] Ireland's approach here follows international norms with the health-care system required to improve health status, be equitable, be responsive and people-centred, deliver high quality care, and be efficient, transparent and accountable.

Equity and Fairness: The principle of equity and the related goals to reduce health inequalities and ensure fair access in the system are in fact linked to a very complex concept.[16] In line with international practice, we interpret equity in health care as meaning that health-care delivery is based on user need, and paid for in ways that reflect ability to pay for, rather than the need to use, services. However, separating payment for health care from decisions governing how health care is delivered and allocated does not automatically imply that all health care needs to be publicly funded. Rather the separation requires that health care is prepaid (and this can be done using public or private sources of funding).

Quality of Service: Improving quality reflects the increased emphasis on safety which is directly linked to it. Central to safe care is the role to be played by clinical protocols in supporting more effective and evidence-based best practice methods of delivery of care which will improve health outcomes.

Clear Accountability: Ensuring accountability in the delivery of services means having a rational framework of service delivery underpinned by a resource allocation model that promotes good governance and effective mobilisation of resources to deliver complex care in an accountable manner. This means having a framework where clinical, managerial and economic drivers reinforce each other.

People-centred system: This requires a resource allocation model which ensures that resources follow the service user across different care settings, so that the right care is delivered in the right setting at the right time.

In line with previous documents, the Group treats principles as signposts for how it wants the sector to behave with regard to resource allocation and financing, and it outlines specific actions to tie in with those principles.

[16] As discussed in more detail in the Evidence Report, ESRI (2010), Chapter 1, there is no universally agreed definition of equity and this can cause problems when interpreting policy statements on equity. There are two issues arising from analysis of how equity is defined in the Irish health-care policy statement: (i) There is no definitive statement on how fairly or otherwise health care in Ireland should be financed. (ii) Policy is clear that the delivery of health care should not be linked to ability to pay, but that further clarity is needed on whether the policy seeks to equalise health-care need, health-care access, or health status in the population. See Health Service Reform Programme, Department of Health and Children. Available at www.healthreform.ie/background/purpose.html

1.4 Methodology

The Expert Group met in plenary session on 12 occasions between April 2009 and June 2010.[17] The Group took as its starting point the policy priorities identified in a range of policy documents published by the DoHC since 2000, and the findings of two Commissions that had addressed, *inter alia,* the issue of resource allocation previously. The key points in the most recent documents are set out in the Appendix.[18] Taking these starting points, the Group's approach was to then see how improvements could be made to the resource allocation and financing systems currently in place so that these stated policy priorities might be achieved more successfully, while maintaining the sustainability of the system. The Group set out the following basis for its work:

1) It would review the international evidence on resource allocation and financing in eight jurisdictions to ascertain best international practice.

Extensive international evidence was gathered by a research team at the ESRI on behalf of the Group. It drew on the international literature on resource allocation and financing in health care and on the research literature on individual countries as well as assembling a comprehensive data set on the eight jurisdictions. It was decided early on that this evidence should form part of the reporting process and it takes the form of a document published jointly by the ESRI and the Department of Health and Children (DoHC). In effect, it provides the international evidence together with detailed analysis of the Irish system on which this Report is based.

2) It would review the current resource allocation systems and financing systems in the Irish health-care sector to identify the challenges implicit in the present models.

The structure of delivery in the Irish health-care system has changed dramatically in the last decade, with the establishment of the HSE in 2005.[19] A consequence of this is that analysing patterns of resource allocation could really only start from 2006, and the data on the continuing and community care sector are particularly scant. A further problem was that the structures of the HSE are still in flux and the internal HSE data were not readily comparable across years in certain cases, despite considerable efforts on the part of the research team and the HSE personnel. Yet another problem was that policy changes continued to occur in the period since the Group was established. Some of the substantial changes included:

[17] The Expert Group worked in both plenary session and by way of sub-groups. The sub-groups covered three areas: Service Delivery (co-chaired by Derry Gray and Rowena Pecchenino) covering Acute Hospital Services, Primary, Community and Continuing Care; Financing (chaired by Charles Normand); and Sustainability (chaired by Nuala Hunt). The Group and its sub-groups were supported by a Project Team comprising officials from the DoHC, the HSE and the Voluntary Hospital Sector. The Project Team met regularly to consider issues raised by the Expert Group, to draft working documents/discussion papers for the Group and its Sub-Groups, to provide comprehensive briefings by numerous departmental line divisions and to keep the Group informed of the changes that were ongoing in the health-care system throughout the period. The Group also had administrative support from the DoHC in the organisation of its meetings and in assisting the research team in arranging meetings with, and obtaining data from, the DoHC and the HSE.

[18] This Appendix was prepared for the Group by the DoHC Secretariat.

[19] The HSE was created on foot of the publication of the Report of the Brennan Commission (completed in January 2003) and the Report by Prospectus Consulting completed in June 2003. Both were published in June 2003. See the Appendix.

- *Salaries and Working Conditions*: Significant reductions in fees and allowances for certain health professions and reduction in salaries for health-care staff in line with the rest of the public sector, together with agreement on reviewing work practices aimed at increasing efficiency in health-care delivery (Croke Park agreement)
- *HSE Structures*: Merger of the two-pillar structure within the HSE [National Hospital Office (NHO) and Primary, Community and Continuing Care (PCCC)] to create an Integrated Services Directorate (ISD), and create Integrated Services Areas (ISAs) to deliver these integrated services at local level under newly-created Regional Development Directors
- *Clinical Protocols and Practices*: Establishment of HSE Directorate of Quality and Clinical Care, and appointment of almost 50 Clinical Directors (in line with the Consultant Contract negotiated in 2008) tasked with developing and strengthening clinical management within hospital service
- *Private Health Insurance*: Proposal by Government to introduce a new Risk Equalisation Scheme to take effect from 2013, and (including a transitional scheme for 2012) to provide funds to recapitalise the main health insurance company (*Vhi Healthcare*) with a view to privatising it in two years
- *Nursing Homes Support Scheme*: Introduction of Fair Deal to support individuals needing long-term nursing care, under a single transparent system covering both public and private providers
- *Pharmaceutical Charges*: Significant reductions in the retail mark-up from 50 per cent to 20 per cent and the wholesale mark up from over 17 per cent to just 10 per cent of the ex-factory price of drugs.

These changes added to the challenges faced by the Group but also pointed to the need for having frameworks in which to consider the direction of policy changes.

3) It would seek submissions from interested parties to inform itself of stakeholder perceptions of the challenges perceived in the present system.

The Expert Group engaged in a consultative process by inviting submissions from the public and relevant interested groups/parties on the issues within its remit between May and the end of June 2009. Submissions were asked to focus on suggestions for change in the resource allocation system to enhance delivery of the core objectives of health reform, with particular emphasis on providing access to the care/treatment that individuals need as quickly as possible, on equity of access, and ensuring this is done is a sustainable way. In total sixty-one written submissions were received and the contents were used to inform this Report.

While some of the submissions did not concentrate on the above brief, some common themes emerged. These included: need for multi-annual budgeting; only core health services should be included in the health budget; current funding system a major obstacle to development of individual person-centred approach; budget should follow the person rather than be allocated to a particular service. A summary of the findings and the list of groups who made submissions are set out in the Appendix.[20]

4) It would work in subgroups so that the wide ranging terms of reference could be addressed as comprehensively as possible.

Given the cross-disciplinary nature of the Expert Group, the subgroups provided an opportunity for members of the Group to develop a shared understanding, given the very different perspectives from which group members were coming to these particular issues. An early decision to establish subgroups on Acute Hospitals and PCCC had to be reversed when it became evident that the integration issue in service delivery is now so powerful that it did not make sense to decouple these two sectors. These are given separate and joint treatment in the Evidence Report (ESRI 2010) as this reflects the situation in most other countries that are striving, as Ireland is, to integrate services so that safety and quality can be enhanced and costs contained.

Drawing on its own experiences, the Group has included in its report some illustrations of cases which show the weaknesses of the present Irish health-care system, together with some examples where changes made have improved health care. These are set out in Boxes in both Chapters 2 and 3.

In writing the Report, the Group was concerned to ensure that, since health care is so complex, different elements of it could be fully contextualised. See Figure 2.2 in Chapter 2. As a consequence, there is some unavoidable repetition in Chapters 2-5.

1.5 Outline of the Report

Chapter 2 begins by providing an overview of the international literature and experience on resource allocation and financing of health care. Drawing on this literature, set out in more detail in the Evidence Report, ESRI (2010), and on the Group's specific experiences and expertise, the Chapter concludes by setting out five guiding principles in relation to resource allocation and two further principles in relation to financing and sustainability.

Chapter 3 summarises the present 'as is' situation in Ireland, following on from the discussion of high-level issues in Chapter 2. The seven guiding principles in Chapter 2 are then used to evaluate the present system.

[20] The consultative process was organised by the Secretariat, which also prepared the analysis of responses.

A coherent resource allocation framework is key to ensuring that resources are allocated to support safe and most effective care. The requirements for such a framework are outlined in Chapter 4. This framework is driven by the need to ensure integration across services, which in turn reflects the growing importance of chronic diseases and comorbidities in health.

Chapter 4 also outlines a framework for financing health care that would allow a systematic and coherent development of the present financing system. The framework is designed specifically to manage chronic diseases more effectively and to reduce the most distortionary elements in the present financing system. In the case of both frameworks, the emphasis is on coherence, which should operate irrespective of the level of the total (public and private) funding for health care.

Chapter 5 uses these two frameworks and the guiding principles from Chapter 2 to set out the Group's recommendations. The recommendations take the form of actions, with specified time lines, to make the present system more coherent.

Chapter 6 discusses some implementation issues and recognises that the move to a coherent system will involve changes for many of those involved in the health-care sector.

The Appendix contains a summary and analysis of recent reports and studies relevant to resource allocation in Irish health care and of the submissions received by the Group. As noted above, there is a separate Evidence Report.

CHAPTER 2

Improving Resource Allocation, Financing and Sustainability of Health-Care Systems

Chapter 2

Improving Resource Allocation, Financing and Sustainability of Health-Care Systems

2.1 Introduction

This Chapter begins by outlining some of the major issues currently facing health-care policy makers internationally, as the arrangements for the financing and delivery of health care goes through major changes in all Western countries. The traditional model of health care was designed to deliver episodic care on a reactive and fragmented basis, whereas today care is conceived of as providing integrated services that focus on the promotion and maintenance of health. Today's needs explain why so much importance is now attached to the relationship between different care settings. Because of this very significant change, driven primarily by changing patterns of disease (especially the shift towards improved survival and increased prevalence of chronic disease), technology and costs, most health-care systems internationally are engaged in very significant change. As no country is starting from a green field site, a key challenge for governments is to guide change and move from the traditional to the new model of care.

Financing and resource allocation in health care are sets of tools that are used to drive the systems towards greater efficiency, effectiveness and equity. Programmes of reforms in Western countries have included developments and experiments from which much can be learned, especially in how resource allocation can support integration and encourage efficiency, and how equity can be improved. Systems have been developed to improve the equity of access across different geographical locations, to incentivise the delivery of care in appropriate settings, and to encourage greater efficiency in the delivery of care. Priority setting has become more explicit, with wider use of formal assessment of new and existing treatments. Systems for classifying workload and assessing costs are becoming more sophisticated, and wider roles for primary care and community-based services are developing. This chapter reviews some of the learning from other countries on these developments. As the scope for effective health-care interventions rises, and as the population who can benefit expands as well, a key issue is how to contain health-care costs so as to maximise the available services within available resources. There is, therefore, a particular emphasis on the evidence relating to drivers of costs and how they might be managed.

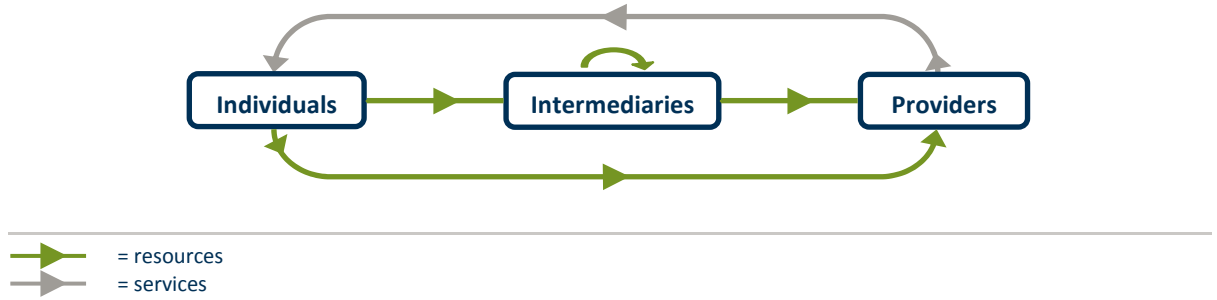
It is possible to identify the guiding principles for resource allocation that are associated with the modernisation process from reviewing what has taken place in a range of countries and what has been analysed in the health-care literature. This Chapter identifies those guiding principles and examines them in the context of access to and delivery of care, financing of health care, and its sustainability.

Before reviewing the international literature, it is useful to highlight the inter-linkages between resource allocation, financing and sustainability. Figure 2.1 (taken from Chapter 1 of the Evidence Report, ESRI (2010)) gives a stylised overview of the broad structure of a health-care system, showing the flow of health-care resources (green arrows) from payment source (individuals), to financial intermediaries (e.g. the Government), through to providers. Health-care services (grey arrows) flow from providers to individuals. Important decisions are required on the overall level of resources that flow through the system, and how resources and services are to flow from one part of the system to the next so that health care is financed and delivered in accordance with stated policy priorities. Decisions on how one of the components operates can affect the rest of the resource flow.

Figure 2.1 provides a diagrammatic snapshot of the health-care system. It highlights the fact that decisions around the resources that are available for resource allocation in health care (sustainability issues), the way in which these resources are generated (financing issues), and how they are subsequently allocated (resource allocation issues) comprise different parts of a complete resource flow in a health-care system.

FIGURE 2.1

Flow of Health-Care Resources and Services



As noted in Chapter 1, throughout this report the term ‘health care’ and ‘care’ are used to include various elements of social care that are linked to what is traditionally thought of as health care. This is consistent with how these services are organised in Ireland. Social care services, such as community services for those with disabilities and mental illnesses, home help for older people, meals on wheels, child protection, etc., are associated with supporting wellbeing rather that just health and are consistent with the concept of the continuum between health and wellbeing.

Section 2.2 reviews some of the key issues in the international literature in relation to resource allocation in and financing of health care. Section 2.3 summarises the key drivers of health-care costs, while Section 2.4 sets out the guiding principles.

2.2 Resource Allocation in and Financing of Health Care – A Brief Review of the International Evidence and Experience

2.2.1 Addressing General Resource Allocation Challenges

The purpose of any resource allocation system should be to support the delivery of care in line with national policy. It needs to provide the mechanisms that encourage users to access the system appropriately and should incentivise provision in the right ways and in the right places. It needs to assist in achieving equity and fairness and should facilitate change where this is needed.

Evidence from health system reform in other countries suggests that, in general, it is better to avoid major re-organisations of structures (Fulop *et al.* 2002), and to focus instead on changes in the mechanisms and incentives within existing structures. It is important also to take a whole-system approach in order to minimise incentives to shift costs inappropriately (such as use of acute hospital facilities to care for people with social and nursing care needs and provision of primary care in an emergency department (ED)). Since the main business of the health system is the prevention, diagnosis, treatment and care of chronic disease, the patterns of incentives in the care system must support co-operation between providers in hospitals and primary and community services, and must encourage users to access care where this is most cost-effective.

It is important also to recognise features of health care that make it different from other services that people routinely access. In particular, limited knowledge of disease and treatment in the patient population and asymmetrical information between providers and users of services reduce the effectiveness of what economists refer to as the 'market mechanism', and consequently there is always an important role for government in setting standards for information provision and in regulating appropriately providers of health-care services.

Despite the fact that most health-care systems aspire to providing health care based on need, research shows that in many countries those best able to pay for services are those least in need and vice versa. This outturn is due to many interacting factors, some of which relate to the design of health-care systems themselves.

There can also be other unintended consequences of some important and desirable features of health systems. For example, registration requirements for clinical professions are important for safety and quality of care, but also have the potential, unless carefully monitored, to limit entry and the extent of competition.[21]

In sum, the design of resource allocation systems is challenging and it is not possible to avoid tradeoffs between features that would be generally considered desirable.

[21] Registration requirements can limit the extent to which it is possible for potentially useful new professions and new roles for existing professions to develop. For example, in South Africa people with shorter periods of training can carry out some tasks traditionally limited to dentists, and roles of nurses in chronic disease management may require limited rights to prescribing.

2.2.2 Resource Allocation Challenges – Promoting Equity

It is policy in most Western countries for access to effective health-care interventions to be dependent on need and not on ability to pay. This has two practical consequences – first the entitlements to care should not depend on the person's income, and second, access to care should not depend on where he/she lives.

Separating access to care from ability to pay requires financing arrangements that provide insurance (in the sense that those who are lucky support those who are unlucky), and solidarity (i.e. those who can afford to pay more subsidise others). Health insurance can be provided through conventional risk-based systems, but these have the consequence that people who have (or people who are clearly at risk of having) expensive illnesses pay more, and those who are well pay less. It can be provided through non-risk based insurance,[22] where payments are uniform or income related, or through taxation. Some countries also ensure some insurance through compulsory savings arrangements, which guarantee that, when well, people save for when they are sick.[23] However, this provides only very partial security for those with long-term illness. Compulsory social insurance and tax funded systems have many similarities, and provide both the insurance element (i.e. the lucky pay for the unlucky) and the solidarity element (i.e. overall, richer people pay more than poorer people). Simpler systems tend to work better in terms of equity than more complex ones, since the combination of user charges, tax or social insurance tends to leave some access dependent on ability to pay. It is not possible to remove all possible advantages for richer people, but most statements of health policy suggest that there should be no barriers to access to the most effective types of care.

Geographical inequities arise largely because of the availability or otherwise of local provision of care. Experience internationally has been for services to be concentrated in large urban centres and to be more available in more prosperous parts of countries.[24] Attempts to reduce such inequities have tried to ensure that funding is available to support care on an equal basis across the country, and equal access can be achieved by paying for services to be delivered by providers in neighbouring areas and providing appropriate transport or by developing capacity locally. In other words, areas should be self-sufficient in terms of funding but not service delivery.

Regional resource allocation formulae have evolved over more than 30 years and have typically been based on population by age and gender, adjusted for indicators of need for services. The more crude approaches used *easy to calculate* indicators such as standardised mortality ratios, but more recently there have been models that try to measure need for services more directly by looking at use of services

[22] In Ireland this is often described as 'community rating'.

[23] Singapore has adopted a system of medical savings accounts that ensure that funds are available to pay for care when it is needed, but experience has shown that in practice this works only for those who have infrequent and episodic care needs, and the costs for long-term illness fall on the state system.

[24] The Australian state of New South Wales provides an illustration. There, some populations were receiving substantially more than their population health resource requirements and others substantially less. Removing these disparities from the system took a decade.

adjusted for availability of services. All such approaches have limitations, but the overall experience has been that it was possible to reduce significantly the geographical inequities using this approach. A challenge faced in setting up and managing geographical equity is determining the size of the 'local' units. It is easier to develop skilled management in larger units, and there is less year to year variation in larger units, but this has to be balanced against the need to reflect what is perceived locally as local. The consensus has favoured a lower limit of 250,000 to 300,000 except where population is very remote and dispersed.

It should also be noted that inequities can remain within local areas, and actions may be needed within, as well as between, geographical areas to ensure equity in access to services.

2.2.3 Resource Allocation Challenges – Promoting Efficiency

Promoting efficiency (and containing costs) has been a major plank of policy across health systems. Features that have been commonly introduced include prospective payment (so that providers of care share the risk and have incentives to keep costs low), payment on the basis of work done, and the separation of responsibility for commissioning care and providing care.

Prospective payment systems require the capacity to classify a case in advance in terms of its likely costs, and then to agree a fixed payment for that case.[25] This changes the financial incentives towards lower costs of services and incentivises more efficient delivery of services, but does also run the risk that service quality will fall and corners will be cut. It requires clinical protocols to be in place along with good data for classifying cases and for costing the different types of cases.

A key change, especially in systems that have mainly public providers of care, is to move from paying organisations 'to exist' to paying them to provide specific sets of services. Historically hospitals and other care providers were given annual budgets (which might or might not be linked to a plan to deliver particular types and levels of services). Shifting from budgets to contracts, and particularly to contracts based on services provided, changes the financial incentives to providers. Contracts can be of different types, and can be associated with different types of payment. For example, the contract for an ED service is unlikely to specify the number of cases, but would specify opening hours and protocols for service delivery, whereas contracts for elective cases would be based on numbers treated, adjusted for complexity. Contracts for long-term support might use capitation payments, but payments might be per case where the aim is to encourage take up, e.g. vaccination.

[25] The US was the first country to introduce casemix funding in an attempt to control rising costs (associated with fee-for-service payments) for in-patient care for Medicare patients in 1983. It has since been adopted in Sweden, Australia and several European countries. The payment system in Canada is still predominantly budget-based, but these countries are experimenting with casemix funding.

A common feature in many public health systems (and a feature of most social insurance) is the separation of the role of determining what should be provided, and that of managing the delivery of care (often described as the 'purchaser-provider split'). See the Evidence Report, ESRI (2010), Chapter 2. This approach recognises that both these roles are complex, and that both need special skills.[26] Although the evidence on the success of this approach is incomplete, moves in this direction are widespread, and there are additional benefits, e.g. in the greater ease of planning access to complex packages of care across different providers.

2.2.4 Resource Allocation Challenges – Shifting from Hospital Led to Primary and Community Care Led Service Delivery, and from Reactive to Proactive Care

For many decades, and especially since the Declaration of Alma-Ata in 1978, there has been a renewed focus on the delivery of health care in primary and community-based settings, and for a shift from managing illness to managing health.[27] The change of focus is about where services are delivered, how services are delivered and by whom they are delivered. Roles of primary care doctors have shifted to include support for managing chronic disease, and roles previously carried out by doctors have in some cases shifted to nurses (and roles of nurses to other professional and non-professional staff). The change in approach has also been to encourage a shift from episodic care for the sick to care to reduce illness, and to early management of illness.

Modern models of disease management require teamwork across care settings, additional skill sets (such as specialised disease management nurses[28]), and management of established chronic disease that anticipates and avoids acute episodes.[29] Health Maintenance Organisations (HMOs) in the United States have pioneered programmes that aim to keep people out of (relatively expensive) in-patient facilities. Disease management protocols and guidelines are being developed and used in many countries. The role of hospitals remains important in modern disease management, but may include shifts of out-patient activity into community based facilities, and may involve support to those who deliver care directly outside of hospital settings. Lengths of stay in hospital for any given procedures have been falling, and can fall further if suitable services outside hospital are available.

Modern models of care have usually seen the development of primary care facilities, teams working in primary care, and a shift away from solo practice by primary care doctors. In some cases nurses and allied health professionals work from the same base as primary care doctors, and there are strong links with social care service

[26] As a result of political concerns about lack of separation between purchaser and provider in Sweden, county councils have replaced GPs as purchaser and now contract directly with all health-care providers.

[27] International Conference on Primary Health Care, Alma-Ata, USSR, 06-12 September 1978.

[28] In Ireland these might be described as Clinical Nurse Specialists or Advanced Nurse Practitioners.

[29] A vision for community-based care in the UK was set out in the 2006 white paper 'Our Health, Our Care, Our Say: A New Direction for Community Services'. Although the white paper recognised the need for integrated care, implementation was largely left to the initiative of individual Primary Care Trusts rather than being rolled out nationally.

providers. Since care needs are complex, patients and their families may often need professional help to access the necessary care services. Such assistance (for example, through a social worker) would take the form of advocacy where needed, as well as co-ordination of the appropriate services. These models require that there is a clear responsibility for ensuring the needs of patients are met effectively across the different care settings and service providers.

Box 2.1: Potential Benefits from Better Management of Chronic Illness and Co-Morbidities

Maeve is an 84 year old widow who has the following conditions:

- A new heart valve
- High blood pressure
- Poor kidney function
- Irregular heart beat.

She is on seven different medications and needs regular blood tests to monitor her Warfarin, a drug used to prevent the formation of blood clots.

Up until three years ago she attended three different hospital out-patient clinics (heart, kidney and geriatric) twice yearly and hospital coagulation clinics monthly. However, for the last three years, she has attended a special vascular clinic at her local general practice, run by a practice nurse, which monitors all of the above. In the last year, her coagulation test has also been done immediately at the practice. She now just goes to the hospital kidney clinic. As a result of these changes to her care, her quality of life has significantly improved.

Comment: New technologies benefit patients and can reduce costs further if care is in the community.

2.2.5 Resource Allocation Challenges – Capital and Current Decision-Making

It is now widely recognised that it is essential to consider capital resources and their allocation in the context of establishing models designed primarily to allocate current resources. There is now evidence that better facilities can reduce the costs of care (Ulrich *et al.,* 2008), and that moving services to more appropriate levels and locations depends on the availability of suitable building and equipment.

Capital resources, which require major outlays at a point in time, represent only a small part of the total cost of health-care provision. Despite this, they can have very large effects on the configuration of services and on the current costs of services over a long period of time. Consequently, new capital expenditures should reflect future need and not merely seek to simply catch up on past unmet needs. Incentives surrounding the funding of capital resources should encourage efficient use of existing capital, and link the development of new capital to the priorities for service development.

There are no simple answers as to how best to manage the allocation of capital resources, but certain general features suggest themselves:

- As in the case of current expenditure, capital resources should be determined on a population health basis
- There should be a transparent process for setting capital priorities which should be determined in the context of (i) the associated current costs, and (ii) the net improvements in or expansions of services (e.g. better/safer care)
- There should be incentives to use facilities efficiently once provided
- Financial incentives should encourage managers to replace/reconfigure space that is unsuitable
- Accounting rules should encourage managers to purchase/maintain/dispose of equipment rationally and account for the cost of capital on an ongoing basis. The use of internationally accepted accrual accounting practices would achieve this.[30]

There may be benefits to be gained from adopting an approach to the use of capital similar to that used in the private sector. Options include allowing health-care providers to borrow for capital developments with the cost of capital being recovered through current funding (an approach currently being explored in Germany), or separating ownership of facilities and their use (effectively shifting to a model where hospitals/institutions rent their capital resources).

Box 2.2: Planning Hospitals – Comparing the USA and Ireland

In many US states, health-care providers are required to submit a 'Certificate of Need' application and obtain state approval before new facilities are built, existing facilities are renovated, major medical equipment is acquired or services are materially altered.

Applications are assessed against the following criteria:

- Public need
- Financial feasibility
- Character and competence of operator
- Building and construction design.

In Ireland it is possible for anyone to develop new or to expand existing health-care facilities without any reference to the need for the additional capacity or service. Local planning authorities, who are tasked with giving approval to build, have no responsibility or remit in evaluating the need or determining the impact such developments have on the overall heath care service in the region.

Applying an American approach to capital planning in Ireland could prove difficult, costly and time consuming given the absence of key economic and demographic data. Notwithstanding this, there is a strong case for integrating population needs assessment into capital and service planning together with applying a more structured and formal process to approval/certification of major development plans for both public and private health care systems.

Comment: Whole-system planning can provide better care infrastructure and greater efficiency.

[30] While the Irish public sector continues to operate cash flow accounting, there are public sectors internationally that use accrual accounting.

2.2.6 Approaches to Financing Health-Care Systems

It is often not properly recognised that, directly or indirectly, the source of funds for almost all resources for health services is households. The mechanisms through which households finance health care vary, and may involve:

- direct payment (no intermediary)
- private insurance companies
- publicly-mandated insurance arrangements[31]
- health maintenance organisations
- government agencies and
- local or national governments.

Affordability of health services in any country depends mainly on the overall wealth of households and only to a more limited extent on the exact mechanisms chosen to manage the flow of resources. In this context it is important to see the costs of health care as the overall costs to citizens and not the costs that fall on particular insurance organisations or government budgets. Since all resources come ultimately from citizens there is little advantage to them in simply changing the way in which they pay, such as when savings to government budgets are achieved by simply transferring costs onto the users of services themselves.

Key principles in the choice of financing mechanisms are:

- equity (to allocate the burden fairly)
- acceptability and transparency (to have a system that is acceptable to the public)
- stability (i.e. funds not prone to too much annual variation)
- low costs (administrative and transaction costs, and to control costs overall)
- appropriate incentives to service providers
- appropriate incentives to service users

while facilitating timely access to appropriate services in the right places to those who will benefit from them. To avoid inappropriate constraints on the use of certain important services, this will require some form of pre-payment.

The different mechanisms for mobilising and managing funds are discussed in greater detail in the Evidence Report, ESRI (2010), Chapter 9. While all countries use a mixture of mechanisms, and there is in all cases some complexity, the system where possible should aim to be kept simple and transparent (Thomas *et al.,* 2008, Thomas *et al.,* 2010). It is more difficult to control the pattern of incentives for appropriate and efficient use where there are multiple funders and complex patterns of entitlement. Tax reliefs on private health insurance or on health expenses have similar effects to public spending of this amount, but tend to be less effective at achieving efficiency and equity objectives, and lack transparency. Furthermore, complex systems of financing services are associated with weak overall costs control and high transaction costs.

[31] For example, Universal Health Insurance or Social Health Insurance which may be managed by public or private bodies within government-specified rules.

2.3 Sustainability - Key Drivers of Health-Care Costs

Sustainability in the health system has to be achieved in the context of pressures for increased resources. The most common pressures are demographic changes (in particular increases in the total population and ageing of populations), growing expectations in the population with greater resistance to constraints on access to effective services, and advances in health-care technology (with the associated expansion in the range of effective medical interventions). These three drivers are considered briefly in turn, before discussion of the costs of care themselves.

2.3.1 Demography

The key demographic drivers of health service costs are:

- the increase in the overall population[32]
- the ageing of the population and particularly the numbers over 80[33]
- the narrowing of the life expectancy between males and females.[34]

A complication in assessing the likely effect of population ageing is the observed concentration of the use of health services at the end of life. To an extent the effect of ageing is to postpone the use of services (Wanless Report, 2004). Furthermore, there is evidence from a range of countries, and more recently from international comparisons that costs of care at the end of life are lower for those who die older (McGrail *et al.* 2000, Wren 2010), although the costs of long-term care near the end of life are higher for people who die at older ages.

The complex effects of population ageing make it difficult to predict the likely consequences for health-care services. However, estimates in other countries suggest that the pure effects of ageing will increase demands on services by between 1 and 2 per cent per annum (Wanless Report, 2004). This is on the basis that access and entitlements to care for people of any age are unchanged, and the cost pressures come purely from the increased numbers of people in particular age groups. In practice, it is unlikely that access and entitlements will remain unchanged if there is dissatisfaction with current limitations on access, and it is likely that improved entitlements and greater access rather than ageing *per se* will account for higher costs.

[32] The issues in relation to ageing are complex. International evidence shows that the effect of ageing on the demands and needs for health services depends crucially on patterns of demographic change, with ageing having much greater effects on the need for community and primary care than on the need for hospital services (McGrail *et al.*, 2000).

[33] See Wanless Report, 2004, Layte, 2009.

[34] The narrowing of life expectancy between men and women may reduce the demands on the health and social care sector since it is reducing the number of elderly people living alone, and there is emerging evidence that this reduces the use of both health services and long-term care (Wren, 2010).

2.3.2 Changing Expectations

Studies suggest that changing expectations in the population are an important source of pressure for higher health care spending (Layte, 2009). There are many formal and informal ways in which access to care has been rationed in the past.[35] Some explicit rationing of access to certain facilities and to elective surgery by age used to be common in most countries and informal age-related rationing still persists.[36]

Several factors are changing attitudes to both explicit and implicit rationing of health services, and more people are demanding access to what are demonstratively effective treatments.[37] While there are some circumstances (such as having other serious illnesses or overall frailty) where older or sicker people may not benefit or may benefit only marginally from certain treatments, there is likely to be increasing resistance to such rationing as patients and families become better informed and are less willing to accept advice from professionals. It is therefore likely that changing expectations will remain an important source of cost pressure.

Patterns of entitlements and access to services reflect a combination of incremental (not always evidence-based) policy-making and some outdated approaches to service delivery. Where entitlement patterns are seen to be arbitrary it is difficult for calls for fairer access to be resisted. Experience suggests that managing the pressures for improved access to health care is best done in the context of more explicit evaluation of the effectiveness and cost-effectiveness of different services, and priorities that more clearly reflect population health objectives.

2.3.3 Technology and Increased Efficacy of Interventions

While it is often argued that improvements in medical technology are drivers of higher costs, the direct economic effect of technical progress is to lower costs. Despite this, in some countries an allowance has been made in health-care budgets to accommodate improved technology, where technology includes new treatments, new forms of treatment and new drugs. The mechanism through which improved technology can justify increased spending is through some increased opportunities to provide effective treatments. Possibly the best way to manage such cost pressures is a rigorous system of evaluation for new services, formal evaluation of technologies, and official evidence-based guidance such as that provided by the National Institute for Health and Clinical Excellence (NICE) in England.

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[35] There is good evidence to show that the capacity to navigate access to specialist services is correlated with social class and education (Langham et al., 2003).

[36] Until recently dialysis services in some countries were available only to certain categories of people, and access was denied to older or sicker people. Women have sometimes been given more limited access to cardiology and cardiac surgery than men with similar disease (Ayanian et al., 1995).

[37] Some studies suggest that this accounts for more of the growth in spending than ageing (Layte, 2009).

Improvements may come from new drugs, devices or equipment, but probably more importantly they come from new ideas, and better use of existing equipment or better skills in using existing technology.[38] Less invasive techniques allow shorter hospital stays, but length of stay has been falling in all countries even for procedures where there is no change in the techniques used. In a similar way it has been shown to be safe and effective to substitute nurses for doctors in managing some diseases, and to substitute non-professional staff for professionals in some areas of health delivery. In some cases it is also likely to be more effective to use specially-trained staff in the management of certain chronic diseases. Approaches such as these can allow services to be developed despite low numbers of some professional groups such as GPs.

Greater efficiency can be seen in:

- the replacement of in-patient procedures with day cases
- more rapid recovery from minimally invasive interventions
- reduced hospital stays.[39]

While there is no robust evidence on the scale of the effects of improved technology on costs, international comparisons suggest that countries that adopt improvements have significantly lower costs than those that are slower to change practices.

Improved technology and techniques have expanded the range and degree of effective interventions, some of which may also be more cost-effective than existing services. It is difficult to resist calls for additional services to be provided where they are demonstrably more effective than those currently available. This is made more difficult by the fact that many existing services have developed without robust evidence of their usefulness or cost-effectiveness. However, withdrawal of existing services, however poor or costly, is generally met with resistance.

Health Technology Assessment (HTA) and priority setting based on the best available evidence is now common practice in many countries. HTA is costly to carry out, and no country should aim to be self-sufficient in this field.[40] To a large extent studies from other countries can be adapted to take account of specific country circumstances, but there has to be a well developed process for setting priorities and defining entitlements to care.[41]

[38] For example, experience has allowed the time in intensive care following open heart surgery to fall by more than 50 per cent since the techniques were first used.

[39] Improvements in drugs and other interventions are important drivers of shorter hospital stays.

[40] The scale of HTA in the United States is expanding rapidly in the context of the recent Obama reforms, and HTA is well established in the Netherlands, the UK, Canada and Australia.

[41] There are inevitable commercial pressures for the adoption of new drugs and medical devices, and many of these are clearly useful. However, if the pressure for expanded access is to be managed there needs to be a more formal approach to assembling and using cost-effectiveness evidence in the development of new services (and the critical evaluation of some existing services).

It is not possible to quantify precisely the effect of changing technology on health-care costs, but with more robust assessment processes and effective management it should be possible to achieve savings from cost-reducing developments and to allow the development of new services only when their value has been demonstrated.

2.3.4 Measuring Costs of Care

In considering costs of health services and changes in these costs it is important to distinguish between an increase in total health service costs and an increase in those costs that fall on government or insurance funders. Thus, for example, a reduction in the costs borne by government that is matched by a compensating increase in costs borne directly by users carries no economic benefit, though it clearly would leave the government in a better fiscal position. If the shift in costs to users falls on them at the time of use of services, it may even make the situation worse if it has a negative effect on user behaviour and if there are large transactions costs involved in collecting the user charges.[42] In some cases the imposition of user charges increases transaction costs and therefore overall cost, even though they may decrease costs falling on government and insurance agencies.

There are particular cost pressures that result from the labour intensive nature of many health services, and the relatively limited scope for replacement of manual with automated services (Baumol, 1996). As wages in general rise with economic growth it has been shown that there is a tendency for the relative cost of services that cannot switch to more automated production to rise. Hence, over time the cost of *some* health services tend to rise more rapidly than the costs of goods and services in general.

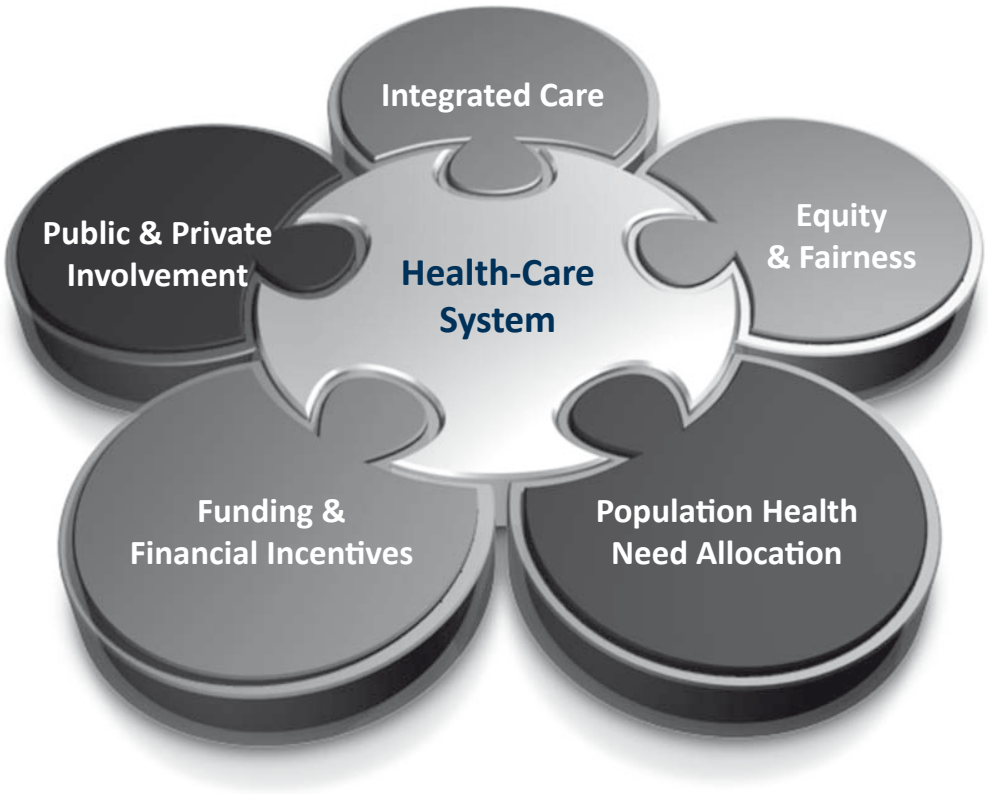
Research suggests that in virtually all industrialised countries the most important driver of rising health-care costs has been changing expectations rather than ageing or changes in available technology. In practice all three interact. The potential benefits of many new technologies are very considerable for older members of the population and indeed research and development expenditures reflect the awareness of a market for interventions which are widely beneficial to those with conditions that are associated with ageing. Growing costs (and growing shares of national income spent on health care) are often presented as inevitable, despite evidence that there is scope for significant improvements in efficiency and the fact that some pressures present legitimate policy choices. Comparisons between countries demonstrate that efficiency can be increased through shifting care to more appropriate settings, changing the mix of staff and equipment used, and generally through better use of existing resources. It is for this reason that more effective methods of resource allocation are important to keeping health-care costs under control and getting maximum value for the overall resources allocated.

[42] There is robust evidence that user charges are ineffective discriminators between important and less important use of services, and deterrent effects of charges affect each proportionately.

The discussions in Section 2.2 and 2.3 indicate the interconnectedness between different elements in health-care systems which are inherently complex. Consequently the design of resource allocation methods must take into account the methods used to finance activity, and vice versa. Any plan to foster integrated care must take on board the population health needs. It must also take account of the funding and financing incentives in place and work to alter these if they are not consistent with care objectives. Equity and fairness may be supported by the combination of public and private providers, but they can also be undermined by such involvement, depending on how it is designed. Figure 2.2 illustrates the interconnectedness between the different elements and underpins the need to cross link different elements as each of the guiding principles in the next section is discussed.

FIGURE 2.2

Health-Care System

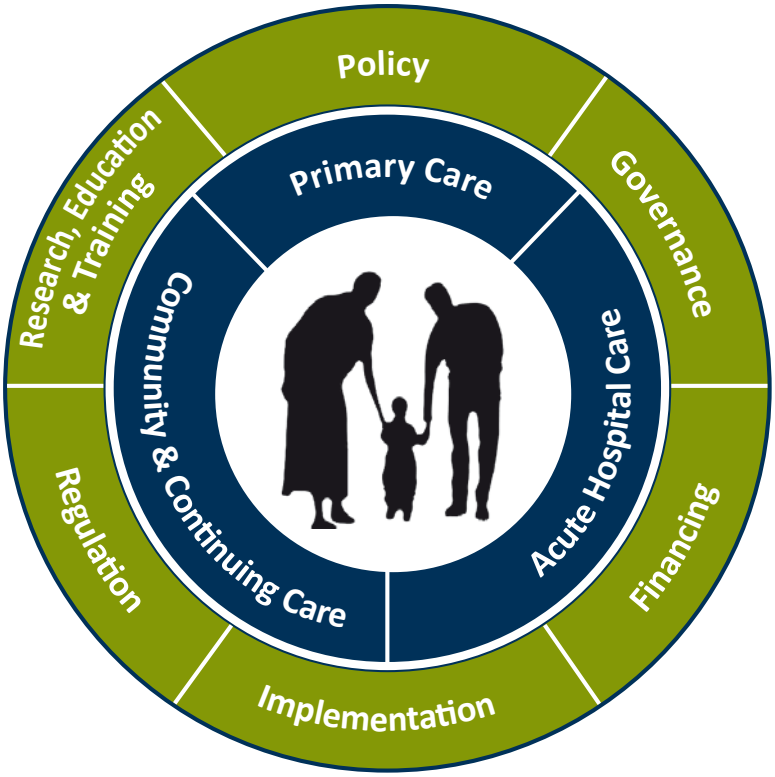


2.4 Guiding Principles for Resource Allocation and Financing

On the basis of the international literature (as outlined in Sections 2.2 and 2.3 and in the Evidence Report, ESRI 2010 (Parts 2,4,6)), the Group set out to identify the guiding principles for the direction of resource allocation in, and financing of, health-care provision that would result in a better health-care system. Before turning to present the principles, Figure 2.3 outlines the Group's conceptualisation of the appropriate delivery of health care – this concept is developed further in Chapter 4. The user (individual/family) is at the centre of the delivery system, consistent with the objective of a genuinely user-centred system. This user (group) interacts with three sets of care providers: primary care, hospital care and community/continuing care.

FIGURE 2.3

A Patient/User Centred Health-Care System



In the majority of cases, primary care should be the individual's first point of contact with the health-care system. The provision of primary, community and hospital services may come from public or private sources (individuals or institutions). From a system perspective, these sets of care providers all sit within a framework covering policy, governance, financing, regulation, implementation, research, and education and training for health-care professionals.

In the Group's view, the starting point for setting the guiding principles is the concept of the user at the centre of services and the health-care vision and goals in a country's relevant national strategy documents (including the future direction of the health-care system), and the backdrop of the international review in Sections 2.2 and 2.3 and the countries benchmarked in the Evidence Report, ESRI (2010), Appendix (Country Profiles). Reviewing these benchmarks, it became clear to the Group that the challenges facing the health-care sector internationally were very significant and there was no single route to achieving the best health-care system possible.[43]

In establishing guidelines for resource allocation and financing, the Group recognised that countries are always building on existing systems. Consequently, it does not seek to identify the perfect system but rather concentrates on guiding principles which, if followed, will generate the characteristics associated with good systems. The Group has identified seven guiding principles to inform how resource allocation and financing should be undertaken and sustainability ensured, drawing primarily on the theoretical and international research evidence as set out in the Evidence Report, ESRI (2010) and on its own expertise. In the case of these guiding principles, the Group explored what is required if they are to be met in practice.

Principle 1

There should be a transparent resource allocation model based on population health need.

Transparency is essential to ensure that resources are allocated to maximise the benefits to the nation's health, and in accordance with the needs of the population. This requires:

P1.1: Committing to coherent planning of all dimensions of health care, both public and private.

P1.2: Establishing programme priorities based on population health need, covering both capital and current expenditures.

P1.3: Setting priorities that take explicit account of the level of public resources available, with nothing to be funded without planning (and no planning of developments without at least a plan to fund them).[44] This emphasis on planning reflects the desirability, from a governance perspective, of clarity in the roles of policy makers, purchasers and providers in line with best international practice (see Principle 5 and Chapter 4).

[43] The dynamics of change are such that the development of health-care policy and the delivery of that policy effectively efficiently and equitably will always be a work in progress.

[44] The concept of planning here is that, where plans to change or develop services are agreed, these are backed up with plans to mobilise and make available the necessary funds. In effect, once plans are agreed, the funding for them should be provided, and nothing should be funded without planning. This follows the approach set out in the UK in relation to commissioning. See www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm. In the case of an unforeseen event (e.g. a flu epidemic), plans are articulated and funding put in place to implement those plans.

P1.4: Organising a planned movement from historic funding patterns towards a population health allocation (on a multi-annual basis) to support a more rational delivery of services both at national and local levels. This is central to addressing the objectives of both fairness of access and responsiveness of delivery, as well as ensuring that the user drives the allocation of resources.

P1.5: Having every member of the population registered (by a unique identifier) with a primary care practitioner, supported by an Information Technology (IT) system and a Management Information System (MIS) for health-care services that covers the whole system.

Principle 2

A resource allocation model should support local implementation of national priorities based on nationally-set clinical, accountability and governance standards.

Local implementation of national priorities and standards is essential to ensure that unintended disparities do not emerge across groups or areas. This requires:

P2.1: Having decision-making structures for resource allocation that promote the most effective use of resources to deliver appropriate care to patients/clients.

P2.2: Having a resource allocation system that is embedded in clinical/management structures, to deliver safer and more effective health care at national and local levels. This is central to ensuring that national standards operate on the same basis across all localities and cost/output data are shared by all the key decision makers.

P2.3: Having resources allocated as close to the users as possible, consistent with the scale of the local delivery system being safe and sustainable in light of demand uncertainty, quality standards and scale efficiencies. International evidence suggests that this should be to a geographic unit with a minimum population of 250-300,000 (although there may be exceptions in areas where there is extreme geographical dispersion and very poor public transport links). See the Evidence Report, ESRI (2010), Chapter 2.

Principle 3

A resource allocation model should support the delivery of safe, sustainable, cost-effective, evidence-based care in the most appropriate setting, whether public or private.

For efficient use of resources, it is necessary to ensure that provision of care (by public or private entities) allows the patient to receive care in the best possible setting. This requires:

P3.1: Having incentives within funding mechanisms that are consistent with and support the agreed care objectives and mechanisms, with resource allocation take into account the dissimilar costs of care across different care settings, both public and private.

P3.2: Having a resource allocation model that promotes the cost-effective delivery of care, i.e. directs users and providers to the most appropriate setting for relevant care delivery for a given expenditure on a particular service.

Principle 4

A resource allocation model should promote the integration of care within and across the hospital, primary and community/continuing care sectors at every level.

Since efficient care requires the seamless transfer of patients between different sectors, it is essential that care is integrated across these sectors. This requires:

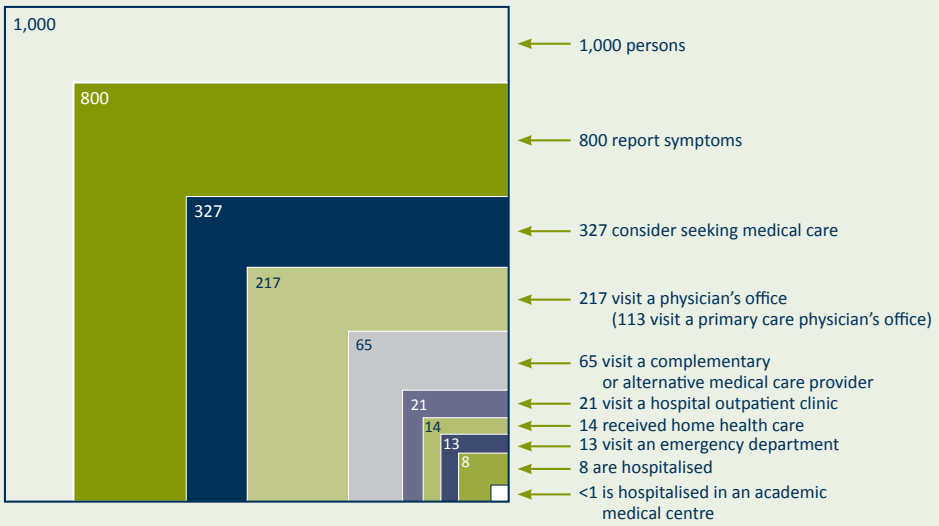
P4.1: Having resources for all types of care within the same budgetary envelope at a local level. This implies that budgets (based on population health needs) to cover hospital, community/continuing, and primary care should be held at local level, and that the budget-holder at this local level should be responsible for ensuring the delivery of services across all areas of care to nationally-set standards.

P4.2: Having the decision-making unit at local level with a capacity to deal with the clinical/care and managerial demands of handling integrated care priorities set at national level.

P4.3: Having an oversight management structure that ensures local adherence to care protocols/standards and financial management.

Box 2.3 Continuum of Health-Care Need

Figure 2.4 illustrates the continuum of health-care need among a nationally-representative sample of 1,000 adults in the US over a period of one month. At one extreme, a proportion of the sample will not require health-care services. Some of those who do experience ill-health may decide not to attend for care, opting instead perhaps for self-treatment. Those who do contact health-care services do so at differing levels: the majority visit their physician (GP), but at the other extreme, few require hospitalisation. Although changes in the supply of health-care services may be expected to influence these patterns of demand, Green et al. (2001) have found that the continuum of health-care needs depicted in Figure 2.4 has been relatively stable over time.



Source: Adapted from Green et al., 2001

Principle 5

Financial incentives should align as far as possible across all actors (including users and providers) in the system, consistent with promoting good health and well-being and in line with nationally-determined priorities.

If the health-care system is to be effective, then all providers and patients must be encouraged to behave so that health is better and costs are lower. This requires:

P5.1: Having incentives/programmes that support users in managing their own health and wellbeing.

P5.2: Developing provider-payment systems that support professionals and institutions in delivering integrated care.

P5.3: Having a blend of methods to pay providers (e.g. capitation and fee-for-service for GPs; activity-based casemix adjusted payments and capitation for continuing and community care; activity-based, casemix adjusted payments, capitation and block grants for acute hospitals).

P5.4: Ensuring that payment methods incentivise improvements in the quality of care for given costs.

P5.5: Ensuring, where feasible, that providers face the same payment methods regardless of whether the user's care is financed on a public or private basis or whether the provider is public or private.[45]

P5.6: Ensuring that purchasers of care on behalf of users (e.g. the state or insurance company) seek the most effective sources of care of a given quality. This generally means having a split between purchasers and providers.

[45] Where services are funded by the Government, this is straightforward. It is more complex in the case of privately-financed services.

Principle 6

The methods of financing health care should be as effective and equitable as possible.

Equity and effectiveness means that there must be transparency and fairness in relation to individual eligibility to different health-care services. This requires:

P6.1: Linking resource generation processes and the amount of resources available for allocation to health care transparently.

P6.2: Creating a separation between what individuals pay towards health care and the health care they are entitled to receive (as per the normal principle of insurance systems).

P6.3: Ensuring that payment for health care by individuals is on the basis of ability to pay, with richer people paying more than poorer people (relative to their income/wealth).

P6.4: Having payment for health care by individuals on a pre-payment rather than pay-as-you-go basis.

P6.5: Having co-payment rates for patients such that they do not deter appropriate use of appropriate health-care services at the appropriate time.

P6.6: Having administration costs of health-care financing mechanisms that are low relative to the cost of the service provided and the amount of revenue raised.

Principle 7

All aspects of the health-care system should be sustainable.

In the face of rising demands for health-care services, it is essential that mechanisms are in place to ensure control of expenditure levels and value for money. This requires:

P7.1: Aiming to ensure economic as well as fiscal sustainability of the health system, i.e. taking account of service quality, minimising the total cost of health care to the population at large, rather than just the fiscal cost to government.

P7.2: Focusing on measures that seek to enhance the capacity of the health-care system to convert resources into value, for example, more flexible work practices.

P7.3: Using economic evaluation mechanisms (involving systematic marginal analytical frameworks) to underpin decision-making at every level of activity, e.g. at the top (national) level of resource allocation, the local level, and the care delivery level.[46]

P7.4: Developing performance management systems that incorporate appropriate measurement tools to enable appropriate monitoring and evaluation.

P7.5: Aligning responsibility for resources to those responsible for service delivery and aiming to ensure adequate planning of services prior to resource allocation.

[46] At the programme level, this is referred to as Programme Budgeting Marginal Analysis (PBMA). PBMA can assist decision makers in directing resources, with the aim of maximizing the impact of health care on the health needs of the local population. The advantage of such techniques is that they allow health planners to see the big picture. The approach relies on marginal analysis, which examines the incremental costs and benefits of shifting resources from one area to another based on opportunity costs (the forgone benefits of the next best alternative use of a given set of resources), to provide insight into whether changes should be made. An example of its use in health care is where Hasting Health Authority in 1993 wanted to see where all its NHS financial resources could be better deployed. A two way matrix of age groups against spend areas was drawn up. Resources were allocated on the basis of age-weighted capitation. All expenditure including overheads (Primary care trusts and hospitals) were ascribed pro rata to age groups giving comprehensive activity in the health region by age. The spread sheet was widely distributed and presented to public representatives and clinicians. Areas that were perceived to be underfunded were enhanced and those with excessive allocation were contracted or frozen, like the 0-4 age group which was found to be receiving well above its allocation share at the expense of the elderly. The clinicians could begin to understand and accept the opportunity costs of their services and discuss relative priorities on the basis of health gain rather than the typical turn taking or pulling rank.

CHAPTER 3

Resource Allocation, Financing and Sustainability of the Irish Health-Care System – Problems and Issues

Chapter 3

Resource Allocation, Financing and Sustainability of the Irish Health-Care System – Problems and Issues

3.1 Introduction

Chapter 2 outlined the key drivers of health-care costs internationally and explored the principles which should guide the allocation of resources and the methods of financing health care that could be used to improve the Irish health-care system. Chapter 3 reviews these guiding principles in the context of the Irish health system. Section 3.2 summarises some features of health care in Ireland which are important for understanding the current arrangements, specific challenges and the feasibility of effecting change. Sections 3.3 and 3.4 review the Irish health system in terms of its performance against these guiding principles and how the current system succeeds or fails to meet these guiding principles. Each of the guiding principles and the details of what they imply are used to comment on the present system, drawing on the Evidence Report, ESRI (2010), on the Group's shared understanding and experience of the system, and on the broad mixture of disciplines it brings to reviewing resource allocation and financing of the health-care system. Section 3.5 provides some concluding comments.

3.2 Key features of the Irish Health System and Challenges for Policy

3.2.1 Introduction

Ireland's population is young relative to other European countries, which is an advantage in terms of current health-care needs/costs. However, our population is ageing more rapidly, creating growing challenges of meeting future needs and keeping health costs at a sustainable level. Ireland also has some unusual features which make it very complex relative to other countries.[47] These features include the entitlement/eligibility arrangements for free or subsidised care, the proportion of the population holding private health insurance (and what that insurance covers), and the complex cross over in the delivery (by professionals and institutions) of public and private health care. Alongside this complex system, there are major changes internationally (as outlined in Chapter 2) in models of care that are now being introduced in Ireland in response to concerns with quality, safety and cost in the delivery of care.

The remainder of this section reviews these issues in turn. Section 3.2.2 discusses the current population age structure and how the demographic cost drivers will operate in Ireland. This provides some important background for the development of resource allocation to meet the guiding principles in a changing environment. Section 3.2.3 discusses current entitlement/eligibility issues and the role of private health insurance in Ireland. Section 3.2.4 outlines key features of health-care delivery

[47] These are discussed further in Chapter 3 below and are set out in detail in the Evidence Report, ESRI (2010), Part 3.

in Ireland, with specific reference to the complex public/private mix. Section 3.2.5 looks briefly at issues for the health-care infrastructure, while 3.2.6 outlines the challenges of introducing new models of care in Ireland.

3.2.2 Demographic Change

The key demographic drivers of health service cost are the increase in the overall population, and to a lesser extent the ageing of the population (Wanless Report, 2004; Layte, 2009). Ageing in populations is often measured by the expected increase in the number of people over 65, but the more important driver of costs of health services is the increasing numbers in the older population, particularly those over 80. International evidence is now clear that ageing has complex effects on the demands and needs for health services, depending crucially on patterns of demographic change, and ageing has much greater impact on the need for community and primary care than on the need for hospital services (McGrail *et al.*, 2000).[48]

One way of understanding the dramatic changes in life expectancy is to reflect on the fact that a girl born in Ireland today has a 50 per cent chance of reaching the age of 100.[49] A recent study published by the ESRI (Layte, 2009) provides estimates of the likely changes in the size and composition of the Irish population, and the likely effects on the health sector. In comparison to other European countries the Irish population is young, but is consequently ageing more rapidly than in other countries. The rise in the number of those over 85 is particularly rapid, and is likely to increase by nearly 70 per cent by 2021 whereas the rise in those between 65 and 74 is likely to be around 42 per cent. Thus the most rapid increases are in the age groups that have the most significant effects on health-care costs, and particularly on costs of primary and community services. Table 3.1 summarises the likely changes in the Irish population from 2011 to 2021.

TABLE 3.1

Ireland, Total Population by Age Groups, 2011 to 2021 (Thousands)

Year	0-4	5-14	15-49	50-64	65-74	75-84	85+	Total
2011	332.4	606.5	2,392.6	744.8	308.3	176.4	63.0	4,623.9
2016	321.5	651.9	2,445.4	824.5	378.8	203.2	81.4	4,906.7
2021	300.9	665.4	2,463.0	911.3	438.1	248.1	105.9	5,132.6

Source: Layte , 2009

[48] In the past decade Ireland has also experienced rapid increases in the total population as a result of inward migration, reduced emigration and a birth rate above the replacement rate. Although much of this rise is in age categories that are relatively low users of health services, nevertheless this rapid rise in the overall population has increased substantially the overall demands on health services at all levels.

[49] www.welfare.ie/EN/Press/Speeches/2007/Pages/sp050506.aspx

The overall increase in the population in Ireland has caused and will continue to cause upward pressure on the costs of care. The extent of the rise in costs depends on the responsiveness of the health-care system overall to these increased numbers. The effects of the increase in population (assuming no change in entitlements or patterns of delivery and use) have been estimated by Layte, (2009). These include the possibility of significant increases[50] in the need for acute services which in the current delivery model would require additional beds until 2020 and a large increase in the need for long-term care places (See PA Consulting Group, 2007). Since these estimates were made there has been a slowing of population growth, and there are now initiatives in place to shift care where possible from hospital to primary and community care setting – see Section 3.2.6. As outlined below, unless dealt with, the current pattern of entitlements may hinder attempts to make the shift in the balance of hospital and community services happen, thus building up undesirable pressure on limited hospital capacity.

It should be noted that the population increases would lead to increases in total health-care activity and spending, but to a much lesser extent in *per capita* activity and spending. Clearly, increases in Ireland's population will make possible higher overall levels of economic activity, higher tax receipts and higher levels of personal spending on health services. It should be noted that the dependency ratio in Ireland (which is a measure of the proportion of the population available for work relative to those not available to work) is currently falling – that is the number of older and younger people being supported per person of working age is falling. The effect of the increasing overall population on health spending differs from the effects of ageing or of technology since it brings with it the potential for higher levels of resources to pay for it.

3.2.3 Health-Care Entitlements in Ireland and Private Health Insurance

Entitlement to free or subsidised health services in Ireland has evolved in response to perceived problems and resource availability since the introduction of the Health Act in 1970. By international standards, the structures of user fees are complex and the patterns of entitlement arrangements are very unusual. Essentially all Irish residents are entitled to free or subsidised public hospital care, and the major differences regarding entitlements relate mainly to primary care. For hospitals, while all members of the population are entitled to free or subsidised public hospital care, there are differences in access to hospital care which relate to whether or not an individual holds private health insurance.

[50] An increase of as much as 4 per cent per annum could be needed on the basis of present delivery mechanisms.

The population can be categorised into four broad entitlement groups:

- medical card only with no private health insurance ('medical card')
- privately insured only with no medical card ('privately insured')
- individuals with both medical card and private health insurance ('dual cover')
- individuals with neither medical card nor private health insurance ('non-covered').

In 2009, approximately 65 per cent of the population did not hold a full medical card or a GP Visit card ('non medical card holders') and were therefore required to pay the out-of-pocket fees for private GP care. Notwithstanding the eligibility for heavily subsidised public hospital care, in 2009 close to 50 per cent of the population held supplementary private health insurance, which mainly covers hospital care.[51] This figure includes the 4 per cent of medical card holders who also have health insurance – the dual cover group. People with supplementary private insurance do not pay the daily charges for hospital care (since they are covered fully as private patients), but in most cases pay all or some of the cost of their private out-patient care, emergency department visits and primary and community-based care. Some 19 per cent of the population had neither private insurance nor medical cards.

The full medical card, which is means tested,[52] entitles the recipient (and dependents) to free access to public hospital services, GP care and prescription medicines, dental, ophthalmic and aural services, medical appliances, maternity and infant care services, and a maternity cash grant on the birth of a child.[53] The GP Visit medical card grants the recipient (and dependents) access to free GP services only (i.e. does not include prescriptions or any other primary/hospital care).

Individuals without a medical card are required to pay for private GP care at the point of use. The fees set are not regulated in any way and such evidence as we have indicates that the charge for a visit to the GP surgery ranges from €45 to €60 at present. These payments can then be reclaimed against income taxation at a standard rate of 20 per cent. In addition, non medical card holders, including GP Visit card holders, are liable for statutory in-patient and out-patient charges for public care in public hospitals. The standard daily charge for public in-patient care is €75 up to an annual maximum of €750 (and exemptions apply). Visits to an ED are free if the individual is referred there by a GP, otherwise a charge of €100 applies.

[51] This high percentage reflects in part the unusual role of the VHI in the Irish health-care sector and the late arrival of free hospital cover in Ireland. It also reflects the fact that private health insurance in Ireland has been available at low prices in comparison with other countries, linked to the limited scope of services covered, subsidy of services in public hospitals and tax relief on premiums.

[52] Some people whose income level is above eligibility for medical cards may get them because of ongoing illness, but the process of applying for and getting a medical card in these circumstances is complicated and slow. It usually means applying in the normal way and being refused on income grounds and then appealing on medical grounds.

[53] In addition, the Medical Card provides other 'passport benefits' as it is used administratively to determine entitlements to certain social services. This practice confuses the role it plays in the wider Irish social welfare system.

Additional schemes provide specific entitlements for some patients with some diseases (e.g. individuals who contracted Hepatitis C from the administration within Ireland of blood or blood products, the Heartwatch programme for secondary prevention of cardiovascular disease in pilot GP practices) and free immunisation and monitoring services for young children. Non medical card holders (including GP Visit card holders) are eligible for government subsidisation on drug payments above a monthly limit (currently set at €120 per month) under the DP Scheme or, for certain diseases, all drugs under the Long-Term Illness (LTI) and High-Tech Drugs (HTD) Schemes.[54]

Under current patterns of entitlements, the planned shift of services into primary and community settings means that, for many individuals, hospital-based services that are effectively free at the point of use would be replaced by services in the community which currently involve significant charges for those without medical cards or GP Visit cards. It is not plausible to expect patients to make this change voluntarily. A further complication is that some community services are available only for patients with medical cards and that the whole pattern of entitlement to community services is complex and confusing.

The present pattern of charges also makes integrated care less likely to develop since patients are faced with significant costs for certain parts of the service, and are incentivised to find packages of care that do not involve high charges. Patients with long-term illnesses may need regular health checks or monitoring (which can be done in the primary care setting), but this is expensive for most patients under current entitlements. Once a private patient has been referred to a hospital service it is in his or her financial interest to avoid being discharged back to primary care.

[54] This includes families on below average incomes (including most services for children) and people with some chronic diseases such as heart disease and mental illnesses (except children with mental illness).

Box 3.1: Anomalies in the Delivery of Health Care Related to Different Eligibility

Because there are two different sources of funding for healthcare, there are discrepancies that occur in the system. Sometimes it is the private patient who benefits and sometimes it is the public patient. Usually the differences are associated with efficiency losses.

The Private Patient Wins: VHI now offers a home package where patients can receive their intravenous antibiotics at home instead of being in hospital for certain common conditions such as cellulitis (an infection of the skin). While this system has benefits, it is accompanied by a widening in the availability of care to patients. It is limited to certain geographic areas (a form of geographic apartheid). More worrying is the fact that such a service is not universally available for public patients. Hence the following scenario can occur: Two patients are sitting on chairs in an overcrowded Accident and Emergency (A&E) department in Dublin with exactly the same clinical condition (cellulitis). Once diagnosed, Patricia, the patient with VHI insurance goes home to her own bed with a nurse visiting three times a day to administer antibiotics. Pauline, the public patient has to wait in A&E to be attended and then admitted. Although only requiring 'hotel' facilities and regular intravenous injections, her insurance status means that she will occupy a very scarce hospital bed for about five days.

The Public Patient Wins: VAC dressings are special dressings which involve a machine to apply suction to the wound to facilitate closure of a complex open wound. Because she is a public patient, Deirdre can obtain a portable VAC dressing to facilitate her discharge from hospital – this allows her to move out of hospital care quickly and back to her home. Dorothy is a private patient, and because her health insurer is not set up to provide her with the portable VAC at home, she has to stay in hospital to keep her VAC dressings applied. The historic focus of private health insurance on hospital care results in its funding the more expensive option of keeping Dorothy in hospital and paying for a prolonged hospital stay, rather than facilitating an early discharge.

Comment: Anomalies in relation to care treatments for both public and private patients reduce patient experience and raise costs.

3.2.4 Health-Care Provision in Ireland

This section looks briefly at each of the areas of health-care provision in Ireland.

Primary care in Ireland is delivered by private GPs, who are gatekeepers for hospital treatment, providing letters of referral to acute care for their patients. GPs are located in the community in single/multi-person practices although the trend for single-handed practices is declining and primary care teams (PCTs) are being created gradually throughout the country in line with national policy. See the Evidence Report, ESRI (2010), Chapter 8 for further details.

Primary, continuing and community care is also provided by a range of other health professionals including community-based pharmacists (private practitioners), public health nurses, social workers, health-care assistants, home helps, midwives, occupational therapists, physiotherapists, etc. Current policy is that PCTs will integrate formally the work of these and other professionals with that of the GPs (See Evidence Report, ESRI (2010), Chapter 8 for further discussion). In addition, there are public and private facilities that provide non-acute long-term health care. Public long-stay units include geriatric hospitals and homes, district and community hospitals, and HSE welfare homes.

Acute health-care services are delivered in HSE public, voluntary public and private hospitals. There are 34 HSE hospitals and 18 voluntary hospitals. Although the total number of beds in acute public hospitals has not grown substantially in recent years, the composition of these beds has changed significantly, with a shift from in-patient beds to day beds. The acute public hospital sector is currently undergoing substantial reconfiguration, involving the concentration of acute services in regional hospitals, with local hospitals focusing on elective services. See the Evidence Report, ESRI (2010), Chapter 7 for further discussion. There are approximately 20 purely private hospitals (including private psychiatric hospitals), which receive no direct state grant funding.[55] The private hospitals operate in parallel to the public hospitals but there are some services that are not available in the private sector (e.g. complex treatments such as liver transplants). See the Evidence Report, ESRI (2010), Chapter 7 for further discussion.

Public/Private Sector Mix is a further unique feature of the Irish health-care system. The complex public/private mix in service delivery arises because of the high level of integration between the public and private systems at the level of institutions and professionals. For example, the majority of GPs have both public (GMS) and private patients, receiving capitation fees in the case of the former and fee for service (i.e. patient contact) in the case of the latter. Hospital consultants receive a salary for their public patients but a fee for service for the private patients. Many public hospitals have 'private beds' and they face different payments for both public and private patients. Taking the system as a whole, there is also a mismatch which creates tensions within public hospitals in relation to the treatment of private patients. Some patients with private insurance that would allow them to be treated in private beds in public hospitals are treated in public beds due in part to explicit limits on numbers of designated private beds.[56] Some private hospitals are not able to provide some of the more urgent and complex treatments available in public hospitals, so can take up only part of the demand.

[55] They may receive other types of state funding, for example from charges for public patients whose treatment is paid for by state funds under the National Treatment Purchase Fund.

[56] In such cases fees can be charged to insurance companies by consultants but hospitals are not permitted to charge for other services. In his report in 2008, the Comptroller and Auditor General identified that the public system could charge twice as many patients as it currently does if charges were to apply to all private patients in public hospitals and not just those patients who are admitted to a bed designated as private.

The overlap between public and private care in the public hospital system is supported in government policy. The rationale for this arrangement is that it permits public hospitals to retain the services of top specialists and, therefore, to have them available to care for public patients. The national health strategy states that the current public/private mix of beds in the public hospital system is intended to ensure that the two sectors can share resources, clinical knowledge, skills and technology (DoHC, 2001). However, the revised consultant contract includes a new 'public only' category whereby a consultant is not permitted to treat patients on a private basis. While this introduces greater clarity into the system, it does raise new issues for the hospital (reduced income from private patients). See the Evidence Report, ESRI (2010), Chapters 7 and 13 for further details on the consultant contract.

A further interconnection between the public and private hospital sectors arises through the National Treatment Purchase Fund (NTPF) which was established in 2002 to purchase spare capacity from the private sector (and also from public hospitals) in order to reduce the number of public patients waiting for treatment in public hospitals. The NTPF has been very successful in monitoring waiting lists and in effecting a substantial reduction in the numbers on waiting lists for the specific elective treatments for which it is responsible.

In recent years, there have been sustained attempts to address some of the perverse incentives caused by this complexity in the public (including voluntary) hospital sector. In particular, the new consultant contracts either restrict the consultant to public care only or set explicit limits to the amount of private work that a consultant can do.[57] Recent reports from the HSE suggest that these contracts are being monitored carefully, though it is too early to say whether or not they will have the desired effect. There have also been significant increases in charges for private patients in public hospitals in recent years and there are currently proposals in preparation to move to full economic costing of beds in public hospitals. These changes will help to reduce the cross-subsidisation of private patients and consequently of private health insurance.

Perhaps the greatest deficiency in the current provision of public health services in Ireland is the poorly developed system of community health services. Although this has been a major focus of developments since the establishment of the HSE, this sector remains small and weak when compared to provision in other European countries. As in the case of hospital care, the development of community health services has lacked a fully coherent framework that would determine priorities in terms of needs for care (especially in the management of chronic disease).

[57] While a significant number of consultants have opted for the new (public only) contract, it is not clear how much impact this will have over the longterm as the Group was unable to obtain any demographic data on consultants disaggregated by contract type, either by area of specialty or even as a totality.

Box 3.2 Cancer Care: The Benefits of Integrated Planning and Resourcing

Five years ago the following would have been the typical situation for a patient with a breast lump who presented to a non-designated cancer centre for evaluation. She would have been seen by a surgeon for whom the only audit of his practice would have been the total number of cancers treated each year. The surgeon's breast conservation rate, the diagnostic methods used, whether older methods, such as breast cytology, or modern techniques, such as sentinel node mapping, or whether reconstruction was offered immediately following mastectomy, if at all, would not have been audited and would be unknown.

The patient's case would have been discussed at what was then called a multidisciplinary meeting of the breast cancer team. However, if the single pathologist in the unit was away on holiday, a locum pathologist would have reviewed the breast cytology specimen. If the breast radiologist was also away, he/she too might have been replaced by a locum. Neither locum would have necessarily had breast cancer expertise. Because of the small size of the cancer centre, and despite all the appearance of a comprehensive breast team, in that each specialist was represented, the individual patient would not have got access to the expertise of all of the disciplines required in the diagnosis of breast cancer. Consequently, the patient's lump could have been misdiagnosed as non-cancerous, and treatment delayed until a point where the condition was much more advanced.

A patient with the same symptom presenting to one of the eight designated public centres in 2010 is seen within a specific time-line. If her case is designated as urgent, she is seen within 14 days, as per HIQA requirements, and her breast imaging is done at the same appointment. Her case is discussed at a multidisciplinary meeting where there are at least ten consultants present who have expertise in breast cancer across all the various disciplines. The multidisciplinary meeting commences with an audit reviewing care standards for the previous month. All matters of clinical practice are regularly reviewed and audited ensuring maintenance of standards. Access to the operating theatre and to immediate reconstruction is standard, as is an evaluation of whether the patient is suitable for entry into a clinical trial. Today's cancer patient is correctly diagnosed and successfully treated following a care pathway guaranteed to quality assured standards on a par with the best centres internationally.

Comment: This demonstrates the benefits to patients of providing genuinely expert multidisciplinary teams.

3.2.5 Health-Care Infrastructure and Access to Capital Resources

Despite considerable investment in new hospital buildings and equipment, the current capital stock in Ireland has many shortcomings, including some very poor primary and community service facilities, too few single rooms in hospitals, and inadequate information systems. Improvements in infrastructure in recent times have come through the building of new primary care centres but these are relatively few in number and in the current economic climate, further developments are likely to take some time to come on stream.

With current patterns of service delivery there is a shortage of certain types of public acute hospital capacity in Ireland, resulting in unsustainably high occupancy rates.[58] In addition, there is additional pressure on the space coming from the growing population. It is noted that there is also capacity to improve the internal efficiency of hospitals, for example, by moving increasingly to day case activity as clinically appropriate and by shorter stays for in-patient cases. This has been a factor in admitting patients from emergency departments, cancelled elective procedures and operational difficulties in running hospitals at high levels of occupancy. The poorly developed primary and community care services and infrastructure has been a further constraint on shifting the balance of services out of hospital, and has contributed to unnecessarily long hospital stays (especially for some elderly patients). It is noted that the recently introduced 'Fair Deal' scheme is having the effect of accelerating improved access to community nursing home capacity and allowing the patient choice of facility. The majority of patients are choosing to go to private nursing home accommodation.

In Ireland, the processes for setting capital priorities for public hospitals have not been transparent and have not been clearly linked to current expenditure plans. Within public hospitals capital funds have been hard to acquire, but when allocated to a hospital they have become effectively a 'free resource', with no direct incentive to use facilities efficiently once provided. The incentive to replace worn out capital has been reduced by public sector accounting practices (i.e. the cash flow system that ignores asset depreciation) that discourage proper planning and funding of replacement equipment. The current capital stock in the Irish health system is not in general configured to provide efficient and high quality services, particularly in community and primary care. It is important, therefore, to consider ways in which the capital resources might be better managed to encourage greater efficiency of service provision and better facilities for patients.

There are difficulties in making rapid changes in the systems of allocating capital and using capital to encourage more appropriate and efficient service delivery. The quality of existing facilities varies greatly, with some facilities being old and no longer 'fit for purpose'. At a time when all resources are scarce, there is a particularly good case for moving towards a more rational system of allocating capital funds that is

[58] Occupancy rates in some acute hospitals are over 90 per cent where the recommended norm (based on international experience) would be no more that 85 per cent.

integrated with plans for service improvements, minimizing risk to patients/clients, increasing efficiency, and linked in turn to the planned use of current resources.

In this context, there may be benefits to be gained from adopting an approach generally to the use of capital similar to that used in the private sector. Capital resources in commercial organisations are often rented and not owned by the firm using them, and this converts a need for one-off resources into an annual cost. This provides incentives to use only what is needed, and to replace and reconfigure space that is unsuitable. There are also various possible approaches which would involve a shift towards annual costs of capital or renting facilities from private or public landlords. Options include allowing health-care providers to borrow for capital developments with the cost of repayments being recovered through revenue funding (an approach being explored in Germany), or separating ownership of facilities and their use (effectively shifting to hospitals renting their capital resources).[59]

In contrast to the public sector, there is a surplus of some types of private hospital space that has developed on foot of subsidies for these investments via the tax system. Unfortunately, despite the tax incentives given, these developments took place in the absence of any integrated health planning structure. Consequently, there is a major challenge ahead to explore how these facilities can be used optimally in the future in light of the very significant state investment in them via tax reliefs. The one part of the private hospital development that was part of the overall health planning system, in that the DoHC was directly involved in it, were the co-located hospitals. In the present economic climate, these may not come on stream.

Since there is currently a shortage of certain types of acute hospital space (with unsustainably high occupancy rates) and pressure from a larger population, and since there is a surplus of private hospital space (which may be in some cases suitable for elective treatment services) it may be possible to address these shortages by allowing public hospitals to rent space in private hospital in their areas.

The Group recognises that the management of health-care capital resources is a specialised area that could not be dealt with adequately within the analysis in this report. Thus the recommendation made in Chapter 5 relates to further work and policy development in this important area.

[59] The capacity of the public system to borrow is determined by the Department of Finance.

3.2.6 Integrated Models of Care

As noted in Chapter 2, health-care delivery tended to be reactive, episodic and fragmented in the past. Over the past few decades, the model of health care internationally has moved to being focused on maintaining individual health and well-being through planned, integrated services (linked explicitly to national priorities). Ireland has been relatively late in adopting the new integrated models but has moved progressively in this direction in the past decade, as is evident in the health-care strategy published in 2001. Such a move is essential in terms of three key factors: safety, quality and cost.

The changes needed involve breaking down the traditional medical hierarchy model, which is challenging and demanding for health professionals. The new models of care involve more team-based approaches within professional groups; for example, different specialist consultants jointly consider the diagnosis and care of patients with complex illnesses. The models also involve more team-based approaches across professional groups, involving consultants, nurses, GPs, social care professionals, psychologists, allied health professionals and other staff. This kind of team is especially crucial to the general maintenance of health and to the management of chronic diseases through seamless provision within and across care settings.

In these new models the patient/care recipients rather than care providers are at the centre of care provision, so that the delivery of safe, effective and efficient health-care services can be assured. In order to operate properly, these models involve the end of an era in which decisions on quality and quantity of care were decoupled from decisions on expenditures within an overall budgetary framework. Consequently, the change in the way that health care is delivered must be reflected in new resource allocation mechanisms which are aligned with the new care protocols and pathways that guide the delivery of care. In other words, incentives for good care must be aligned with incentives for cost-efficient care. For example, if integrated care is mandated by newly-defined clinical protocols then the resource allocation mechanism must ensure that professionals and institutions are rewarded for behaviour that promotes integration through the design of payment systems.

Ultimately this means engagement by the health professionals in understanding and responding to the cost implications of their proposed actions, and supporting the decisions that stem from combining clinical and resource management. In Ireland, the first step of this process has got underway with the appointment of clinical directors at the local level and clinical leads nationally. The second crucial step has yet to happen – connecting these clinical activities with resource allocation processes.

3.3 Resource Allocation – Applying the Guiding Principles in the Health-care System in Ireland

In the subsections below different elements in the current resource allocation system in the Irish health-care sector are reviewed using the guiding principles developed in Chapter 2.

Principle 1

There should be a transparent resource allocation model based on population health need.

Five requirements have been identified in relation to meeting this principle:

P1.1: Committing to coherent planning of all dimensions of health care, both public and private.

The Group's view is that the existing planning framework within the Irish health-care system is weak and needs to be developed and strengthened. For example, the development of the private health-care system proceeded without any serious national planning or regulation (notwithstanding the very welcome proposals in relation to the licensing of providers). Under the HSE, there is now greater clarity in relation to public service delivery but moves to a more rational method of resource allocation are piecemeal rather than systematic or strategic in terms of population health.

P1.2: Establishing programme priorities based on population health need, covering both capital and current expenditures.

The Group's view is that, in the past two decades, many programme priorities have developed in response to crisis needs as they have arisen rather than from a coherent consideration of the totality of health care, covering both public and private, and capital and current resources. For example, while there are some exceptions where planning and decisions on resources have been strong (e.g. cancer care), Ireland lacks a wider health-care resource framework for deciding where funding should be increased or reduced based on population need.[60] Another positive example is the planning of the new children's hospital which has taken a broader approach to all children's services across the country. Both instances point to the absence of similar overall processes for considering other adult services, and how priorities should fall between adult and children's services.

[60] The ring-fencing of cancer itself raises issues for how resources should be allocated between cancer and other illnesses.

P1.3: ***Setting priorities that take explicit account of the level of public resources available, with nothing to be funded without planning (and no planning of developments without at least a plan to fund them).[61] This emphasis on planning reflects the desirability, from a governance perspective, of clarity in the roles of policy makers, purchasers and providers in line with best international practice.***

The Group's view is that changes to wider system planning within the HSE are happening very slowly and most budgets are still largely based on historic patterns (see the Evidence Report, ESRI (2010), Chapters 6 and 7). Furthermore, it is concerned at the potential for perverse incentives facing the HSE in its role as both purchaser and provider of certain services, e.g. hospital care (see the Evidence Report, ESRI (2010), Chapter 2).

P1.4: ***Organising a planned movement from historic funding patterns towards a population health allocation (on a multi-annual basis) to support a more rational delivery of services both at national and local levels. This is central to addressing the objectives of both fairness of access and responsiveness of delivery, as well as ensuring that the user drives the allocation of resources.***

The Group is aware that this objective has been discussed in policy circles for some time and most recently enunciated in the Brennan Report (2003), PA Consulting Report (2007) and Staines (2010). While some important changes have been introduced in the context of new programmes in PCCC, e.g. Fair Deal, the total volume of non-historic based funding remains low, and where budgets are following activities, these do not as yet formally reflect population needs.[62] See Evidence Report, ESRI (2010), Chapter 6.

P1.5: ***Having every member of the population registered (by a unique identifier) with a primary care practitioner, supported by an IT system and a management information system for health/social care services that covers the whole system.***

The Group is aware of the legal impediments that caused the extensive delays in getting agreement on a unique health identifier, and that the identifier will be legislated for in the forthcoming Health Information Bill. The absence of an identifier combined with the weakly-developed IT infrastructure in the health-care sector have reduced Ireland's ability to follow the modern international practice of taking an integrated approach to care and of measuring the effectiveness of care interventions.

[61] In the case of an unforeseen event, say a flu epidemic, plans are articulated and funding put in place to implement those plans.

[62] The HSE estimates that, following recent changes, close to €4 billion of PCCC expenditures are now linked to activities. However, not all of these are on a population health basis, in the sense that activity is adjusted for need (proxied by age, sex, deprivation, etc.).

Box 3.3: The Benefits of GP Registration for Prevention Programmes

Susan is a 70 year old retired nurse who suffers from chronic respiratory problems. She thinks these were caused by smoking when she worked the night shift as a newly qualified nurse. She has a medical card and is therefore registered with a general practice. Every October she gets an invitation from the practice to come in to have the annual flu vaccine. This year she got the swine flu vaccine as well and remained healthy throughout the winter.

Gillian is a retired widow aged 71 years who is borderline obese. She is otherwise in good health and never attends a GP. She has a good pension and is consequently not entitled to the medical card. Because of all the publicity, she intended to get the swine flu vaccine but failed to do so. As a private patient, she is not registered with a practice, so was not invited to receive the swine or annual flu injection. She was one of the unlucky ones and got a bad dose of swine flu and was admitted to hospital. Had she had the vaccine, it is possible that she would have remained healthy and not required a stay in hospital.

Comment: This shows the potential benefits of preventative care through GPs.

Principle 2

A resource allocation model should support local implementation of national priorities based on nationally-set clinical, accountability and governance standards.

There were three requirements identified in relation to meeting this principle:

P2.1: ***Having decision-making structures for resource allocation that promote the most effective use of resources to deliver appropriate care to patients/clients.***

The Group's view is that present decision-making structures do not meet this requirement. For example, while the barriers between acute hospitals and the primary, continuing and community care are being reduced following the abolition of the twin pillars structure within the HSE, it is not clear that the emerging structures facilitate integrated care delivery in the most effective way possible. The Group believes that the HSE structure should be as flat as possible and that that priority should be given to the development of clearer roles, responsibilities and accountability within the HSE as the route to improving its capacity to manage resources more effectively.

P2.2: ***Having a resource allocation system that is embedded in clinical/management structures, to deliver safer and more effective health care at national and local levels. This is central to ensuring that national standards operate on the same basis across all localities and cost/output data are shared by all the key decision makers.***

The Group has noted the progress being made in integrating clinical/management systems in the hospital sector, supporting the new models of care outlined in Section 3.2.6 above. However, it is concerned that the roll out of clinical protocols is not yet reaching far enough into the primary care system, and that current HSE plans to restructure service delivery (by creating Integrated Service Areas (ISAs)) may not be adequate. The Group sees a real risk that the quality and safety potential of care protocols will not be realised if the resource allocation drivers are not consistent with these protocols, e.g. if budgets cannot be shifted from the hospital to the primary care sector in line with protocol requirements.

P2.3: ***Having resources allocated as close to the users as possible, consistent with the scale of the local delivery system being safe and sustainable in light of demand uncertainty, quality standards and scale efficiencies. International evidence suggests that this should be to a geographic unit with a minimum population of 250,000-300,000 (although there may be exceptions in areas where there is extreme geographical dispersion and very poor public transport links). See the Evidence Report, ESRI (2010), Chapter 2.***

The Group is concerned that the unit size currently being considered for some ISAs may fall significantly short of the scale needed to run a sustainable, safe and effective system of resource allocation at local level.

Principle 3

A resource allocation model should support the delivery of safe, sustainable, cost-effective, evidence-based care in the most appropriate setting, whether public or private.

There were two requirements identified in relation to meeting this principle:

P3.1: ***Having incentives within funding mechanisms that are consistent with and support the agreed care objectives and mechanisms, with resource allocations taking into account the dissimilar costs of care across different care settings, both public and private.***

The Group found that the incentives within funding mechanisms did not generally support the agreed care objectives. In particular, despite the widespread commitment to integrated care pathways linked to phrases like 'the money should follow the patient' the Group found evidence to the contrary.

At present, there is no framework in which different costs of care can be taken into account in a systematic way. For example, chronic care that should be delivered in the community is often being delivered at greater cost in the hospital setting, at

least in part reflecting the lower costs to patients of hospital out-patient care (when they are able to access it) compared with GP care.

In this context, the Group is concerned that the definition of a PCT needs further development to meet the diversity of settings in which PCTs operate (urban/sub-urban/rural towns/rural areas). In the Group's view, the pace of development needs to accelerate to allow a significant shift of functions from the hospital to the primary care setting and this will require very considerable support from the HSE at local level.[63]

The Group has noted that the development of primary care teams internationally takes time, and indeed reflects the challenges of moving to the new integrated model as outlined in Section 3.2.6 above. In the context of a resource allocation model based on population health, the Group notes there are currently no guidelines on how the catchment population of a PCT is defined, and that this will take some time to implement as it is linked to patient registration.

Box 3.4: The Cost of Services not being Team-Based and Integrated

Kevin is a 59 year old male who suffers from kidney stones, asthma, depression, osteoporosis and severe back pain due to narrowing of his lower spine. He is currently on 22 medications resulting in a total of 45 tablets to be taken daily. He attends four different hospital out-patient clinics and has waited months to see a consultant about his back. He is now confined to a wheelchair.

His actual main current problems are loneliness, worry about his children, from whom he is separated, and significant debts. He has a medical card, receives home help, meals and regular house calls from his GP. It has not been possible to have his case reviewed by a social worker, occupational therapist or psychologist as these require he be admitted to hospital.

Over the last three years, his quality of life has deteriorated significantly and he has threatened to take his own life on a number of occasions.

Comment: This shows the need for multidisciplinary teams and individual-centred care which can account for multi-morbidities. Local co-ordination and delivery of services could be through a combination of the GP (who should have direct contact with the hospital) and the social worker.

[63] A working PCT is defined by the HSE as one 'holding clinical team meetings'. In practice some PCTs are very well developed (Virginia and Ringsend are the oft cited examples of excellence) but clearly many others are only just operating to this basic criterion.

P3.2: ***Having a resource allocation model that promotes the cost-effective delivery of care, i.e. directs users and providers to the appropriate setting for relevant care delivery for a given expenditure on a particular service.***

The Group found little evidence of mechanisms in place to promote the delivery and utilisation of appropriate care in the appropriate setting. In fact, in many cases, the resource allocation mechanisms actively encourage care in less appropriate settings, e.g. diagnostic costs are covered by public hospital budgets and not by primary care budgets so that GPs and patients have an incentive to seek such tests in a hospital rather than a primary care setting.

Principle 4

A resource allocation model should promote the integration of care within and across the hospital, primary and community/continuing care sectors at local level.

There were three requirements identified in relation to meeting this principle:

P4.1: ***Having resources for all types of care within the same budgetary envelope at a local level. This implies that budgets (based on population health needs) to cover hospital, community/continuing, and primary care should be held at local level, and that the budget-holder at this local level should be responsible for ensuring the delivery of services across all areas of care to nationally-set standards.***

As far as the Group can understand, there is now a plan being developed to ensure that all types of care are handled with budgets being held at local (i.e. ISA) level. The Group welcomes this as long as the local level has the capability to manage the budgets and that clinical protocols currently being developed at hospital level are extended fully into primary care and, where relevant, the community and continuing care sectors.

P4.2: ***Having the decision-making unit at local level with a capacity to deal with the clinical/care and managerial demands of handling integrated care priorities set at national level.***

The Group is concerned at the very significant 'transformation' costs within the health-care system in the past decade and the need to extend this transformation to restructure the HSE to remove the original 'two-pillar' structure. The Group agrees with the decision to move to an integrated care model within the HSE and that, in taking a population health approach, service delivery should be as close to patients/users as is feasible, taking account of safety and cost. The Group sees it as being essential to local delivery that well-defined procedures are set by HSE Corporate to ensure that the problem of differences in availability and quality of services across the former Health Boards does not arise again. In the context of having to manage local budgets based on population health, the Group is concerned that the populations to be covered by some of the planned ISAs are too small in terms of budgetary sustainability, local management capacity, and integrated care. The total number of ISAs should reflect the (small) overall size of Ireland's population (taking account of population dispersion).

P4.3: ***Having an oversight management structure that ensures local adherence to care protocols/standards and financial management.***

In the Group's view, it is vital for HSE Corporate to have the capacity to oversee and monitor the performance and delivery of integrated care at local level. This will require integrated teamwork between care professionals, people managers and financial decision makers at Corporate and local level. As noted above in Section 3.2.6, the Group believes that central to making the changes necessary to develop the Irish health-care system is that health and social care professionals become more engaged with understanding the costs and benefits of their actions, and ultimately share responsibility for this with relevant management.

Principle 5

Financial incentives should align as far as possible across all actors (including users and providers) in the system, consistent with promoting good health and well-being and in line with nationally-determined priorities.

There were six requirements identified in relation to meeting this principle:

P5.1: ***Having incentives/programmes that support users in managing their own health and wellbeing.***

In the Group's view, Ireland still has a health and social care system that is predominately traditional in the sense that professionals 'fix' the problems of their patients/clients. Similarly, until recently, institutional providers of care were seen as the main focus of funding decisions, which in part explains the lack of development in the Irish primary care sector compared with other reference countries. The Group recognised that current measures of output do not adequately capture preventive and health promoting interventions on the part of professionals and consequently too little of such care is delivered. Where preventive interventions are rewarded (such as vaccination against influenza) this is to carry out a particular act rather than being part of a continuing responsibility for the health of patients and developing their ability for self-care.

P5.2: Developing provider-payment systems that support professionals and institutions in delivering integrated care.

The Group found widespread evidence that provider-payment mechanisms promoted disintegrated rather than integrated care. The historic separation of budgets and structures has meant that any integration has been deterred rather than promoted. In effect, patients are incentivised to go to acute public hospitals for the management of their chronic diseases whether appropriate or not, because out-patient treatment there involves no out-of-pocket payments (which contributes to longer waiting times and more limited access for public patients). For example, a patient with a chronic mental illness or a patient with stable angina pays less for care if they receive regular out-patient appointments than if their care is managed by their GP. Furthermore, under the current system, there is a financial incentive for GPs to refer Medical Card patients, for whom they receive a capitation payment, to hospitals at an early date, if they get no financial reward for a further consultation. By contrast, they do not have an incentive to refer private patients so quickly, since they receive a fee for subsequent consultations; indeed, in the absence of defined protocols, say in the case of chronic disease management, they actually face an incentive to delay appropriate referrals. Integrated care of such patients happens despite rather than because of the structure of incentives. See the Evidence Report, ESRI (2010), Chapter 8.

P5.3: Having a blend of methods to pay providers (e.g. capitation and fee-for-service for GPs; activity-based casemix-adjusted payments and capitation for continuing and community care; activity-based, casemix-adjusted payments, capitation and block grants for acute hospitals).

At present, there are blended systems in operation but these are not of the type that good practice would suggest, as they are differentiated by the public/private status of the patient. Thus, while GPs are rewarded predominately on a capitation basis for medical card patients, they are rewarded on a fee per contact for their private patients. This creates an incentive for them to spend less time with public patients and to encourage revisits on the part of private patients. See the Evidence Report, ESRI (2010), Chapter 6 and 8. Consultants get no additional remuneration for seeing public patients in out-patients clinics but receive fees (that are high by international standards) for seeing patients on a private basis. This difference in payments means that consultants who have long waiting lists are more likely to have patients apply to see them privately.

P5.4: Ensuring that payment methods incentivise improvements in the quality of care for given costs.

The Group recognises that Ireland is currently addressing the issue of quality of care through the implementation of care protocols across the system and the establishment of stringent licensing systems for both professionals and institutions. As the body responsible for quality assurance, HIQA should set the institutional standards and adopt the clinical standards being developed by teams of clinical leads in the HSE. In due course, when these are in place, it would be timely to explore how payment methods could systematically incorporate quality of care. At minimum it would be important that payment methods do not incentivise behaviours (by individuals or institutions) that run counter to good care. The Group has some concern that the current protocol plans do not yet go far enough in relation to integrated care and while much is to be gained in terms of patient safety by having better procedures in hospitals, much of the gain in safety and cost reductions will come from integrated care across care settings.

P5.5: Ensuring, where feasible, that providers face the same payment methods regardless of whether the user's care is financed on a public or private basis or whether the provider is public or private.[64]

The Group found that there was very little information available on the prices that are used to reimburse providers of care. Even in the case of the National Treatment Purchase Fund, which purchases specific interventions, there is no standard publicly visible price. However, It appears that there are widespread differences in the implicit prices being used in paying for care generally and in the primary care sector these are built into the very different mechanisms for paying GPs – fee for service in the case of private patients and predominately capitation in the case of public patients. A review of the current GP contract is overdue; it was designed in a different time and is no longer fit for purpose.

P5.6: Ensuring that purchasers of care on behalf of users (e.g. the state or insurance company) seek the most effective sources of care of a given quality. This means have a split between purchasers and providers.

The Group noted that, other than in the case of the NTPF, which purchases specific interventions from public and private providers, there is a strong overlap in the Irish public health-care system between purchasers and providers. This arises through the HSE being both the purchaser of care and the owner of hospitals and nursing homes. It clearly creates conflicting incentives for the HSE in seeking to purchase care at the lowest cost for a given quality.

[64] Where services are funded by Government, this is straightforward. It is more complex in the case of privately financed services.

Box 3.5 The Potential Benefits of Integrated Care for Chronic Illnesses Patients

Paula is a 28-year-old married woman who is trying to get pregnant. She lives in the midlands and works in a local firm as a legal secretary. One Saturday morning, her husband wakes to find her having her first convulsive seizure in the bed beside him. He puts her in the recovery position and calls 999. By the time the ambulance arrives the seizure is over but Paula is drowsy and confused and she is brought to A&E at the local hospital where she is evaluated and admitted. Within a couple of hours she is awake and alert.

Scenario 1. Not uncommon now

The patient is given no specific treatment for seizures but kept in hospital for tests. These tests are only available outside the hospital and it takes five days to complete two different brain scans (EEG and MRI) which are done in other institutions. It is now Thursday of the following week. One of the tests shows that Paula 'may' be at risk of further events and she is started on a standard medication, Valproate, Valproic acid for seizure prophylaxis. She is discharged on Friday with advice to her and her GP to seek specialist opinion from a neurologist in Dublin or Galway. Her GP sees her on the following Monday and writes a hand written note for referral to a Dublin neurology service. The GP is reluctant to change the dose of medicine, even though Paula feels a little drowsy on it. He orders a blood level; the results will take ten days. Two weeks later Paula gets an appointment to see a neurologist in ten months. She meanwhile has read up on Valproate on the internet which has suggested that it may be bad for foetal health should she get pregnant. Her GP tells her the levels are fine and that she should not stop the medication to get pregnant. During the following ten months, Paula has gleaned everything she knows about epilepsy from friends and the Internet. She is anxious and a little depressed. At the neurology clinic in Dublin, she is six months pregnant, when the specialist informs her of the risks associated with Valproate and pregnancy. She spends the next three months worried about the outcome of her pregnancy. Eventually the baby is born normal. It's been a very difficult year for Paula even though she had no more seizures.

Scenario 2. With very modest change

The patient is given no specific treatment for seizures but expert advice from the national epilepsy service of Ireland (NESI) 24/7 video-phone advice service suggests that her current status means that she can be discharged with a plan to follow up at her nearest regional Epilepsy centre in Dublin early the following week. On Tuesday she arrives and is met by a clinical nurse specialist who takes her details and arranges for appropriate scans, which are done that day. The EEG and clinical history suggests an enduring risk of further events. She is reviewed by an epilepsy specialist and during the routine counselling and education section it emerges that she is planning to get pregnant. The risks of treatment are discussed and a medication with a suitable side-effect profile for pregnancy is decided upon. She is put in touch with the epilepsy and pregnancy registered nurse who will provide ongoing support by phone during the pregnancy. An electronic summary of the clinical episode, investigations and plan are e-mailed directly to the GP, who can access her information online for updates and he is also encouraged to monitor for certain side effects of the medicine. Telephone and e-mail advice is offered post-diagnosis from the regional epilepsy centre and referral is also made to the offices of the local epilepsy voluntary organization. An offer to participate in research is made and the patient is discharged the same day with plan for routine follow-up. A year later, with no side effects of medication, and after a number of follow-up visits to NESI, a healthy baby is born. It has been a very satisfactory year for Paula.

3.4 Financing and Sustainability of Health Care

Principle 6

The methods of financing health care should be as effective and equitable as possible.

There were five requirements identified in relation to meeting this principle:

P6.1: Linking resource generation processes and the amount of resources available for allocation to health care transparently.

The Group believes there are problems with poor transparency in how public tax resources for health care in Ireland are determined. Only a small proportion of resources are earmarked (the health levy) and this is too small to affect decisions on the overall level of public health expenditure. Public subsidies (e.g. tax relief on private health insurance premiums and on specified medical expenses) reduce transparency in the use of public resources since they reflect individual choices and not public priorities. As a first step a financing model that explicitly identifies all public resources for health care is needed to support an effective resource allocation model. More transparency between the resources that are collected from individuals and those that are available for health care increases the understanding by the population of the challenges faced by the health-care system.

The Group recognises that some financial resources in health care are not part of the resource allocation model (e.g. private payments for private services). These additional resources may or may not be spent in a way that is consistent with national policy priorities. In the Irish system, private health insurance and out-of-pocket payments are not directly controlled by the Government (although the level of private expenditure is influenced by tax relief on health insurance premiums, etc.). While these sources account for less than 20 per cent of total health-care resources, they have important implications for financing specific services for specific groups in the population. Out-of-pocket payments for primary care for the majority of the population means that, at present, government influence on how primary care is utilised is limited to the medical card population. Measures taken by Government to promote continuity of care and appropriate use of the system could be seriously affected by the financing structure that requires non medical card patients to pay the full cost of primary care at the point of use. This is discussed further in Sections 4.3 and 4.4. Appropriate models of care require that primary care is more fully integrated into the health system (rather than operating largely in parallel to it).

P6.2: ***Creating a separation between what individuals pay towards health care and the health care they are entitled to receive (as per the normal principle of insurance systems).***

The Group believes that the present payment systems have a strong impact on the services that different individuals receive in relation to health care. For the services that are financed using public tax resources, there is separation between what individuals pay towards health care and the health care they are entitled to receive. However, for the majority of the population, payment for primary care is directly linked to receipt of care. Furthermore, in many areas of care, privately insured individuals can use their private health insurance status to gain faster access to public hospital care.

P6.3: ***Ensuring that payment for health care by individuals is on the basis of ability to pay, with richer people paying more than poorer people (relative to their income/ wealth).***

The Group recognises that contributions to health-care financing which are made through the tax system are linked to ability to pay. However, the Group believes that the mix of health-care financing sources in the Irish system weakens the principle that health care is financed according to ability to pay. Public subsidies have the effect of making some parts of the system more progressive and some more regressive. For example, all taxpayers indirectly contribute to the cost of tax relief on private health insurance which benefits those who can afford to purchase private health insurance.

The Group is concerned about the dominant role played by out-of-pocket payments in financing primary care for non medical card holders, many of whom are on relatively low incomes. User fees are regressive, posing a greater burden on patients with lower incomes. The Group supports recent developments in community and continuing care which link payments to ability to pay, e.g. Fair Deal. The Group also believes that it is essential to remove the current disparities and anomalies that give rise to large jumps in entitlement from below to above medical card eligibility thresholds, and from one chronic disease to another.

Box 3.6: The dangers of excessive co-payment costs for GP services

James is a relatively wealthy 59-year-old accountant who has high blood pressure. He conscientiously attends his GP every six months for monitoring and takes three tablets a day. Although he is charged for each visit, cost is not an issue to him and he likes the fact that he is getting 'regular NCT's'. His blood pressure is now very well controlled.

John is a 59 year old small farmer whose income has always been just above the threshold for the medical card. He found attending his GP for monitoring of his blood pressure, which did not greatly affect his daily activities, expensive as were the tablets for the blood pressure. Although his children paid for private health insurance for him and his wife, he considered the amount he got from the company to cover rebates for his visits and drugs as ' not much'.

Visiting his GP was therefore not a priority and he only went now and again. He knew his GP was concerned about his blood pressure control. However, he was always well and active about the farm. Unfortunately he had a small stoke last Christmas. This was due, his GP says, to 'uncontrolled blood pressure'. His family have said they will now bring him regularly to the GP, despite the cost.

Comment: Early interventions can be deterred by co-payments, and can result in much more costly procedures being required later.

P6.4: Having payment for health care by individuals on a pre-payment, rather than pay-as-you-go basis.

The Group is concerned at the absence of pre-payment in primary care, except for those with medical cards and those with private health insurance that cover primary care. There is also no scope to pool resources across payers who have varying ability to pay, and varying risk of ill health. Payment for health care at the point of use conflicts with the goal of developing continuity of care which is particularly important for effective chronic disease management. The Group notes that in the present system, only medical card (and GP Visit card) holders have a financial incentive to register with a GP. Private health insurance is heavily biased towards hospital cover and it is only in recent years that cover for out-patient care has been expanding (slowly). A review of policies offered by the private health insurers indicates that, for the most part, private health insurers are not promoting specific pathways of care, though some health insurance policies do encourage annual check ups.

P6.5: Having co-payment rates for patients such that they do not deter appropriate use of appropriate health-care services at the appropriate time.

The Group notes that for non medical card patients, there is no direct public subsidy for GP services and that this is unique compared with other developed countries. (There is of course an indirect subsidy through ex-post tax relief where it is claimed.) This acts as a serious disincentive to people to attend primary care, particularly for lower income groups, given the relatively high cost of GP visits in Ireland. There are indications that the level of utilisation by non medical card holders is low relative to need, and, as noted above, that some patients are using hospital in-patient and emergency department services rather than going to a GP.

A patient with a chronic condition may require regular monitoring which can be managed readily in a primary care setting. However, once a patient has been referred to public out-patient services there is no further consultation charge (although in some cases gaining access can be slow and difficult). This encourages patients to continue to see a consultant specialist even if a GP consultation would be more appropriate. There are also complicated incentives around charging for out-patient diagnostic tests (e.g. when a patient is referred by a GP to the hospital for diagnostic tests, the cost of the test is absorbed by the hospital). The variation in the out-of-pocket charges for the patient impedes integrated health-care delivery.

P6.6: Having administration costs of health-care financing mechanisms that are low relative to the cost of the service provided and the amount of revenue raised.

The Group believes that administration costs generally should be kept as low as possible consistent with having appropriate governance and accountability. In the case of co-payments, the Group recognises the balance that is required between setting user fees at a level low enough not to seriously deter utilisation, but at a high enough level that the revenue raised justifies the administrative burden of collecting the fees. In the view of the Group, the recently introduced capped co-payment for prescriptions for medical card holders is unlikely to meet the criterion of raising enough revenue to justify the administration costs (including costs to pharmacies and patients.)[65] Evidence suggests that any deterrent effects will be to reduce the use of both necessary and less necessary drugs, with possible harmful effects on health. In so far as it is intended to reduce use of drugs, a better approach would be through protocols and incentives to doctors to reduce unnecessary prescribing.

[65] Since the fees are capped it is necessary for the level paid to be recorded and for no further fees to be paid once the threshold has been reached. This imposes greater administrative costs on pharmacies and patients.

Principle 7
All aspects of the health-care system should be sustainable.

There were five requirements identified in relation to meeting this principle:

P7.1: ***Aiming to ensure economic as well as fiscal sustainability of the health system, i.e. taking account of service quality, minimising the total cost of health care to the population at large, rather than just the fiscal cost to government.***

The Group believes that inadequate attention has been paid in the past to the rise in the overall cost of health care, with the fiscal cost dominating the discussion. While the latter is clearly important, a transparent system would show that nothing is achieved overall by simply shifting funding sources from government to the private individual. Similarly, the Group has concerns that the very high levels of out of pocket expenditure by households of modest means on health care have been very significant. Because these rates have been determined in a private market context, there has not been adequate emphasis on the relatively high inflation rate in health-care costs and the rise in certain out of pocket charges in recent decades as the range of services (e.g. house calls) has reduced.

Box 3.7: The Cost of Primary Care
Mary was widowed at age 84, and survived her retired executive husband by 9 years. She became increasingly frail in the intervening years, and for her last three years was essentially housebound with 24-hour (non-nursing) care, which was possible because her accommodation was on one level. Although very frail, Mary did not require hospital care. However, GP home visits were a regular occurrence and possibly because of these, hospital care was avoided.

Mary had a very good relationship with her GP, but he was not a member of the GMS. Accordingly, when medical cards became available to those over 70, she was persuaded to change GP in order to be able to avail of the new support. However, the new GP was reluctant to make house calls (he called only once to visit Mary at home). Since Mary could not easily visit the GP, she opted to return to her original GP as a patient. This had a number of consequences:

- Little or no access to community health services – public health nurses, chiropodists, physiotherapists, etc.
- She would have benefited from access to a public health nurse, as no equivalent service was available to her from the private sector.

The cost of her medical care was extremely high. GP visits, in her last two years, cost €150 per visit, approximately €120 per visit after claiming tax relief. In addition €40 was charged for repeat prescriptions, and there was a €60 charge for any discussions with family members with regard to her health or care.

The GP visited at least once a month during her final years, and in the last year of her life, this increased to approximately once a fortnight. The bill for visits during the week prior to her death amounted to €950.

Comment: Elderly patients who can be cared for at home can face very high personal costs of care if they require regular GP home visits.

P7.2: ***Focusing on measures that seek to enhance the capacity of the health-care system to convert resources into value, for example, more flexible work practices.***

The Group's view is that current budgetary mechanisms do not reward such conversions in the absence of a connection between resources and outputs. The Group notes that the HSE has placed considerable emphasis and focus in recent years on achieving greater value for money (VFM), and that has contributed to reducing its costs in 2009/2010. Notwithstanding this, the Group sees potential in ensuring that health-care costs are at a more sustainable level. The Evidence Report, ESRI (2010,) Part 6 suggests that Irish health-care costs (in terms of both pharmaceuticals and labour) are high by international standards. More flexible work practices could provide greater opportunity to reduce unit labour costs throughout the health care sector.

P7.3: ***Using economic evaluation mechanisms (involving systematic marginal analytical frameworks) to underpin decision-making at every level of activity, e.g. at the top (national) level of resource allocation, the local level, and the care delivery level.***

There is little evidence of a system of economic evaluation currently underpinning the health-care system in Ireland. One recent exception is the move by the HSE to undertake an economic evaluation of new drugs. While there are some other areas, for example the new Children's Hospital where a more holistic, evaluative and systems approach is being adopted, the Group believes that the historic legacy of decision-making, that focussed primarily on the acute hospital system, remains still implicitly dominant in the decision-making process. The Group's view is that the introduction of a more transparent economic evaluation system, covering both capital and current expenditures, is overdue. Such a system would also be helpful in handling issues in relation to service rationalisation, hospital reconfiguration, and the development of primary care services.

P7.4: ***Developing performance management systems that incorporate appropriate measurement tools to enable appropriate monitoring and evaluation.***

The Group encountered significant difficulties in drilling down through the HSE spend due to the historical lack of investment in databases, financial systems and performance tools. The Group is of the view that significant investment in IT will be required for implementation and ongoing appraisal of a population health allocation budgetary model. In addition the Group noted difficulties in underspecified and overlapping roles of the different statutory bodies for quality of care. The Group also noted that the review of international practice on health system change also highlighted that a frequent problem with evaluating the success or otherwise of the health system changes was a lack of focus at the time of implementation on how the benefits of the system would be monitored and measured post implementation.

Box 3.8: The Potential for Information and Benchmarking to Drive Change

The Challenge: HealthStat was launched in March 2009 with 29 Hospitals participating. Its aim is to improve standards by allowing individual hospital performance (Access, Integration and Use of Resources) to be compared against international or national best practice/peer performance. To facilitate easy review by patients as well as professionals, performance is registered under the red/amber/green categories and the detailed 'dashboard' for each of the hospitals and their performance against each of the metrics is publicly available on the HSE website. This allows each manager to identify the hospital that is best in class and facilitates sharing of best practice across hospitals. HealthStat was established at a challenging time – when cost containment policies were being introduced, along with a moratorium on recruitment/replacement of staff.

One Response: Waterford Regional Hospital (WRH) commenced a radical change of its management programme in terms of reorganising the service delivery model for in-patients and out-patients in response to the HealthStat challenges. Clinical and managerial leadership and input from across the hospital was critical for the success of the Clinical Director and Management Team as they undertook these changes. A Senior Clinical Manager was redeployed to project-manage the centralisation of waiting lists and to improve processes of access to out-patient services. The 'New to Review' patient ratio was improved through the establishment of additional clinics. Bed stock was reorganised to facilitate increased access to day case surgery for patients scheduled for surgery following the out-patient review. In-patient beds were re-designated as Day beds and protected for elective admissions. Pre-admission assessment to improve day case rates was improved and the span of day care was expanded to 08:00 – 20:00 to optimise access. A 5-day ward for Surgical Capacity was also developed. Concurrently, via internal transfer of staffing resources and skills, an Acute Medical Assessment Unit was developed to optimise management of acute medical admissions. This unit, similar to the Emergency Department and Medical Assessment Unit, has rapid access to diagnostics and to senior clinical decision-making which are critical to improving length of stay and maintenance of the Accident and Emergency maximum six hour waiting time. An ethos of safe early discharge including rapid access to the Out-patient Department including (e.g. Neurology, Rheumatology and Age Related Day Care), is well established.

Key to Success: The key to success in meeting the challenges of HealthStat is clinical leadership supported by management and ensuring the right staff members are in the right place at the right time to deliver the right care in line with the service reconfiguration. Additional gains were a fall in the hours lost due to absenteeism, an increase in employee satisfaction, and increased day care and 5-day versus 24x7 rosters. But the main beneficiaries were the patients. The internal reconfiguration model has ensured that patients are at the centre of the decision-making process, access to services has improved, and resources are realigned to optimise performance (as evidenced by WRH being the first hospital to achieve total system green light on 26 Feb 2010).

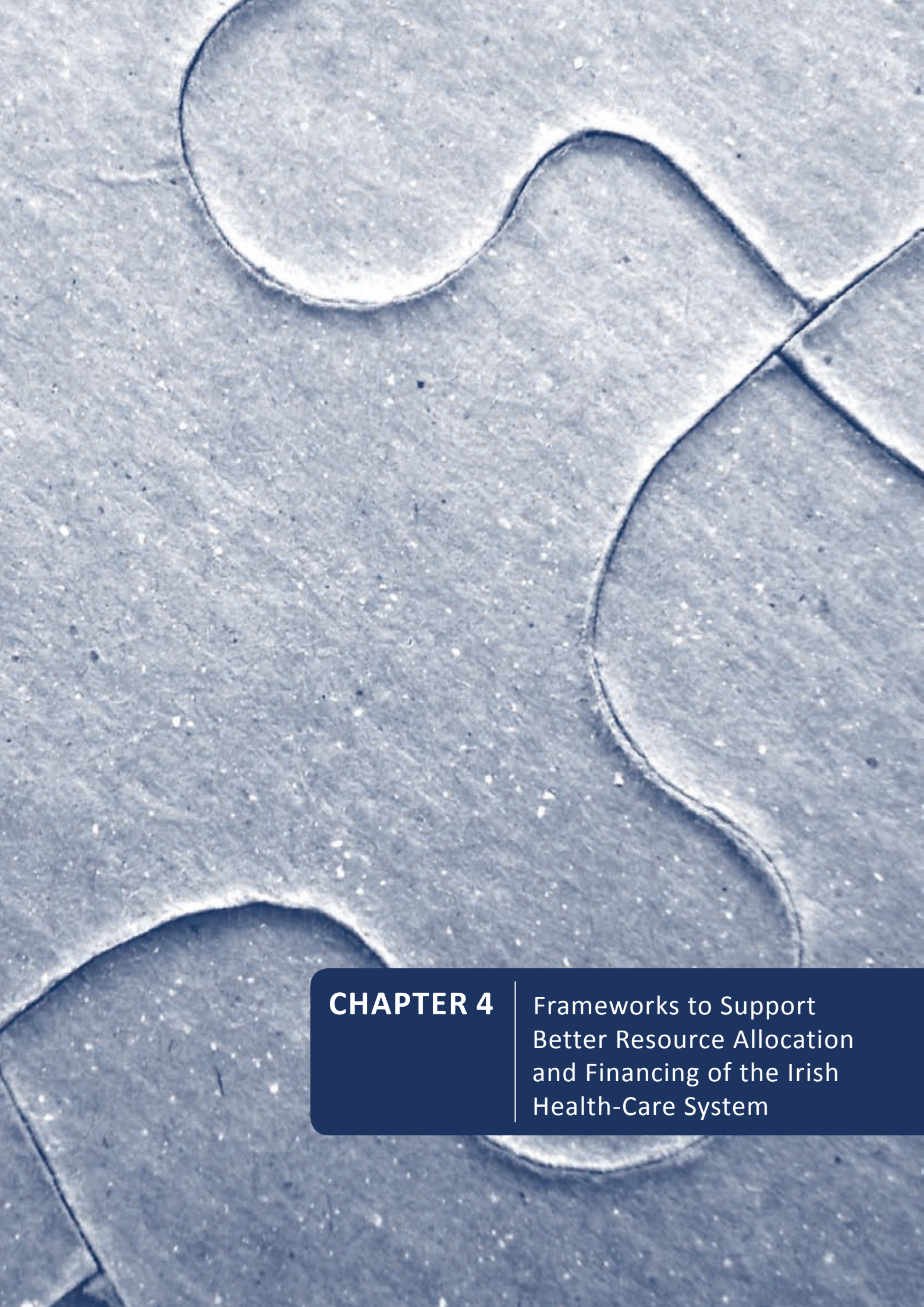
Comment: Information can support change driven by clinicians and management.

P7.5: Aligning responsibility for resources to those responsible for service delivery and aiming to ensure adequate planning of services prior to resource allocation.

The Group noted the difficulties for achieving sustainability arising from the way in which the HSE is financed from Government funds (on a cash based annual budgetary model, with funding allocated once annually to the HSE via the Health Vote). The current set up, with many demand-led systems generates difficulties for the HSE as 'underspending' is perceived as failure to provide the planned services and 'overspending' is perceived as a failure to control the budget adequately. A consequence of this method is that resources are devoted to managing this process which might be better spent in ensuring a more efficient use of the HSE's resources. In effect, the current allocation system encourages the spending of resources whether necessary or not, as unspent budgets lead to allocation cuts in subsequent years. In addition the current methodologies incentivise reduced output and therefore reduced costs even if this is not in accordance with policy.

3.5 Concluding Comments

The Group's view of the current system of resourcing, funding and sustaining the present health system is that it fails to meet most of the guiding principles that the Group would consider essential to have a system that is 'fit for purpose'. For example, while the system seeks to be patient/client centred, the resource mechanisms do not support that. While integrated care is seen as being crucial to meeting the health needs associated with chronic disease management and ageing, the resource allocation mechanisms fail to support this. While equity and fairness are key objectives of Irish health care, the financing mechanisms used in Ireland to finance health care are highly inequitable, placing particular burdens on people who are just above the medical card and GP Visit card thresholds and/or who require regular contact with primary and community care services (e.g. people requiring chronic disease management). Thus while much has been achieved following the Brennan Report in terms of controlling expenditures on health care, very little has been achieved in terms of better allocation of the resources available to the system. Furthermore, the issues and risks associated with the current financing system have been exacerbated in the present economic climate. In the context of reduced resources for health care it is crucial that Ireland has a resource allocation system that can allow government to deal with budgets equitably, to prioritise different types of care and ensure the most efficient and effective use is made of the available resources.



CHAPTER 4

Frameworks to Support Better Resource Allocation and Financing of the Irish Health-Care System

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Frameworks to Support Better Resource Allocation and Financing of the Irish Health-Care System

4.1 Introduction

As outlined in Chapter 3, the Group has identified a number of problems in the way resources are currently allocated in the Irish health system, and in the mechanisms used to reimburse service providers and to finance the system. Specifically, some elements of the current system are either completely or partially at variance with many of the guiding principles that the Group believes follow from the publicly-stated health-care priorities. These guiding principles, outlined in Chapter 2, reflect the stated priorities for health care in Ireland and the Group's understanding of what comprises a good health-care system, drawing on a review of both the theoretical literature and international evidence on alternative resource allocation and financing models (Evidence Report, ESRI (2010), Parts 2 and 4).

Before addressing how the system can be adjusted to become more consistent with these guiding principles, it is useful to recall the central components of Irish health and social care policy, namely, equity and fairness, people-centredness, quality, and clear accountability.

Equity and fairness, as discussed in Chapter 1, translate into care delivery that is based on user need, and paid for in ways that reflect overall ability to pay rather than specific use of services. This means resources should be allocated at national level to meet need across different health/social care areas and geographical areas.

A ***user-centred system*** requires a resource allocation model which ensures that resources follow the service user across different care settings, so that the right care is delivered in the appropriate setting and at the appropriate time.

Achieving ***good quality of service*** is reflected in the increased emphasis on quality and safety, as outlined in the Report of the Commission on Patient Safety and Quality Assurance in 2008. Central to safe care is the new role to be played by clinical protocols in supporting more effective and evidence-based best practice methods of care delivery.

Clear ***accountability in the delivery of services*** means that a rational framework of service delivery must be underpinned by a correspondingly rational resource allocation model that promotes good governance and effective mobilisation of resources, so that complex care is delivered in an efficient and accountable manner.

In a time of limited and declining resources, improvements in the systems of resource allocation and financing in Irish health and social care are essential to maintaining the sustainability of the health-care system, and rational frameworks are the key to achieving these improvements. These frameworks must ensure that clinical, managerial and economic drivers reinforce each other – any alternative will undermine the aspirations of health policy.

The Group made a decision early on in its deliberations to operate, where feasible, within existing managerial structures in the Irish health system, and committed only to modify these where essential to the achievement of goals. This reflects the Group's recognition that the costs of structural change in any context are likely to be very substantial, and where possible, functions rather than structures should be altered. A further focus of the Group's work throughout was the need to integrate care across all relevant settings, since this is the key to managing chronic diseases safely and effectively.

Section 4.2 describes a framework wherein clinical protocols, resource allocation and good governance can operate successfully in a mutually reinforcing way. Section 4.3 sets out the requirements for financing Irish health care in a more cost-effective and equitable manner, while Section 4.4 outlines a framework for moving towards a structure of user fees that supports the approach to the delivery of services outlined in Section 4.2.

4.2 A Possible Framework for Resource Allocation for Integrated Health-Care Delivery

This section sets out a framework within which the provision of care at all levels can be better integrated, with the objective of providing better and more efficient services, especially in managing chronic diseases more effectively. The following section suggests ways in which the financing system might be adapted to support this approach to delivery of care. A major theme of this Report, following on from international best practice, is that if the delivery of care is client-centred, the structure in which care is delivered must be integrated across the three relevant domains: primary care (PC), community and continuing care (CCC) and acute hospital care (HC). While the individual is most likely to interact in the first instance with the PC system, his/her ongoing relationship may be more concentrated in the CCC rather than the PC system. The nature of what individuals require over the course of a lifetime, in terms of supporting their overall health and well-being, means that it makes no sense in resource allocation terms to treat these three sectors as separate entities. Without integration, acute hospital services are likely to get used when they are neither necessary nor desirable, leading to greater cost and possible safety risks to patients. With proper integration, acute hospital services will only be drawn on as needed to support primary and community-based services.

In Ireland, there have already been moves at a national level to integrate these three components with the dismantling in 2009 of the previous two pillars in the HSE (National Hospitals Office and Primary, Community and Continuing Care). While

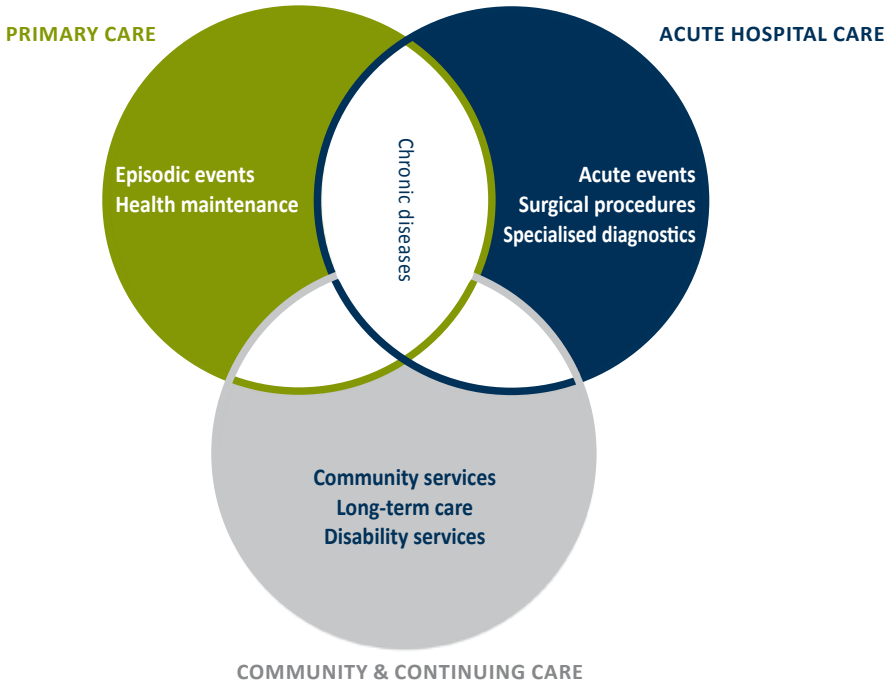
the Group sees the integration of the two pillars as a step in the right direction, it is not convinced that it is appropriate to see PCCC as a single entity because of the very different ways in which the PC and CCC sectors operate. Furthermore, the challenges for development in terms of infrastructure and governance are different in each of the three sectors. Specifically, while it is appropriate that the PC sector, like the HC sector, operates to a medical model, the medical model of care is not the most effective approach in delivering certain elements of care in the CCC sector.

For example, international best practice in disability services (among the largest expenditure programmes within community and continuing care) is to move away explicitly from a medical model of care to a social model of support, with the emphasis on maximising self-determination, community participation (inclusion) and equal citizenship. In this context, service planning is best done with, not for or to, the client, a development that is mirrored to some extent in primary care by the increased emphasis on self care. This change in orientation and relationship in the area of disability services requires fundamental change in the understanding of the duty of care that is typically held, where the client is viewed as a dependent and passive recipient of services.

The Group sees the PC, CCC and HC sectors as distinct but strongly overlapping and it is the overlaps which drive the need for an overarching framework to encompass all three of them. Figure 4.1 illustrates the interconnectedness across the three areas of care, and shows how chronic disease, often associated with the process of ageing, is at the centre of the overlap. Given this overlap, it is clear that resource allocation, planning and delivery of services must take all three dimensions into account.

FIGURE 4.1

Integrated Care Provision

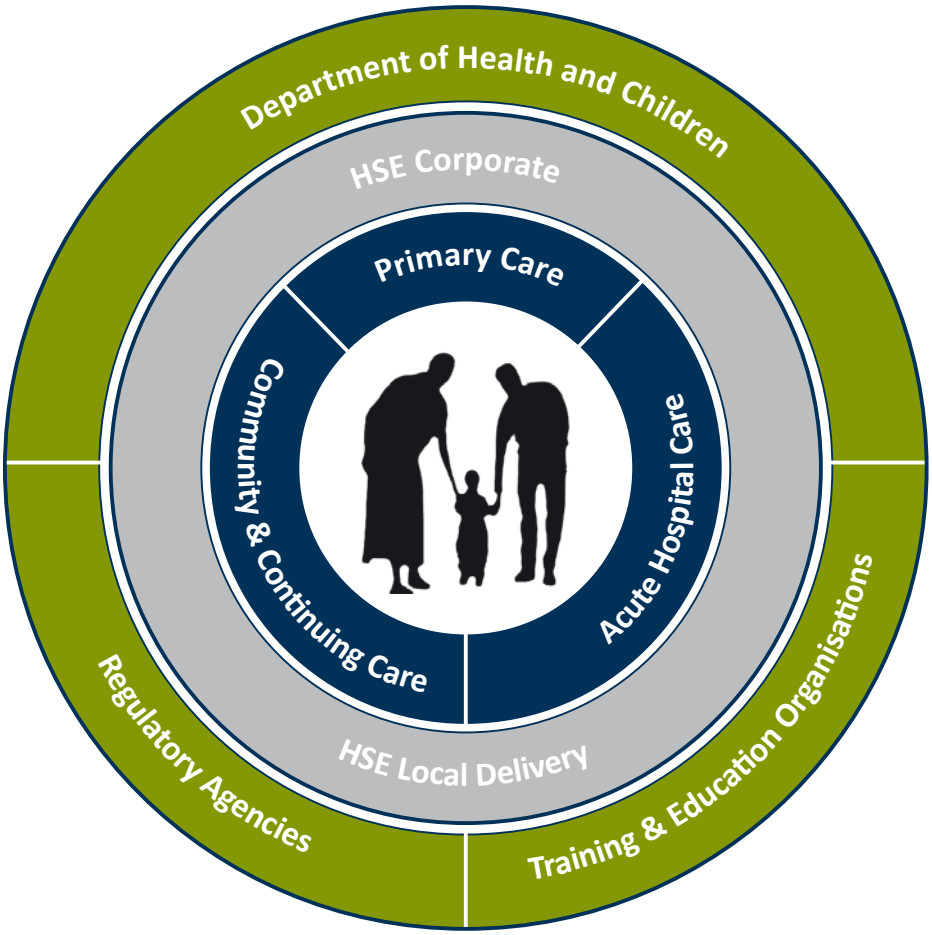


This overlap necessitates a broad awareness of integration at each decision-making level. For example, at the policy level within DoHC, priority setting should be based on a review of the totality of available funding and identifiable needs across the three areas. It is vital to recognise in a planning context that the length of hospital stays and the extent of primary nursing care depend on facilities that are in the community to support more dependent members of the population. Thus, a more strategic reconfiguration of resources has the potential to yield efficiencies and care benefits that would not be possible if each sector were considered separately. In the current context, this means having a formal decision-making process which covers all three sectors, so that explicit account can be taken of the fact that higher expenditure on a programme in one sector means either less for another programme in that sector, or less for a programme in one of the other two sectors.

This policy level integration then needs to be reflected in how the HSE plans the delivery of services at corporate level and how these plans are rolled out at local level. This requires a decision-making system that combines setting clinical protocols, allocating resources and planning service delivery within the same framework. From the Group's perspective and in the context of funding across different geographical areas on the basis of population health, the links between DoHC priorities, HSE Corporate strategic planning and the implementation of nationally set standards at local level must be very precise. Figure 4.2 depicts these relationships with the HSE Corporate and local structures sitting inside an overall structure that contains the policy setting role of the DoHC, the monitoring role of the regulatory bodies and the bodies that ensure continuing improvements in professional care (education/ training/research).

FIGURE 4.2

Agencies Delivering Irish Health Care



In terms of the logic of the population health approach, the local budget would be based on population health needs of the local area and its primary function would be to manage service delivery for that population. Where a specific service required by a user is not available locally, the HSE in that area should be responsible for organising the acquisition of that service from another area, thus reducing the need to duplicate service delivery systems in each area.

As noted above, local standards and deliverables come from HSE Corporate. The HSE locally would be concerned primarily with the provision of publicly-funded care but it should also have a co-ordinating role in relation to the provision of services that are effectively publicly mandated but privately delivered, such as the 'Fair Deal' nursing home places. The HSE would be responsible, along with HIQA, for ensuring that the delivery of all (public and private) care is of an appropriate standard. In the Group's view, it would be to the benefit of both organisations if there were greater clarity in the respective roles and responsibilities of the two organisations. HIQA has statutory roles that cannot be fully met within existing resources.

While the Group recognises that international evidence favours a full purchaser-provider split, it does not think it feasible to move fully to such a system in the very short term but favours moving systematically in that direction over time. Consequently, in the near term the HSE locally would have responsibility as a provider of certain services and as an agent for those who provide services under contract to the HSE. Increasing formalisation in the arrangements with both outside providers and HSE's own providers should pave the way to an orderly shift to a better purchaser-provider split in the medium term. From the user's perspective, all care needs required should be organised by the HSE locally, whether delivered inside our outside the area.

In essence, the proposed structure would involve a geographically-distributed, integrated, national health-care system. What the Group is suggesting here is emphatically *not* a return to the previous Health Board arrangements. What is envisaged is a national system of services and entitlements delivered locally. While it is appropriate to have variation in the way services are delivered (to take account of geographical and infrastructural differences), it is not appropriate for access to care and standards of care to vary across geographic areas. Responsibility for health policy and priority setting would lie with the DoHC and responsibility for the national planning and health-care delivery would lie with the HSE. Within the HSE, budgets would be allocated transparently to each local area on a population health basis, so that their populations could be cared for in an equitable and cost-effective way. Design of the most efficient mechanisms for achieving national priorities would be done centrally and these mechanisms would be implemented at local levels, under the supervision of HSE Corporate which would have responsibility to monitor all spending at local level.

The Group noted that the present infrastructure, organisation and governance structures in the PC and CCC sector are relatively weak, especially when compared with the HC sector. For an integrated care strategy to be successful these two sectors need to be developed and this will require strong focus from the HSE. The Group saw significant advantages in the HSE's delivery structures being as flat as possible, with the PC/HC/CCC relationships mirrored at all levels, recognising how important it is to mainstream the integrated approach to care.

4.3 Requirements for Financing Health Care in a more Effective and Equitable Manner in Ireland

On the basis of international evidence (Evidence Report, ESRI (2010), Part 4), of a review of the way in which the Irish health-care system is financed (Evidence Report, ESRI (2010), Part 5), and of the analysis in Chapter 3, changes in the current financing structure are required to align the system better with the guiding principle that 'the methods of financing health care should be as effective and equitable as possible'. This guiding principle should ensure that the methods of financing health care are equitable and that they support the delivery of integrated care in the system. Achieving equity generally requires that payment for health care is fair (linked to ability to pay) and is separate from decisions on how to deliver health care (prioritised according to need). Supporting effective resource allocation and integrated health care require financing structures that (i) encourage registration and continuity of care with a primary care provider and (ii) support the delivery of the most appropriate health care at the most appropriate level and location.

Key weaknesses in the Irish health-care financing system are due to insufficient transparency, inappropriate incentives, and inequitable resource flows (Evidence Report, ESRI (2010), Part 5). These issues interfere with efficient and effective resource allocation in the system and do not support continuity of care or care in the most appropriate location.

4.3.1 Appropriate Resource Contribution Mechanisms

A key issue in international debates on health care is whether it should be financed through taxation or social health insurance. Social health insurance is typically associated with higher overall funding levels. This can mean that there is a greater degree of pre-payment[66] for services, with the generally desirable effects on incentives to users (i.e. a lower proportion of health care is financed on a pay-as-you-go basis), but in some cases also represents poorer control of costs. The funds ultimately flow from households under either system, and the choice of financing system is not itself necessarily related to the level of funding (see Figure 2.1 in Chapter 2 and further discussion in the Evidence Report, ESRI (2010), Chapter 9).

Increased transparency is often associated with social insurance systems as they provide a direct link between the rate of contributions paid by households and the defined set of entitlements to services and support. Thus, switching from a tax contribution to a social health insurance contribution could improve transparency. However, there are ways to improve transparency significantly within the present tax-based mechanism. For example, the development of care protocols allows service delivery in each disease area to be more clearly defined and thus facilitates the system moving towards more specific entitlements, thereby enhancing transparency. Similarly, funding arrangements for health-care providers at all

[66] Pre-payment means that the cost of care is not paid for at the time of use, and the cost to individuals does not depend on how much they use. Typical systems of pre-payment are insurance (both private and social) and services funded through taxation. Pre-payment is important when needs are uncertain or where it is important not to deter people from using services (e.g. checking or monitoring blood pressure).

levels could make clearer the services to be provided and therefore the possible entitlements. A second element of transparency that is associated mainly with social insurance is the direct link between what people pay in contributions and the budget for prepaid health care (and therefore the option in principle to pay more in order to improve access or vice versa). Under a tax system this would be achieved only with a fully earmarked tax for health services.

Following a thorough review of the international experience the Group accepts that there are legitimate arguments either for retaining a mainly tax-financed system or for shifting formally to a social health insurance system. It noted that there are many different models of social health insurance, and it should not be seen as a single option, but rather a set of options with potentially very different features. Thus, the Group concerned itself more with how the mechanisms for collecting and managing funds are structured (rather than with higher level decisions on tax versus social health insurance based systems).

The Group's emphasis is on exploring how to

- increase the equity and fairness in how funds are raised (including user fees), how collective funds (whether government or social insurance) are spent, and how tax allowances or expenditures are related to privately provided services
- increase transparency (with the link being clearer between the levels of spending and the associated service entitlements), which will facilitate a better-informed national debate on levels of public (or social insurance) spending and associated service availability and quality
- increase the extent to which health-care is prepaid where this is important to encourage use of effective services
- increase the extent to which the system encourages greater efficiency in provision and transaction costs
- ensure that the chosen system helps to contain costs.[67]

While contracting for service delivery is a requirement of social health insurance, it can equally be used in tax funded systems, and while tax funded systems have typically had better cost control, this is not universal. Single buyer arrangements can reduce costs and should be in place in any financing system. The recent reduction in the prices charged for prescription medicines is evidence of the State, acting on behalf of individuals, successfully reducing the costs of drugs. Entitlement systems and the level of user fees should be designed to reduce the undesirable consequences of asymmetric information and power between the individual and the providers.

[67] As the Group completed its work, it became aware that DoHC is planning to initiate discussions with the Health Insurance Authority in relation to the possibility that health insurance companies might provide some level of cover for chronic disease patients in the non-hospital setting.

Evidence indicates that the overall structure of tax payments in the Irish system is marginally progressive. Looking at the tax system from the viewpoint of health care, we can see individual contributions to tax as being effectively equivalent to pre-payments (i.e. taxes are paid in accordance with the tax laws and hence do not have direct links to the use of health care). In contrast, user fees do not allow separation between payment and use of health care. With standard co-payments rates, the burden of payment is relatively greater on lower incomes (i.e. regressive), and the payments are made at the point of use rather than prior to use. User fees in the Irish health-care system have been found to deter utilisation and provide no financial incentive for registration with primary care providers for the majority of the population, interfering with efforts to ensure continuity of care and care in the most appropriate location within the system. For further discussion of this point, see the Evidence Report, ESRI (2010), Chapter 10.

4.3.2 Structure of Entitlements and Implications of User Fees in the Irish Health-Care Financing System

As was noted in Section 3.2.3 above, the requirement for the majority of the population to pay in full the out-of-pocket costs for GP care is unique to Ireland compared with other developed countries (Smith, 2010).[68] There are significant inconsistencies in the current set of entitlements particularly with regard to providing equitable cover for publicly-subsidised care, and for supporting integrated health-care delivery:

- The equity principles underpinning medical card eligibility are difficult to identify.
- There are large differences in costs to families whose incomes are relatively similar but who lie on different sides of the medical card/GP Visit Card eligibility thresholds – an increase in income that moves someone above the medical card limit by a small amount may make them worse off.[69]
- The rationale for providing free prescription medicines, but not free GP care, for people with specified long-term conditions under the LTI scheme, while at the same time providing free GP care, but not free prescription medicines for GP Visit card holders (defined by income rather than illness), is not clear. In principle this encourages use of GP services but underuse of drugs in the latter case, and greater use of drugs without adequate clinical review and supervision in the former. The rationale underpinning what conditions are included in the LTI scheme is also not clear, and the most common long- term illnesses are not included.

[68] This requirement also arises for some other services provided commercially in community settings, for example physiotherapy).

[69] These differences, which are known to adversely affect decisions on moving from unemployment to employment, are compounded by the fact that having a medical card also grants entitlements to other (non-medical) subsidies.

- Public out-patient services in Ireland are provided at no charge to referred patients. In contrast, for most of the population, primary care services including GP visits and prescription drugs dispensed in community pharmacies (up to a monthly limit) are charged at full price to users. There are good arguments for these services to be provided free or at lower prices for at least some of the population (and certainly the case for this is at least as strong as for out-patient visits at no charge).
- In most cases private insurance (and its associated tax subsidy) supports in-patient care and does little to support access to community services that facilitate more cost-effective care of chronic diseases.

4.3.3 Direction of Change

A priority for changes in entitlement must be to encourage and facilitate access to primary and community health services where these play a useful (and cost-effective) role in shifting patients to coherent (usually protocol driven) care pathways, mainly outside the acute hospital sector. There is a particular concern about access for people with established chronic diseases who may under-use primary care services and who may be incentivised to use inappropriate and unnecessary hospital care. There is also concern about the needs of those on relatively low incomes just above the threshold levels for a full medical card or a GP Visit card. A further priority is to support the shift to more holistic and health promoting approaches to care by ensuring that all residents register with a primary care provider.

Specifically, changes in the structure of user fees in the system should ensure the following

- Registration of all residents with a primary care provider. This would encourage GPs to: take continuing responsibility for their patients; improve the possibility of early diagnosis of potentially serious and expensive diseases; and enable the better planning and management of ongoing diseases
- Except in the case of serious medical or surgical emergencies, the incentive should be to use primary care in the first instance
- It should not be cheaper for patients to make ongoing use of acute services when primary or community care is more appropriate
- Patients should not be deterred from using services that are likely to benefit them, and should be encouraged to seek help early rather than late in the progress of an illness.

Full pre-payment, i.e., providing services free at the point of use, avoids some of the difficulties in encouraging regular use of the different levels of care that are required in managing certain chronic diseases. This does not necessarily imply a change in who bears the cost, but increases the extent to which services are prepaid and insured (in the technical sense). Increased pre-payment removes the disincentive in relation to seeking services at the point when needed.

The Group recognises that user charges are a feature of all health-care systems, and have the advantage that they can mobilise necessary resources.[70] Notwithstanding the policy priority of moving patients from acute hospital to primary care (and the associated need to reduce financial barriers to achieving this), it is clear that out-of-pocket payments for GP care and drugs are likely to remain an important source of revenue in the Irish health-care system for the foreseeable future. Because some user fees will continue to be part of the financing system for GP services, the Group believes that the fee policies must be very carefully designed, taking into consideration their impact on user behaviour and the burden that they pose on those with low incomes:

- Since it has been shown that user charges deter use overall but do not discriminate between appropriate and less appropriate use of services, fees that aim to reduce unnecessary use inevitably do harm by also deterring use when there is a real need. This means that user fees should be seen mainly as a way of mobilising resources rather than of altering behaviour. Where there is a desire to encourage or discourage behaviour (such as lower levels of prescribing) the best approaches will normally involve incentives and controls for prescribers and not for patients. While high charges for clear misuse of hospital services may be effective, they will only work effectively if they are enforced and this can be difficult if people with outstanding debts are to be restricted from using services.
- Where user charges are levied at the point of use they should fall mainly in areas where demand is not sensitive to price, in other words, where the charges have little effect on patterns of use.[71] This means that they should be strenuously avoided where there is a desire to encourage particular patterns of behaviour by particular groups of patients, such as those requiring regular blood pressure checks or those with chronic diseases. Given the evidence that they deter use of primary care for all parts of the population, but particularly for those on low incomes, and that this has measurable effects on the health of people on low incomes, they should be kept as low as possible for this part of the population.

[70] For example, if there were to be free GP care and drugs to the whole population the estimated additional cost to government would be between €1.2 billion to €1.3 billion per year, equivalent to around 8.4 to 9.0 per cent of net non capital public health expenditure per year at low cost estimates or (12.2 to 12.8 per cent at high cost estimates. See Evidence Report, ESRI (2010), Chapter 15 for a more detailed discussion.

[71] Economists refer to this as 'low price elasticity of demand'.

- Since it is important that the cost of collection should not exceed the revenue generated from the user fees, there may be some instances, such as small co-payments for drugs, where no fees may be more efficient than low fees.

Since stated policy is to provide services on the basis of need and not ability to pay, and since supplementary private health insurance normally provides faster or better access for those who can afford it, there is a need for the role of private health insurance to become more genuinely supplementary, providing greater comfort and convenience, but no significant clinical or health advantages. Any tax subsidies to private insurance providers can be justified only if insurance policies reduce the burden on publicly-mandated funding, improve the efficiency of use of services, and do not introduce any significant inequities in access to useful services.

4.4 A Suggested Framework for Moving Towards a Structure of User Fees that Supports Policy on Service Delivery

4.4.1 Introduction to the Framework

There are two main constraints to achieving the changes that would begin to move service delivery (particularly for chronic diseases) into non-hospital settings. First, there is a poorly developed physical and human resource infrastructure to manage and deliver such a system of care, and second, there are important barriers that come from the lack of integration of primary care with the wider health system for most of the population.

The Group recognised the importance of strengthening community service provision, which has the potential to improve greatly the integration of services for people with chronic disease, and based on evidence from other countries it is clear that shifts from acute hospital to community-based services can lead to large savings. Some new community services would use different mixes of professionals and staff, such as the wider use of specially trained nurses in managing chronic diseases. There are also opportunities to provide some services currently available in hospitals in community settings using the same or similar people. Where the change is simply to move people to work in more appropriate settings there may be no net cost (and indeed there may be some savings) and where services are provided in new ways there is greater scope for savings. In some cases, the first steps in shifting services into community settings could be done quickly.

However, achieving a substantial shift from hospital to community provision will inevitably be slow, requiring some more physical infrastructure, some new investment in training, and developing new ways of working. Although primary care is only a part of the desired integrated care system, it is a core part. Some patients could more easily be discharged from out-patient care to GP care if that did not impose large financial penalties on users, and the role of GPs could be developed in chronic disease management if registration were the norm. The suggested framework for integrating primary care and rationalising the systems of fees and subsidies aims to bring GP services fully into the health system, and to reduce the barriers to the use of such services as is needed. It can be seen as the first (and currently most feasible)

step in developing integrated care and improved chronic disease management. The Group's primary concern was to find a system that would reduce costs of primary care to

(i) those on low incomes, who are more likely to be deterred from using the services)

(ii) those with chronic illnesses, who currently make excessive use of acute hospital services and in some cases make too little use of primary care.

The proposed framework can be seen as a way to improve access to primary care where this is most necessary, or as a systematic way of gradually improving access for all residents.[72] It would replace the current complex and fragmented system which does not encourage registration of the whole population, presents serious financial burdens on many poorer and sicker people and lacks a logical progression of subsidies that addresses equity and disease management needs.

Any sustainable pattern of financing must therefore have lower user fees and/or fees more widely distributed across the different types of care. Furthermore, they will have to be more closely related to incomes, i.e. the level of co-payment should be higher for those on higher incomes.[73] Registration with community and primary care providers can allow more coherent community management of chronic disease, giving a continuing responsibility to a primary care physician for medical inputs to care and for ensuring access to other important community-based services. Taking all of these points together, sustainable financing of services for integrated health-care delivery requires significant changes in the patterns and roles of user fees for primary and community services.

It is against this background that the Group has considered changes to the entitlement structures in the system, focusing on adjusting the structure and level of user fees towards being more closely aligned with the desired ends of supporting integrated health-care delivery – with registration, continuity of care, and appropriate health care at the most appropriate location.

The suggested framework of health-care entitlement aims to support integrated health-care delivery. The framework is designed to

- encourage registration
- incentivise the use of primary care in the first instance (except in the case of serious emergency)
- incentivise appropriate service use in the most appropriate location
- encourage patients to seek treatment where necessary
- encourage patients to seek treatment earlier rather than later.

[72] It is also compatible with the staged improvement in access to primary care that might be carried out in the development of social health insurance, should that path be followed at some point in the future.

[73] Co-payment means the share of the cost of services paid by the user at the time of use.

As outlined in the Group's analysis of problems in the Irish health sector, the levels of user fees that are charged at point of use for GP care to the majority of the population are not supportive of continuity of care, nor of appropriate care in the appropriate location. In parallel, other community-based services are simply not available to many people, with or without a fee, and there is presently very little co-ordination between primary care and private community based nursing and allied health professionals. Changing the patterns of fees and entitlements for primary care will improve incentives for appropriate care for some patients, and will make it easier to develop such services for all patients. However, other developments in the range and availability of services will also be crucial to success.

While further *ad hoc* changes to the current set of entitlements could reduce some of the anomalies in the present system, without co-ordination they would do very little to promote more appropriate use of services. The Group believes that a better approach is to shift towards a more logical and consistent framework that is designed to meet policy priorities in a structured way.

It is important to note that such a framework is completely independent of the particular envelope of funds available at any point in time.[74] Its purpose is to establish a set of consistent and coherent subsidies that support integrated health-care delivery, while the exact level of subsidisation is a matter for cost/capacity considerations. Decisions on the levels of subsidy, and the speed with which improved access could be phased in over time, will depend on the speed at which resources are released from other health-care uses. The Group's approach is to identify the best path to improving entitlements in a systematic and transparent way, rather than to attempt quick fixes in the face of such obvious entitlement anomalies. Put another way, the current pressures on resources for health is not a reason to continue using those resources inefficiently and not to plan to make better use of additional resources that might become available over time. In summary, the availability of funds influences the initiation and sequencing of the roll out of the framework but does not affect its underlying structure.

4.4.2 Overview of the Framework

A single framework is suggested that would replace the existing five schemes that provide public support for GP services and drugs – medical card, GP Visit card, the long term illness scheme, high technology drug scheme, and the DP scheme. It would have four entitlement categories to reflect different income and health circumstances. Public subsidies would be higher for people with lower income and greater needs for services. This graduation would have the effect of reducing the single worst feature in the current system of care, namely the vast differences in the out-of-pocket cost of primary care services to people with and without a medical card. Given the significance of chronic diseases as a driver of health-care costs, the framework also integrates a specific focus on providing a coherent

[74] This type of framework could be seen as equivalent to the income tax framework, where the precise rates and allowance are open to change but the concept of having progressivity through using rates and allowances is built into the structure.

pattern of subsidies to support chronic disease management to ensure that health care is delivered according to need in the most cost effective way. As stated above, strengthening the capacity and delivery of other community-based services is also required for the full benefits of improved primary care access to be realised, and it must be ensured that the fees (if any) that are paid for community services are structured to minimise the constraints in developing integrated care. Furthermore, to promote continuity of care, the subsidy should be available only to those who register with a primary care provider.

This approach is intended to address the key barriers to access to primary care. Within any given resource constraint it would be structured to minimise the perverse incentives to use of services at the appropriate level, and would remove many of the current inequities. Since it is a single framework it should be possible to keep the administrative complexity and costs low.

4.4.3 Categories of Entitlement in the Framework

This section provides brief descriptions of the four entitlement categories in the framework and their suggested benefits. For a more detailed exposition of the framework, see the Evidence Report, ESRI (2010), Chapter 15. The suggested framework has four categories of entitlements, involving lower to higher levels of State support, which are labelled 'Standard', 'Standard Plus', 'Enhanced' and 'Comprehensive' (replacing the five current schemes for public GP and drug support). To demonstrate the feasibility of this approach, it is useful to present the framework with specific examples of the possible reductions in user fees and changes to entitlements. The figures used are for illustration only but their structure is very consistent with the objectives outlined above.

A simpler system of assessing incomes for the purpose of eligibility is suggested, taking account only of household incomes and family size.[75] The new system would not carry entitlements to non-health resources and would be easier and cheaper to administer than the present system.[76] Since the new framework would have graded eligibility categories there would no longer be very large and sudden increases in the costs of health care as incomes rise; hence the risks from a slight loss in precision in the assessment of income is much less. Furthermore, the proposed framework would explicitly include people with high needs and high costs in categories that attract subsidies. In effect, the framework is structured to combine both income and health status.

[75] The exact mechanisms for combining information on household incomes and household composition is not defined in this indicative framework, but in the costing of its application estimates of household incomes were used to identify numbers in each category.

[76] Given its Terms of Reference, the Group does not have a view on the merits of the existing benefits linked to the medical card. However, it recognises that from an economic perspective, entitlement to the medical cards is not a good basis for awarding such non-health related benefits.

Under the proposed framework, four entitlement levels are proposed as follows

4.4.3.1 Standard Primary Care Cards

Who would be eligible?

Standard Primary Care cards would be available to all of the population without means testing and would replace the current Drugs Payment (DP) Scheme card.

What does the Standard card cover?

The Standard card would entitle the holder to avail of GP visits at a capped fee to the user (say €40 per visit) and prescription drugs at 80 per cent of the price up to a monthly maximum out-of-pocket payment (say €95).[77]

What would be the conditions?

The cards would be issued when registration with a single primary care provider is verified.

How would the primary care provider be paid?

The primary care provider would be paid a capitation fee for each registered person. This would be set taking account of the reduction in the level of the capped user fee compared to the current unregulated prices. Primary care providers would retain the user fees.

4.4.3.2 Standard Plus Primary Care Cards

Who would be eligible?

Standard Plus Primary Care cards would be available to all members of households with incomes between 40 and 50 per cent of the national average. It would be means tested using data on incomes as assessed for tax purposes in the previous year. Standard Plus cards would also be available for people with high risk of disease that make regular contact with primary care a priority (such as those with high rates of heart disease risk).

What does the Standard Plus card cover?

The Standard Plus card would entitle the holder to avail of GP visits at a capped fee (say €30 per visit), and prescription drugs at 60 per cent of the price up to a monthly maximum out-of-pocket payment (say €70). [78]

[77] This is consistent with maintenance of the present threshold for drug payments of €120, i.e., up to that threshold the user pays a maximum of 0.8 x €120 = €96 and after €120 the State pays the total cost. The number is rounded down in the text for ease of presentation.

[78] This is consistent with maintenance of the present threshold for drug payments of €120, i.e., up to that threshold the user pays a maximum of 0.6 x €120 = €72 and after €120 the State pays the total cost. Again the number in the main text is rounded down for ease of presentation.

What would be the conditions?

The cards would be issued when registration with a single primary care provider is verified, and following an income assessment, or medically certified disease entitlement for inclusion in this category.

How would the primary care provider be paid?

The primary care provider would be paid a capitation fee for each registered person. This would be set taking account of the reduction in the level of the capped user fee compared to the current unregulated prices. Primary care providers would retain the user fees.

4.4.3.3 Enhanced Primary Care Cards

Who would be eligible?

Enhanced Primary Care cards would be available to all members of households with incomes between 30 and 40 per cent of the national average. It would be means tested using data on incomes as assessed for tax purposes in the previous year. Enhanced cards would also be available for people with established chronic diseases, and including those currently on the LTI scheme, but extended to other major chronic diseases.

What does the Enhanced card cover?

The Enhanced card would entitle the holder to avail of GP visits at a capped fee (say €20 per visit), and prescription drugs at 40 per cent of the price up to a monthly maximum out of pocket payment (say €40).[79]

What would be the conditions?

The cards would be issued when registration with a single primary care provider is verified, and following an income assessment, or certified disease entitlement for inclusion in this category.

How would the primary care provider be paid?

The primary care provider would be paid a capitation fee for each registered person. This would be set taking account of the reduction in the level of the capped user fee compared to the current unregulated prices. Primary care providers would retain the user fees.

[79] This is consistent with the present threshold for drug payments being reduced to €100, i.e., up to that threshold the user pays a maximum of 0.4 x €100 = €40 and after €100 the State pays the total cost.

4.4.3.4 Comprehensive Primary Care Cards

Who would be eligible?

Comprehensive Primary Care cards would be available to all members of households with incomes below 30 per cent of the national average. It would be means tested using data on incomes as assessed for tax purposes in the previous year. Comprehensive cards would also be available for some people currently covered by the high HTD scheme. In calculating the costs of entitlements in the Framework it was assumed that all people currently eligible for medical cards would retain eligibility, but new entitlement would be based on the new assessment process[80].

What does the Comprehensive card cover?

The Comprehensive card would entitle the holder to free GP visits and drugs free of charge, exemption from public hospital charges and free access to community services as currently allowed for medical card patients.

What would be the conditions?

The cards would be issued when registration with a single primary care provider is verified, and following an income assessment, or certified disease entitlement.

How would the primary care provider be paid?

The primary care provider would be paid a capitation fee for each registered person. This would be set to reflect no user fees.

The overall pattern of the proposed integrated framework is presented in Table 4.1. The table summarises the entitlements and user fees for primary care and for prescription medicines. The user fee structures faced by non medical card holders in the current system are also included to highlight the changes in entitlement for these individuals in the context of such a framework.

4.4.3.5 Private Health Insurance and Primary/Community Services Packages

Private health insurance companies might wish to offer lower cost access to primary and community services either directly and/or by purchasing upgrades, e.g. to Comprehensive card levels. If private insurance were to provide equivalent primary care access, it would be important to ensure the insured did not effectively get the tax relief twice (see the Evidence Report, ESRI (2010), Chapter 15); this would not apply if tax relief on private health insurance premiums were abolished.

[80] While this is not a necessary feature of the proposed framework, it was used in calculating the cost on the basis of minimising the risk of people losing some important current entitlements.

4.4.3.6 Adjustments in the Framework

The framework as presented above selects a graduated level of primary care subsidisation for the population ranked by income, with specific provision for preventing and treating long-term conditions. Having a framework which can be implemented gradually ensures that policy makers can make coherent and consistent decisions on health-care entitlements, with the ultimate aim of supporting effective resource allocation and integrated health-care delivery. As noted above, that structure is flexible and can be adjusted to reflect existing resource and capacity constraints. The level of subsidy can be calibrated to achieve different rates of use of services.

To achieve a financing system that fully supports effective resource allocation and integrated care, the long-term goal is to ensure (i) that there are no financial barriers (by way of fee levels that individuals cannot afford) to using primary care as the first port of call, (ii) that primary and community care is at the centre of health-care delivery, and (iii) that user incentives are fully aligned with those of providers (e.g. providers paid on the same basis for public and private patients). To ensure sectoral compatibility, the ED charge for those attending without referral might remain to encourage use of primary care except in cases of acute emergencies.

TABLE 4.1

Illustrative Pattern of Entitlement and User Fees for GP Care and Prescription Medicines in the Proposed Framework

Primary Care Card	Who is Covered	Primary Care				Prescription Medicines			
		Current Entitlement		Framework Entitlement		Current Entitlement		Framework Entitlement	
		User fee per GP visit	Subsidy Per GP visit	User fee per GP visit	Subsidy per GP visit[a]	User fee	Subsidy	User fee	Subsidy
Standard	All individuals registered with a GP	€45-€60	0 (Tax relief at 20%)	€40	€5 (Paid as capitation to GP)	Max. €120 per month	100% above monthly threshold (Tax relief at 20% on 'below the threshold' payments)	Prescription medicines at 80% of the price up to maximum out-of-pocket payment of €95 per month	20% subsidy on out-of-pocket payments up to €25 per month; and 100% above monthly threshold (€120)
Standard Plus	Means-tested (incomes between 40-50% of national average) and high risk of illness (e.g. cardiovascular disease)	€45-€60	0 (Tax relief at 20%)	€30	€15 (Paid as capitation to GP)	Max. €120 per month	100% above monthly threshold (Tax relief at 20% on 'below the threshold' payments)	Prescription medicines at 60% of the price up to maximum out-of-pocket payment of €70 per month	40% subsidy on out-of-pocket payments up to €50 per month; and 100% above monthly threshold (€120)
Enhanced	Means-tested (incomes between 30-40% of national average) and chronic illness[b,c]	€45-€60	0 (Tax relief at 20%)	€20	€25 (Paid as capitation to GP)	Max. €120 per month	100% above monthly threshold (Tax relief at 20% on 'below the threshold' payments)	Prescription medicines at 40% of the price up to maximum out-of-pocket payment of €40 per month	60% subsidy on out-of-pocket payments up to €60 per month; and 100% above monthly threshold (€100)
Comprehensive	Means-tested (incomes below 30% of national average)[d,e]	€45-€60	100% (Paid as capitation to GP)	€0	100% (Paid as capitation to GP)	Max. €120 per month	100% above monthly threshold (Tax relief at 20% on 'below the threshold' payments)	€0	100% subsidy on all out-of-pocket payments

Notes:
(a) The subsidy indicated in this table is based on a total payment (i.e. user fee plus subsidy) to GP per visit of €45. Where the total payment is higher, the subsidy is larger.
(b) Claimants in the LTI Scheme are granted an Enhanced card in the framework. The current entitlement under the LTI Scheme is 100 per cent subsidy on drugs for the specified disease, with no subsidy on GP visits.
(c) The Enhanced card replaces the GP Visit card. Existing GP Visit card holders are entitled to zero GP fees. The focus in this table is on the change in user fees facing those who are currently non medical card holders.
(d) Claimants in the HTD Scheme are granted a Comprehensive card in the framework. The current entitlement under the HTD Scheme is 100 per cent subsidy on specified drugs, with no subsidy on GP visits.
(e) Existing medical card holders would retain their entitlement to zero GP and prescription medicine fees. The focus in this table is on the change in user fees facing those who are currently non medical card holders.

4.4.3.7 Supportive Conditions for the Framework

Subsidies of the kind illustrated in the framework cannot work properly unless the total prices of private GP visits and drugs paid to providers (i.e. user fee plus subsidy) are capped. In the absence of such caps, there is widespread evidence that such subsidies would simply result in higher user fees.[81] In the case of GP services this would probably require that the scheme be voluntary for GPs, as is currently the case for the GMS. The capping of user fees is paralleled in the GMS system, where the capped price to users is zero.

The framework proposes a streamlining of the eligibility assessment procedure. The current system of means testing for medical cards would be abolished, and the need for discretionary medical cards would also largely be removed in the context of the framework. This would be replaced by a simpler income assessment process whereby eligibility for public subsidisation (for Standard Plus, Enhanced or Comprehensive cards) would be linked to previous year's income as assessed in the process of determining tax liability (taking account of family size and dependants),[82] or to certified illness in one of the specified categories.[83] While circumstances of families can change radically between years, this approach (given the relatively small steps between entitlement categories) would need only occasional special cases to be managed.

4.4.4 Estimated Costs of Illustrative Entitlements in Table 4.1 and Assessment of the Proposed Framework

4.4.4.1 Costing the Proposed Illustrative Framework

To give some perspective on what the cost of moving towards a more coherent system of entitlements using the framework, the ESRI research team was asked to produce some indicative costs. This was done by estimating what the illustrated system itself would cost if fully implemented. The Group ask the team to adopt this approach recognising that in line with its Terms of Reference, it must restrict itself to proposals that lie within the current quantum of resources made available for health. The next two sections illustrate the bases for calculating the costs and Section 4.4.4.4 identifies some potential sources for funding it, within the existing quantum of resources over the coming years.

[81] Economists describe this well known effect as the 'incidence problem' – without capping, the effect of the attempt to subsidise the patient could end up being a subsidy to the provider.

[82] It should be noted that there would be no need for income assessment to be carried out for most people with Standard Primary Care Cards since any household clearly above the threshold would have no incentive to apply for the Standard Plus Card. High income households would simply apply for the Standard Card (as they do the current DP Scheme card) providing proof of registration.

[83] The usual problems of ensuring that income flows are not artificially distorted to improve eligibility conditions would apply.

4.4.4.2 Data

Available data allow estimation of the cost of the GP and prescription entitlements within the framework. As specified the framework would slightly increase the numbers who would be exempt from public hospital charges (the likely cost is small and has not been included in the calculations). More seriously, it was not possible to include in the analysis public costs for any new entitlements that might be introduced to community-based services outside those specified in the Framework. As suggested in the recommendations, there is an urgent need to develop services that would shift some care out of hospitals, widen access to services that are already in the community on a commercial basis, and fill gaps in current availability of services. Since it will take several years to put the new patterns of services in place it will be important to assess appropriate entitlements, user fees (if any) and public costs.

The cost estimates provided here are based on the best available data with sensitivity analysis to allow for inaccuracies. Costs are expressed in 2009 prices. For full details on data and methodology, see the Evidence Report, ESRI (2010), Chapter 15. The key results are summarised here.

The focus is on the additional costs to the Government of subsidising GP and drug bills as specified in the version of the framework outlined above. Existing expenditure (e.g. under the DP scheme and others) is not included in the estimates. Most of the cost increase to public spending would be balanced by reduced out-of-pocket spending by patients (therefore reflecting a change in who pays but not a change in cost), but part would come from higher utilisation from patients who are currently deterred by high user fees from seeking appropriate medical attention.[84]

4.4.4.3 GP and Prescription Costs

As stated above, the framework does not necessarily imply any particular scale of subsidy, and the levels of support in Table 4.1 are illustrative only. Were the Government to implement the system illustrated, the additional costs for subsidising GP and prescription medicines are estimated to be €513 million per year, equivalent to 3.5 per cent of net non-capital public health spending in 2009. Of this total, providing subsidised access to GP care for non medical card holders accounts for approximately 37 per cent of the costs, with 63 per cent accounted for by increasing the subsidisation of prescription medicines in the framework. The estimate is based on the total payment to the GP (i.e. user fee plus subsidy) being set at the equivalent of €45 per visit, and the per capita prescription expenses being set at a low estimate.

[84] There would also be a cost saving where more appropriate treatment at an early stage would reduce higher hospital care costs later.

Sensitivity analysis around the cost estimates is important. The estimated GP and prescription costs of the framework increase where the negotiated payments to GPs are higher and where prescription cost estimates are higher.[85] For more detailed sensitivity analyses around these estimates, see the Evidence Report, ESRI (2010), Chapter 15.[86]

4.4.4.4 Potential Resources to Finance the Framework

The Group recognises that the funding to roll out the framework, such as the one illustrated here, must take place within the 'current quantum of resources' and it does not propose that more resources be allocated to health at this time. Consequently any movement in the direction of the framework that involves costs must be offset by cost savings elsewhere in the system. In line with its responsibility to show how resources can be reallocated to help fund the next stages of shifting the balance of care into the community by implementing a more logical and coherent framework of the type proposed, the Group sought to identify the scope of such a potential realignment of resources.[87]

In terms of direct current public expenditure on health, via the HSE, the Group explored the likely scope for efficiency savings that might be possible in the hospital sector. It is aware that recent reductions in budgets have already required hospitals and other service providers to reduce costs (or to see reductions in the services provided). Although this reduces the potential for further savings in the short term, there is scope for significant efficiency savings if all health-care providers in Ireland were as efficient as the most efficient provider. Through the research undertaken on behalf of the Group, an estimate of such potential savings has been made, based on well-established analytical techniques being used internationally to assist health-care policy makers in estimating such efficiency savings. See Evidence Report, ESRI (2010), Chapter 14.[88]

A small number of recent studies have applied these techniques to estimate the technical efficiency of Irish acute public hospitals (originally for the period 1995-2002 with a subsequent update and revision covering 2005-2008) and GP out-of-hours services (in 2004/05).[89] Their results indicate potential for efficiency gains in Ireland. Tentative estimates suggest that if all acute public hospitals bring their

[85] For example, were the total payment to the GP set at the equivalent of €60 per visit, and a high estimate of the prescription costs used, the additional cost to the Government of the framework is estimated to be €819 million, or 5.6 per cent of net non-capital public health expenditure in 2009.

[86] These estimates can be contrasted with the cost of totally free access to GP care and drugs that would cost between 8.4 to 12.8 per cent of net non-capital public health expenditure.

[87] These savings are in addition to the potential savings could come from further reductions in the health-care costs, for example, reductions in both the price paid for drugs and the volume of prescribing, which would have an additional benefit to the private patient.

[88] There is now a burgeoning international literature on the measurement of comparative efficiency at provider level and, to a lesser extent, at system level.

[89] Technical efficiency is concerned with the extent to which lower levels of input(s) can be employed to produce at least the same level of output(s). Other than the study of GP out-of-hours services, there appears to be no systematic analysis of efficiency in Ireland's PC and CCC sectors.

performance in line with that of their most efficient national peers, there would be savings of €300 million per annum in current expenditure, and substantially more if the efficiency levels of out-of-hours services are applied to all PC and CCC providers.[90] Further substantial gains may be possible if Irish best practice can be aligned with that pertaining internationally, but there is more uncertainty associated with the magnitude of these potential savings due to, *inter alia*, the obvious difficulties inherent in undertaking cross-country comparative studies. Some of the drive to improve efficiency will come from the recommended changes in the way providers of care are funded and incentivised, including systems of pricing services for funding that reflect best practice in delivery.

Several points can be made with regard to realising these potential efficiency savings in Ireland.

(i) The estimates may understate the full potential for efficiency improvements because they reflect only one type of efficiency and, therefore, do not incorporate other possible savings arising from, say, technological progress, reductions in input costs, or, perhaps most importantly, the appropriate transfer of care from the acute to the non-acute sectors.

(ii) The timeframe for achieving efficiency savings will depend on the extent to which health-care inputs are fixed or variable. It is not realistic, in the short- to medium-term, to alter significantly the capital stock and hence most efficiency savings are likely to be realised from changes in staffing, which comprise the greater part of hospitals' costs. Existing contractual arrangements for health-care staff might be perceived as a barrier to achieving these gains. Implementation may, however, be facilitated by natural wastage since there tends to be considerable annual turnover of nursing staff (McCarthy *et al.* 2002), with the possible redeployment of staff from the acute hospital sector to the primary, community and continuing care sectors. The recent 'Croke Park' agreement opens up further possibilities in that regard. In summary, there will be several practical ways in which savings in hospitals will allow a build-up of community based services – the release of resources from pure efficiency gains, the replacement of hospital staff with community-based staff (not necessarily with the same mixes of skills) and the transfer of hospital-based professionals (on a whole time or part-time basis) into community settings.

(iii) It is crucial that the quality of health care be monitored to ensure that savings reflect improved efficiency and not lower quality services. In this context, the roll out of clinical protocols currently in plan and underway is essential. It is also important with regard to any changes in entitlements to ensure that there is adequate capacity to deliver the specified services.

[90] Applying efficiency scores for GP out-of-hours services to the entire PCCC sector would probably be an exercise of heroic proportions. However, no other PCCC efficiency data exist, and the results provide useful preliminary estimates of possible efficiency gains.

A second source of potential resources could arise from removing some (lower priority) subsidies to health care that are currently in place and replacing them with more focussed subsidies, as suggested in the framework. The logical change here would be the removal of current tax relief on GP and drug bills in the context where pre-payments of GP services and drug use are implemented in line with the proposed framework. However, this suggestion does give rise to the need to discuss further what is meant by the current *quantum of resources*. [91]

It is convention and practice in government expenditure to consider resource spending as reported gross spending of a Government department or, more precisely, a Vote. Gross spending includes net voted expenditure and appropriations-in-aid included in the Vote. Tax expenditures, that is, the value to claimants or cost to government, of tax reliefs, despite their similar economic effects to government expenditure as defined above, are not included as public expenditure under this standard practice.[92] From an economic resource-allocation perspective, however, it is sensible and indeed the norm to consider that the provision of tax reliefs focused on the health sector is part of the State's contribution to funding to funding health, despite not being expenditure recognised directly in the Health Vote.

While fully recognising the existing conventions nationally and internationally on the reporting of public expenditure on health, the Group interpreted the task of advising on resource allocation as necessarily covering all spending on health, and to see the policy options available to government as including existing tax expenditures.[93] It is understood that the decision-making processes for changing tax expenditures differ from those used in determining the Votes for government departments, the optimal use of government resources for health should recognise all public resource involved in the sector.

Were the framework introduced, the Group believes that it would be logical and equitable to remove the present tax relief on GP and drug expenses that are not otherwise reimbursed by the Government or by private health insurers.[94] It is estimated that the value of the tax expenditure was €84.5 million in 2009. The Group favours the approach adopted in the framework since the current relief is not targeted and is not directly linked with encouraging continuity of care. Furthermore, the extent to which the relief is taken up in the population is variable

[91] The Department of Finance notes that various significant tax expenditures have been restricted or terminated in recent years. All revenues raised by such tax base broadening measures have been absorbed into general government revenues. There is no direct link between tax expenditures and expenditure programmes, allocations for which are determined as part of the annual Estimates process.

[92] For example, the OECD follows this conventional definition of government expenditure in its comparisons of spending between countries.

[93] The Department of Finance notes that various significant tax expenditures have been restricted or terminated in recent years. All revenues raised by such tax base broadening measures have been absorbed into general government revenues. There is no direct link between tax expenditures and expenditure programmes, allocations for which are determined as part of the annual Estimates process.

[94] It is noted that in the version of the framework presented in the Evidence Report, the researchers have adopted this approach. They calculate cost estimation exercises focus on the net cost to Government on the basis of the abolition of tax relief on out-of-pocket GP and drug expenses.

and uncertain.[95] Instead, the proposed framework grants a minimum subsidy to GP and prescriptions costs for all of the population who are not otherwise eligible for a Standard Plus, Enhanced or Comprehensive card. Combined with efficiency savings, this would bring the potential resources for funding the framework to close to €400 million.

In terms of the economic definition of *quantum of resources*, the Group believes that there is further potential to resource this type of framework through phasing out tax relief on private health insurance which currently supports access to mainly hospital-based, episodic care, with relatively little contribution to managing chronic disease in the community. The estimated cost of this tax relief in 2007 was €300 million.[96] A shift of economic resources from tax reliefs to specific subsidies via a framework of the type proposed could support meeting policy priorities more effectively, contributing to increased equity and incentivising the shift from acute hospital to more appropriate primary care settings.[97]

4.4.5 Assessment of the Framework

The financing framework illustrated in this chapter can and should be assessed against its own objectives, namely to create transparency, encourage registration, promote the use of primary care in the first instance where feasible, ensure care is provided in the most appropriate location (i.e. it should not be cheaper for patients to use acute hospital care where use of primary care is appropriate), and ensure that patients are not deterred from utilisation.

An incentive to register with a primary care provider is built into the framework as registration is a prerequisite for patients to receive public subsidies. The framework reduces the extent to which individuals pay at the point of use for primary care. This lowers the financial barrier to accessing primary care which has been shown to deter use amongst non medical card holders in the present system, and it also incentivises use of hospital care over primary care even when primary care is more appropriate.

The graduated structure of the illustrative framework also has the significant advantage of removing the large changes in entitlements with changing incomes that are a feature of the present system. Where an individual's income increases above the GP Visit card eligibility threshold, public financial support for GP care falls from 100 per cent of the cost of GP care to zero in the current system. In contrast, in the framework approach, a shift in income from one threshold level to another (e.g. from Comprehensive to Enhanced, or from Enhanced to Standard Plus, etc.) reduces the scale of the reduction in entitlement. Furthermore, the framework

[95] It has been estimated that as much as 60 per cent of potential refunds from this relief have not been claimed, and there have been calls for public information campaigns to increase its uptake (Dáil Éireann, 2006).

[96] Total tax relief on private health insurance premiums in 2006 was estimated at €260.5 million Revenue Commissioners, 2008) and this is estimated to be €300 million in 2007 (personal communication).

[97] The delivery of care in more appropriate settings can give better care to the patient and reduce net costs of delivering the service.

ensures greater alignment with provider incentives. Participating providers are paid on a capitation basis for all patients, although user fees per visit are still collected from all of those patients who do not have a Comprehensive card. Reducing user fees narrows the distinction between public and private patients in terms of how primary care providers are paid.

The framework also corrects key anomalies in the current set of entitlement structures. The fragmented approach to subsidising chronic disease is addressed, by expanding the range of diseases covered to include the leading causes of mortality. Inconsistencies in terms of subsidising one part of necessary primary care (e.g. GP care) for one group, and another part of necessary primary care (e.g. prescription medicines) for another group are also addressed. For all categories in the framework, public subsidisation covers a combination of GP and prescription medicine services.

A key consideration in introducing any framework is to ensure that the entitlements could be accommodated without having destabilising impacts on resource or physical capacity in the system. Consequently, there is a service response factor that needs to be taken account in moving towards such a system. However once a logical framework is agreed, any incremental changes under consideration can be viewed in that context. For example, if there were resources available, there are several possible options that would reduce existing anomalies and be consistent with the illustrative framework considered here:[98]

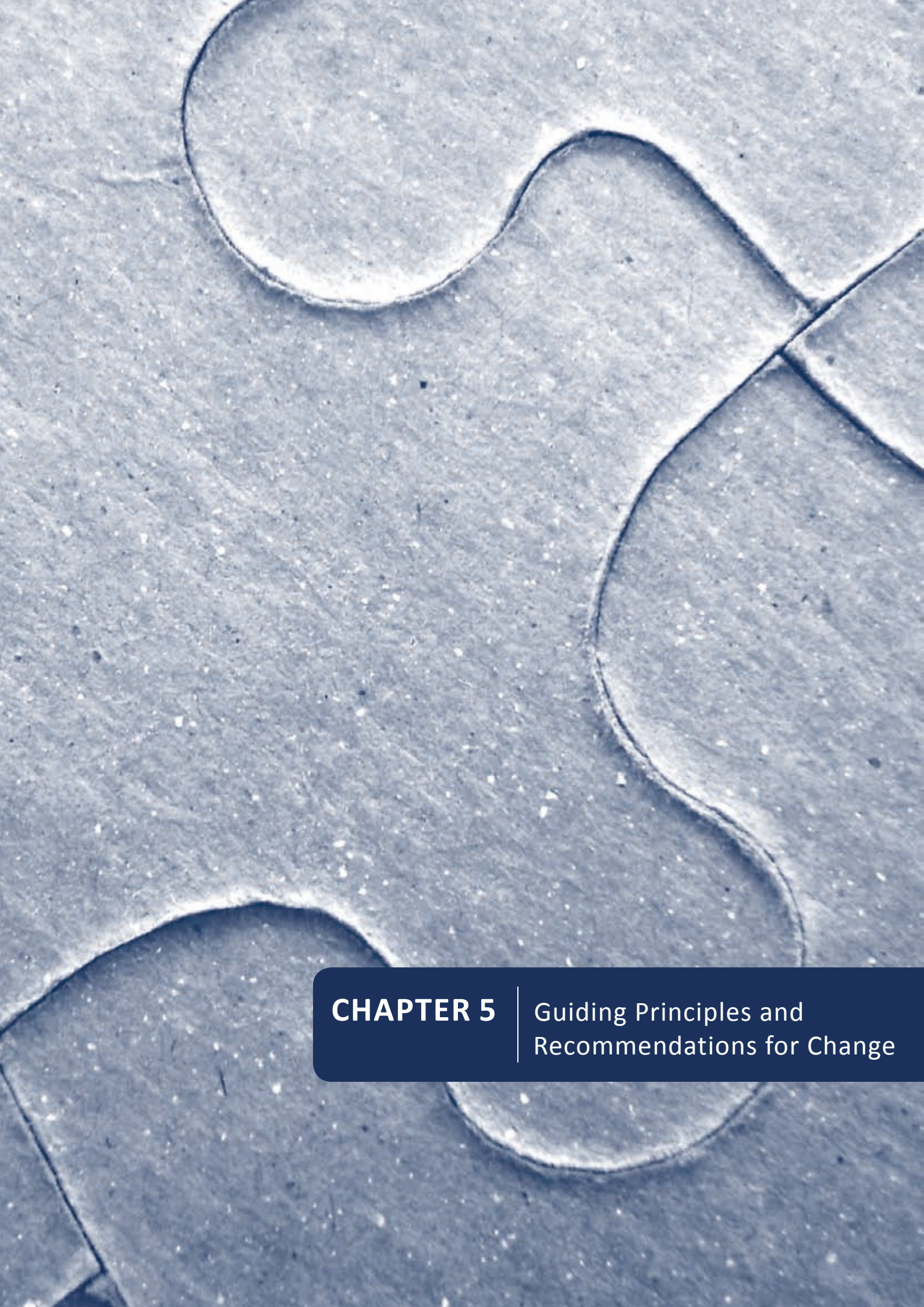
- the provision of a full medical card immediately to all those on the HTD scheme
- the granting of long term illness coverage to those certified with stroke or heart disease
- the provision of GP Visit cards to those with a high risk of cardiovascular disease, or those diagnosed with hypertension that requires regular monitoring.

The fundamental message behind the Group's framework approach as outlined here is to emphasise that decisions around entitlement need to be taken within the context of the whole set of entitlements and not on an incremental, unstructured basis.[99] Furthermore, they need to be assessed in terms of how that whole set aligns with policy priorities for continuity of care, with appropriate care in the most appropriate location, and with equity principles.

[98] In the Evidence Report, ESRI (2010), Chapter 15, the costs of some of these and other changes (e.g. provision of the medical card for children below a certain age) are discussed in more detail.

[99] Over time, the suggested requirement for all the population to register with a primary care provider could refer not only to a GP but other professionals operating in the community, as the role of clinical nurse specialists and other professionals are developed.

Overall, in terms of the focus of this Report on resourcing and financing integrated health care, the type of financing/entitlement framework outlined here supports the direction of shifting resources towards primary care, in line with stated policy. From a health policy perspective, this ultimately provides better care for patients and better value for money for public expenditure.



CHAPTER 5 | Guiding Principles and Recommendations for Change

Chapter 5

Guiding Principles and Recommendations for Change

5.1 Introduction

Chapter 2 explored the principles that should guide the allocation of resources and the methods of financing health care in order to improve the Irish health-care system. Chapter 3 looked at how the current system fails to meet these guiding principles. In Chapter 4 the Group outlined frameworks for resource allocation and financing that it believes should be used in the future for decision-making. In this chapter the Group makes specific recommendations, with associated timeframes, that it believes can be taken to move the Irish health and social care system in the direction suggested by the guiding principles. The timelines suggested in the Report are set on the basis that there is Government agreement to implement the Report in the Autumn 2010. In Section 5.2 the recommendations are set out in terms of the guiding principles for resource allocation to which they relate, while Section 5.3 contains the recommendations in relation to financing and sustainability.

5.2 Actions in relation to the Guiding Principles for Resource Allocation

Principle 1

There should be a transparent resource allocation model based on population health need.

5.2.1 The Group believes that any solution that aims to address the issue of better resource allocation in health care must start with a commitment to rational planning and to taking a holistic approach to funding health and social care. This requires that the DoHC and HSE share a common resource allocation framework which encompasses all dimensions of health care so that the interconnectedness between sectors is built into future planning and where/how current resources are to be allocated. Notwithstanding the shared framework, the governance arrangements should be distinct, with the DoHC being responsible for policy formulation and priority setting and the HSE responsible for national and local implementation of policy. Such a framework should encompass both capital and current expenditures on health and social care, take into account the mixture of public and private provision of health and social care, and allow for explicit consideration of the trade off among options built around meeting current and future health-care needs. In the present economic climate it is not possible to operate a sustainable health-care system with incremental planning and resource allocation that is not tightly connected to addressing needs and policy commitments.

5.2.2 Within this overall framework for strategic planning in health care, the DoHC should then distinguish in the first instance between those resources that are to be top-sliced for national (strategic) planning reasons and those that are to be allocated geographically on the basis of broadly-defined population health need which also takes account of social need. The expectation is that the amount to be top-sliced at this level should be very limited if there is to be a genuine commitment to a population health approach (see Chapter 2). In future budgets for education, high-level training and research should be top-sliced by the DoHC and the funds given to providers on the basis of agreed services to be delivered, i.e. no longer be factored into an adjusted historic budget. This will require a reconfiguration of present budgetary data to identify what is to be top-sliced.

5.2.3 In order to allocate resources on a population health basis, it will be necessary to develop an operational population-health resource-allocation model for Ireland. The Group believes that there are currently sufficient data available to the HSE to develop such a model so that the pattern of resource change could be identified and resources could begin to be moved.[100] A systemic rather than piecemeal approach is required. While the initial model would not be perfect, it would lead to significant improvements on current allocations in terms of fairness of access and responsiveness of delivery.[101]

5.2.4 The Group recognises that the shift to a population health basis requires not just data but also the development of new management skills within the system as it makes the transition from a historic-based budget system. Central to the operation of population health systems is the local delivery of national priorities to nationally agreed standards. This requires monitoring and supervision of delivery at local level to avoid the recurrence of the problems under the previous Health-Board system. Essential to efficient and effective delivery is that the geographic structure for delivery is to areas that have sufficient scale for budgetary stability and management capability. On the basis of these requirements and best international practice, there is a minimum population size that can support a resource allocation system based on population health (see Chapter 2 above and the Evidence Report, ESRI (2010), Chapter 2).

[100] This model should draw on existing research, including, for example, that undertaken by Staines (2010) under the auspices of the HSE/HRB and work within the HSE itself. It should cover all aspects of funding in primary care, hospital care and community and continuing care.

[101] The model (incorporating population adjusted for age/sex/deprivation and utilisation) could be developed over time to incorporate geographically-based epidemiological data.

5.2.5 For population health models to operate most effectively, it is essential that data are collected on the changing state of the health status of the population. This requires that each individual in Ireland has a unique health identifier, allowing health needs to be scoped properly and the effectiveness of interventions measured. The Group is aware of the careful plans being made to ensure that such an identifier is compatible with data protection laws and of the work already undertaken by DoHC, HIQA and the HSE. This is being addressed within the context of the new Health Information Bill to be published in the latter part of 2010.

5.2.6 On the basis of its assessment, the Group makes the following five recommendations, with associated timelines where relevant.

RECOMMENDATION 1

The Group recommends that the DoHC, supported by the HSE, establishes a common framework that incorporates all dimensions of health and social care expenditure based on the best available data, so that decision makers confront openly and transparently the impacts and costs of their actions across the full range of care areas and care programmes. The key data include:

- estimates of known current and future population health and social care needs
- estimates of total (public and private) current expenditure on health care
- estimates of the current and planned stock of capital (buildings and equipment) in the health and social care system (both public and private)
- estimates of the current human capital in the health and social care system (both public and private).

Timeline: The development of this framework and preparation of these data sets would take 12 months, i.e. could be completed by the end of 2011.

RECOMMENDATION 2

The Group recommends that, in the future, the DoHC and the HSE should agree priorities for a five-year planning cycle, based on published care pathways and entitlements (as informed by new care protocols currently being implemented) and the envelope of resources available to the health and social care sector.

Timeline: This process could begin in 2011 with the strengthening of existing plans to reflect heath needs and incorporate protocols of care as they are agreed.

RECOMMENDATION 3

The Group recommends the immediate development of an operational population health needs allocation model, with a steady transitioning to resource allocation based on this model over a five-year time horizon to ensure that the stability of the system is not undermined. The Group recommends explicit top-slicing to cover (i) public health campaigns, (ii) education/high-level training, (iii) research, and (iv) national specialties where there is usually just one national centre of specialisation.

Timeline: The model should start to become operational in 2012 and be fully implemented by 2015.

RECOMMENDATION 4

The Group recommends that the basis for geographic allocation of resources within the population health model should be areas with a population of at least 250,000-300,000 people, and that there should be no upper limit to the range where the areas represent integrated geographical units.

Timeline: All current plans for defining local HSE delivery areas should be reviewed immediately to ensure that they meet this recommendation.

RECOMMENDATION 5

The Group recommends that priority be given to making immediate use of the unique health identifier and providing adequate resourcing for the management information systems needed to underpin its use (in line with previous reports). It further recommends that this be done as quickly as possible and be combined with a national strategy to encourage all members of the population to register with a GP.[102]

Timeline: The process of using the health identifier should begin immediately, starting with the hospital sector and extending into the primary and the community and continuing care sectors.

[102] See also Recommendation 24.

Principle 2

A resource allocation model should support local implementation of national priorities based on nationally-set clinical, accountability and governance standards.

5.2.7 The Group believes that it is urgent for the development of resource allocation systems that the long-term structures for service delivery by the HSE be identified. The Group's own preference, on the basis of efficiency and transparency, is for a system that has the minimum number of layers, having noted the international experience in this regard and the small overall size of Ireland's population. Chapter 4 above outlined one such system.

5.2.8 The Group believes that it is essential that decisions in relation to the primary care, hospital care, and community and continuing care sectors are taken at the same 'level' to ensure that patient/user care is delivered in the right setting and that there is no incentive to shift costs inappropriately. Since the HSE has now decided to organise the delivery of services locally, the Group believes that it is appropriate to devolve budgets based on population health resources locally. However, the Group considers it to be of the utmost importance that local areas operate to (a) a nationally-agreed set of care protocols, (b) a financial format and set of contracts established centrally by the HSE, and (c) a common set of reference prices for services. The Group further believes that, since integration is central to ensuring standards and cost effectiveness in the future, local decision-making processes must involve those in the primary, community/continuing and acute care sectors when national policies are implemented.

5.2.9 Since the HSE has begun a new management transformation programme at local level, ahead of there being a proper resource allocation model to underpin it, the Group believes that it is important that the governance structures being developed within the HSE should cover resource allocation as well as standards, delivery and finance to ensure that national standards and priorities prevail.

5.2.10 The Group recognises that some information systems within the Irish health sector are presently not 'fit for purpose'. This became evident to the Group as it discovered that basic data on the public and private systems could only be obtained with great effort. The lack of a fully developed financial information system reflects at least in part the fact that the majority of allocations represent historic funding levels, with the exception of community schemes (€2.8bn in 2010) and Fair Deal (almost €1bn in 2010).[103] Furthermore, the absence of a single national financial system in the HSE makes analysis across care areas and over time difficult (see the Evidence Report, ESRI (2010), Part 6).

[103] While the Fair Deal scheme is based on a population health approach, some of the other schemes are based on numbers only and do not adjust for population health.

5.2.11 Despite the limitations of existing information systems, the Group believes that it is possible to begin to move resources in a more rational direction if a marginal-type analysis is adopted at all levels of decision-making, i.e. determining high level priorities at national level and specific allocations at local level. Marginal analysis (see Principle 7, Chapter 2) requires that decision makers confront the value/cost of particular decisions in a rational and informed manner, recognising that more resources for one activity means less for another. This is the hard reality of budgetary decision-making in the future, i.e. more for one important priority (say, breast cancer) means less for another (say, prostate cancer). This requires a very different mindset to that which operated in a period during which resources were increasing rapidly and there were few pressures for reallocation of existing resources.

5.2.12 On the basis of its assessment, the Group makes the following five recommendations, with associated timelines where relevant.

RECOMMENDATION 6

The Group recommends that the HSE ensures that its management systems (both at corporate and local levels) are compatible with, and can incorporate, a formal resource allocation process based on population health and integrated care. More specifically, the Group strongly recommends that the system currently being developed be tested to ensure that the incentive structures being generated are compatible with the implementation of a population health resource allocation model.

Timeline: This task should be completed by end 2011 at the latest.

RECOMMENDATION 7

The Group recommends that the HSE be charged with ensuring the robust implementation of national priorities and standards at local area level by

(i) providing formal resource allocation models to be used locally

(ii) resourcing local levels appropriately and monitoring adherence to national priorities and standards

(iii) ensuring that management teams include competencies in primary, community and acute care.

Timeline: Implementation of the priorities and standards should commence in 2012 at the latest.

RECOMMENDATION 8

The Group recommends that, as a matter of urgency, the DoHC and HSE enhance their financial and management information systems so that they can support rational decision-making and achieve satisfactory standards of public accountability and transparency.

Timeline: In the present economic climate this could be expected to take up to three years.

RECOMMENDATION 9

The Group recommends that the HSE review and reduce to a minimum the number of layers of decision-making in relation to resource allocation systems in the context where budgets held at local level should cover all three areas and be subject to central controls.

Timeline: This should be completed by end 2011.

Principle 3

A resource allocation model should support the delivery of safe, sustainable, cost-effective, evidence-based care in the most appropriate setting, whether public or private.

5.2.13 To ensure that resource allocation supports clinical standards, a full set of evidence-based clinical protocols for Irish health care should be established immediately.[104] Plans within the HSE to create such standards are now in train.[105] In this context, the Group sees that Ireland has a late mover advantage in that much of this work of defining protocols has been done for relevant comparator countries. Consequently, the default for setting Irish protocols should be the direct application of a rationally determined set of international protocols. The Group believes that the combination of this set of care protocols (covering the acute, primary and continuing and community care sectors) and the correct incentives in the resource allocation system are vital in ensuring safe and cost-effective care. In order to optimise the total benefits from this modernisation strategy, it would be important that the protocols have reference prices calculated to ensure that the process of rolling out new protocols achieves value for public funds and a higher level of awareness among health professionals of the financial as well as care costs of their action(s)/inaction(s). This information will be particularly important for decision-making at local level in relation to integrated care pathways.

[104] Care needs to be taken to ensure that resource allocation mechanisms do not undermine clinical standards, which is possible if the two are not properly linked.

[105] The planned role out of clinical protocols is being led by the National Director for Quality and Clinical Care at the HSE.

5.2.14 The Group believes that, in order to ensure that incentive structures reinforce these clinical protocols, providers should only be reimbursed for the provision of care that is consistent with clinical protocols. This means, for example, that hospital procedures that could be undertaken on a day case basis would only be reimbursed on that basis, and procedures in primary care that could be undertaken by a nurse would only be reimbursed on the basis of the cost of the nursing service. Similarly, the HSE at local level, in its role as a provider of long-term care, should share responsibility with hospitals for ensuring that patient stay levels are appropriate, with hospitals being reimbursed at an intermediate rate (between the rate for long-term care and the relevant hospital rate) for any patient whose medical care no longer requires his/her being in an acute hospital bed. Furthermore, since best practice internationally is only to fund what is planned, any provider who fails to deliver on an agreed plan should incur a penalty. The Group is of the view that, without this discipline, the approach to proper resource allocation will be fundamentally undermined.

5.2.15 Since good local provision requires the devolution of certain decision-making powers, the Group believes that HSE Corporate must have a major role in the future in monitoring and supervising activities at local level and ensuring that national care protocols are being met. This will be essential if some of the problems in the past in relation to the Health Boards are to be avoided. Furthermore, it will have a key role in drawing up the suite of contracts to be used in relation to service delivery.

5.2.16 The Group believes that the recent introduction and expansion of individualised funding options within the community and continuing care sector represent a significant improvement on previous methods of delivering community care. The wider use of such mechanisms for other groups of older persons and for adults with physical and/or sensory disability should enhance transparency, individual self direction and cost-effectiveness. The Group believes that there may also be further potential for more individualised solutions in relation to child and adult respite within the intellectual disability sector.

5.2.17 The Group believes that the set of costs in relation to standard care delivery items should be used in decision-making throughout the health and social care sector, and a similar approach be adopted in relation to the prices used to reimburse all providers, whether public or private. The development of unit costs for delivery items is a crucial step in ensuring that treatment takes place in the most suitable setting - hospital, primary or community/continuing. The system of costs can be built up and refined over time, and will be much improved as the HSE financial systems develop and a common accounting system is rolled out to providers. The system of prices used should be designed to promote the delivery of care in the most cost-effective way.

RECOMMENDATION 10

The Group recommends the development of national reference prices for all care protocols.

Timeline: This will be done on a phased basis as the protocols are agreed over 2011, with a view to priority implementation in 2012.

RECOMMENDATION 11

The Group recommends that the determination of the prices of care (defined using casemix adjustment) used to reimburse providers be the product of a visibly independent process. When this function is undertaken within the HSE while it is still both a purchaser and a provider in the health-care sector, the Group acknowledges the particular requirement for oversight of the process by an independent group.

Timeline: Arrangements to establish an independent transparent process should begin in 2011, so that it is in place when prospective funding commences.

RECOMMENDATION 12

The Group recommends that the HSE prepares to implement a rigorous and transparent system of incentives to ensure that providers meet delivery plans and agreed quality standards in all three care areas in order to ensure public accountability. The Hospital In-patient Enquiry (HIPE) System could be used immediately as a basis for challenging hospitals retrospectively on any inappropriate use of bed resources and fining them as appropriate.

Timeline: Hospitals should be advised immediately that HIPE will be used to challenge their performance in relation to using efficient methods given set clinical standards. This could be made to apply in 2011 ahead of the full prospective funding system.

RECOMMENDATION 13

The Group recommends that the role of HSE Corporate should evolve systematically through the development of Clinical Leads so that care factors are built directly into strategic planning at every level. It is the HSE's responsibility to roll out the protocols and ensure that they are implemented. HIQA needs to be resourced to ensure that the published standards are being met in all parts of the health and social care system.

Timeline: This should be completed by 2011.

RECOMMENDATION 14

The Group recommends that the DoHC/HSE develop plans for the greater use of individualised solutions that meet care needs in the community and continuing care sector and support the local roll out of such plans. This should follow the principle of money following the needs of the patient/user so that care is delivered in the most appropriate setting.

Timeline: This process should be underway in 2011, building on recent experience within the community and continuing care sector.

Principle 4

A resource allocation model should promote the integration of care within and across the hospital, primary, and community/continuing care sectors at every level.

5.2.18 Given the disciplinary composition of the Group, it was well placed to appreciate how the rapid advances in technology in the past decade have increased the potential for the delivery of a greater share of services from within the primary care sector. The Group believes that realising this potential in practice will require much greater flexibility in the use of resources within health care than has been widespread in the past. The successful conclusion of agreements with public sector unions (the Croke Park Agreement) in June 2010 has paved the way for more active reallocation of human resources in the health-care system. Nevertheless the Group recognises that this will involve challenges, but ones that can be met, and indeed will have to be met, if health care is not to become an unreasonable burden on Irish society at the expense of other societal needs.

5.2.19 In most instances the current sets of contracts between the HSE and the primary and community care sector are not 'fit for purpose'. The Group sees that this is not just a question of exploring what is needed to update the GP contract; it is much more about defining a new suite of contracts which will allow the primary care sector in its totality to deliver services in a more appropriate way in the future. The design of these contracts should start from the premise that care is integrated across sectors, and that the key role for the primary care sector is the provision of preventative care and management of chronic conditions. On the basis of best international practice, such contracts will involve a blend of payment methods with capitation as the main payment for all primary care activities, where the capitation payment is adjusted for other risk factors in addition to age and sex as at present. As far as possible, the reimbursement system in place should leave the provider indifferent as to whether the patient is public or private.

5.2.20 The Group believes that new momentum is required to support the creation of PCTs, which is central to the success of the new integrated model of care. The Group's view is that the terms of the new suite of contracts and the development of care protocols should now be the key drivers of support for the evolution of multidisciplinary teams at the primary care level. This could be reinforced by changes in financing mechanisms (see Section 5.3). Given the differences in settings for primary care delivery in Ireland (across large urban centres, small towns and low density rural population), the Group sees that the HSE should drive this at local level, according to principles and approaches set by HSE Corporate.

5.2.21 The Group recognises the efforts being made to build up community health services, but believes that this needs to be more clearly based on the protocols for care (especially for chronic diseases), and will require the development of clearer and more logical entitlements to community health services. The Group sees a need to strengthen the planning of community service development and to provide clearer guidance for its development at local levels, in parallel with strengthening the development of PCTs. In particular the Group recognises the potential for large changes in the ways in which services are provided, with wider use of public health nurses, social workers and GPs. These changes would provide both care and cost benefits.

RECOMMENDATION 15

The Group recommends that, following the successful high-level agreements with trade unions with regard to flexibility, priority be given to planning, over a three year time horizon, for the transfer of resources within and across HSE local areas to meet health-care needs in a more cost-effective manner.

Timeline: This process should begin as soon as industrial relations arrangements allow.

RECOMMENDATION 16

The Group recommends that a group of experts be established immediately to develop a new suite of contracts for professionals in the primary care sector. Based on international best practice, these experts should advise the Minister for Health and Children on these new contracts. The contracts should take account of the changes in the new role of primary care within an integrated health-care system. In addition, the design system needs to clarify the appropriate governance structure to be embedded and incorporate new mechanisms to support the long-term development of primary care, embracing all of the relevant professionals.

Timeline: The process should begin in 2010, drawing on international evidence in the first instance to scope what would best serve Ireland's needs.

RECOMMENDATION 17

The Group recommends that the HSE develop a more focussed strategy for community service development and PCTs that takes explicit account of the care needs and pathways contained in the new clinical protocols, other nationally set standards of care, special local circumstances, and new models of care delivery. It further recommends that HSE Corporate support the new devolved management structures in implementing the service developments locally in order to allow new patterns of care to develop.

Timeline: This process should start in 2011 and will be an ongoing process but the new community services strategy should be in place by late 2011.

Principle 5

Financial incentives should align as far as possible across all actors (including users and providers) in the system, consistent with promoting health and well-being and in line with nationally-determined priorities.

5.2.22 The Group believes that, in line with international best practice, the separation of purchasers from providers should be a major goal of the Irish health-care system. This separation affords great clarity in ensuring consistent incentives across the system, and hence is important for efficiency (see Chapter 2). The Group's interpretation of the international evidence is that the move towards separation should be gradual and steady, recognising that it would be disruptive to move quickly. As part of the process of moving towards the purchaser-provider split, it is important to have full transparency in the contractual relationships between HSE and all providers (including HSE hospitals). As it stands, the HSE is obliged under the Health Act 2004 (Sections 38/39) to enter into legal arrangements with health-care providers where it seeks to contract services, and this obligation has begun to be implemented in several care areas. The need to meet these obligations in a wider range of areas has been identified as an issue by the Comptroller and Auditor General in reviewing the performance of the HSE.

5.2.23 The Group believes that Ireland should move to reimbursing health-care providers on a predominantly prospective basis, using a blend of payment methods as appropriate (based on a blend for each patient type, rather than across patient types). For GPs, capitation would be the main form of payment as discussed under 5.2.19. For acute hospitals, existing plans should be accelerated, with funding of most care to move on a phased basis to a prospective, casemix adjusted activity-based system. This process will need to build on existing systems dedicated to collecting data on hospital activity and work underway on hospitals costs. The HIPE system currently collects data on hospital activity in acute hospitals nationally. The data collected by HIPE and the approach to clinical coding and casemix classification are consistent with similar systems available internationally. Where required by the proposed funding model, the data collected by this system may need to be expanded and the clinical coding and casemix classification systems may need to be adapted to reflect Irish clinical protocols and to ensure that all hospitals are treated fairly within the system. The collection of data relating to the delivery of diagnostic services, out-patient services and services delivered in the ED is greatly underdeveloped, so developments of these systems will be required if funding for these services is to be effectively based on the types of patients treated in these service areas. Currently, cost data by specialty is collected by the HSE's Specialty Costing Programme. It would be expected that the recommendations of the current patient-level costing project will provide direction for developing cost data. Careful phasing will be needed to ensure systematic adjustments towards the achievement of the core objectives here, to ensure that the stability of the hospital system is not undermined. The Group is of the view that this is achievable on a timescale consistent with the roll out of a population health model, building upon work already underway in the HSE in conjunction with both voluntary and statutory hospitals. Since there is a direct link between the successful implementation of clinical protocols in hospital and prospective activity-based funding, the Group believes that these two initiatives should be rolled out together so that national priorities can be achieved.

5.2.24 The Group believes that the valuable contribution of prospective-based funding to enhancing the quality of care and value for money in the Irish health system will only be realised if all providers (institutions and health professionals) trust that the system will operate credibly and that there will be no bail-outs for those who do not comply. Where the provider exceeds the planned/agreed level of a particular activity for exceptional/unforeseeable reasons, the provider will receive a lower reimbursement rate for that activity as long as it operates within the existing budget envelope.[106] Where it becomes evident that the provider cannot undertake the planned/agreed level of activity, a process should be in place to transfer the funds due back to the HSE for re-assignment to other activities. Plans must clearly provide for a specified level of activity in relation to public patients. Because this system is more transparent than the current system, the level of services to be provided to the public patient will still be protected, as the HSE will be funding public hospital

[106] Obviously the issue of planning is complex in maternity cases, but the timeframe there should allow hospitals to mediate the unplanned events.

activity exclusively for public patients and insurance companies will fund remaining activity. This should improve equity in access for public patients. Inevitably this system will take time to refine, but the Group believes that the process of moving in this direction is essential if the objectives of health policy are to be met.

5.2.25 To reward providers for moving quickly to better care delivery practices and more efficient ways of delivering care, the Group believes that some portion of the pecuniary benefits of that effort should be returned to or retained by them for further service development. To balance this approach, providers who do not follow best practice within two years of these being established should be subject to clearly articulated budgetary penalties. These penalties should cover failures of health professionals to liaise in relation to patient care on pathways through the system. While liaison can be achieved most efficiently by an integrated information technology system and a unique health identifier, it can happen ahead of that using email, logged calls or paper.

5.2.26 The Group believes that once treatment protocols and frameworks are in place in the acute hospital sector to ensure national priorities and policies are implemented locally, and, a prospective funding mechanism is in place, there will be no requirement for the NTPF to continue that part of its role in relation to purchasing services to reduce waiting lists. In effect, the approach to funding on a prospective basis used by the NTPF will be mainstreamed, consistent with the patient-centred approach implicit in the move to integrated care. The related budgets and skills should be moved into the HSE to support the transformation to a nation-wide prospective funding model. This does not mean there will be no need to monitor waiting times in a systematic way, and ensure that patients are treated within the agreed times. Rather, HSE Corporate will need to monitor closely local implementation to make certain that access to treatment is delivered within agreed waiting times. Where waiting time for a patient is exceeded in line with nationally agreed guidelines, local HSE personnel will be responsible for purchasing treatments from the public sector through other HSE local offices or from private hospitals. The Group believes that there should be a careful study of the NTPF, which has been very successful in reducing waiting lists, to improve our understanding of how prospective funding models work on the ground, i.e. how they have impacted on public hospitals, on the efficiency of delivery methods, and on the workloads of health professionals.

5.2.27 The Group believes that, to ensure efficient use of resources, full economic costing should apply to private activity in public hospitals[107]. It further believes that there is a need to provide mechanisms to ensure controls on the costs of demand-driven diagnostics, which are currently met by public hospitals and result from public and private patients being seen by GPs or by consultants in out-patient settings. These currently fall on the hospital as a cost, but the hospital manager is not in a position to control the expenditure in any structured way. A combination of protocols and

[107] The Group notes that a DoHC working group on economic pricing is currently concluding its work.

more detailed cost information is essential to ensure a better use of these resources, and, allow greater transparency in relation to the allocation of costs as between the HSE or insurers.

RECOMMENDATION 18

The Group recommends that the contractual arrangements used by the HSE to reimburse providers be extended to all care areas as soon as possible, and be developed to include more detailed expression of the link between activity and cost in a changing resource allocation environment.

Timeline: The extension of current contractual arrangements to all areas should be completed by end 2010. A project to explore the use of more performance-based contracts should commence no later than 2012.

RECOMMENDATION 19

The Group recommends that national plans should be drawn up for prospective-based funding to be introduced in all relevant areas of the health and social care system on a phased basis.

Timeline: This planning process should start in 2011 with a view to implementation on a phased basis starting in 2012, in order to provide a clear signal of change to the providers and to allow time for the development of the requisite skills among HSE personnel and providers.

RECOMMENDATION 20

The Group recommends that, as prospective funding mechanisms are rolled out alongside the local management of protocol-driven service delivery, the role of the National Treatment Purchase Fund (NTPF) in relation to waiting lists should be mainstreamed within the HSE. The resources currently allocated to the NTPF should also transfer, along with clear responsibility for monitoring waiting times and achieving centrally set targets, so that patients' benefits are preserved. Where public and private providers are undertaking public activity under a prospective funding model, the same basis should be used in relation to negotiating with both. To ensure that there is a clear distinction between the roles of the purchaser and provider in the system, the prospective funding activities within the HSE will be subject to independent oversight. (This is linked to Recommendation 11 above.)

Timeline: The functions of the NTPF in relation to reducing waiting lists should be phased out in an orderly manner over a three year period starting in 2012, in line with the roll out of the prospective funding model.

RECOMMENDATION 21

The Group recommends the implementation of the full economic costing to apply to all private activity in public hospitals.

Timeline: This process should commence in 2011, and should be in place across all sectors within three years.

RECOMMENDATION 22

The Group recommends the introduction of proper protocols and costing for diagnostic services.

Timeline: This process should commence in 2011, and should be in place across all sectors within three years.

5.3 Actions in relation to the Guiding Principles for Financing and Sustainability

Principle 6
The methods of financing health care should be as effective and equitable as possible.

5.3.1 As evident from Chapter 4, the Group believes that the formal financing system within which resources are raised is less important than its detailed features and the ways in which resources are spent. Under Principle 6 the key issues are equity and the ways in which transparency and the incentives in the system make it acceptable and efficient. The Group makes specific recommendations that aim to improve transparency (e.g. Recommendations 3 and 4 regarding geographical equity, Recommendation 19 on payment of providers, Recommendation 21 on charging full costs to private patients). These recommendations concerning equity, transparency and efficiency would bring some of the benefits that are core characteristics of a full social health insurance system.

5.3.2 While the Group recognises the potential advantages and disadvantages of a change from mainly tax-finance to certain forms of social health insurance, the recommendations relate to the features it sees as important in either type of financing system. Since efficiency, the degree of pre-payment, and some improved transparency can be equally well achieved within the current tax financing structure, the main argument for a change must be the greater acceptability of a system where there is a visible link between the contribution rates and the total funds available for providing services. The main arguments against a change over to the establishment of a social health insurance system are the cost and disruption of such a major change and the weaker cost control observed in some social health insurance systems in other countries. The recommendations from the Group relate to further work on transparency, the degrees of pre-payment, and incentives for efficiency and control of costs, and apply whether the current tax funding continues or is replaced by a system of universal/social health insurance.

5.3.3 The present concentration of user fees in primary care, and the lack of free or subsidised access to many community health services for the majority of the population, mean that it will be very difficult to divert patients from hospital to community settings in line with current policy objectives unless they are holders of medical cards. There is a need for controlled and lower user fees especially for those on moderate incomes and for those with high needs for community-based services.

5.3.4 The current set of health-care entitlements and patterns of subsidies and fees has many anomalies. There is a need for subsidies to be more clearly focussed on people with relatively low incomes (but who currently get little support) and people who have high levels of needs. Such subsidies should also be directed to support the use of services that provide efficient, integrated (and usually community based) care, mainly for chronic illness. The framework in Chapter 4 illustrates how such a system might be structured. Currently patients with relatively similar incomes face very different user charges for primary care on either side of the medical card/GP Visit card thresholds. This unwelcome feature of the system would be avoided if the different entitlement categories were linked in a progressive and logical way. Furthermore, the ways in which those with chronic illnesses are supported are somewhat arbitrary and should be more closely linked to their needs.

5.3.5 Reducing the price for GP use is a necessary but not sufficient condition for developing (and getting patients to use appropriately) community-based integrated care. It should be noted that new resources such as specially-trained nurses and allied health professionals, some of whom might transfer from hospital settings, will also be needed. In principle services provided in appropriate settings should be cheaper or no more expensive for patients than those in higher cost settings. In the long run, it would be desirable if there were low user fees and no significant co-payments for drugs for people with chronic illnesses and those on modest incomes.

5.3.6 The incentives associated with pay-as-you-go, unregulated user fees in primary care make it difficult to build teamwork between providers of primary and community services and between hospitals and community health-care providers. Replacing the current system with targeted and regulated user fees would allow primary care to be more fully integrated with the rest of the health system.

5.3.7 From an economic perspective, tax reliefs lack transparency and are generally inefficient in terms of targeting government resources. The resources currently spent on tax reliefs could be devoted more usefully to direct and targeted subsidies for access to community based care and reduced costs for drugs to enhance equity and integrated care.

5.3.8 Since private health insurance is mainly focused on episodic hospital care the tax reliefs provided do little to encourage integrated care models and they reduce equity. The resources involved could be employed more usefully to improve policy related subsidies.

RECOMMENDATION 23

The Group recommends that a more systematic approach be taken to financing health services in terms of improving the extent of pre-payment for access to care, increasing transparency, and increasing incentives to provide appropriate services efficiently and in the appropriate locations. Moves in this direction are contained in Recommendations 24, 25, 26 and 27 below, but further development is needed with regard to entitlements to services in the community and user fees (where applicable) and, to ensuring that changes in entitlements in primary care are appropriate.

RECOMMENDATION 24

The Group recommends that a project be established immediately to set out in detail the way in which a coherent structure of entitlements to primary and community care services and drugs, such as that outlined in the framework discussed in Chapter 4, could be implemented. This would include levels of user fees and drug co-payments to encourage more appropriate patterns of service use. Primary care providers should be supported with appropriate capitation payments to co-fund entitlements to services for patients registered with them. Public subsidies should be focused initially on supporting those with high levels of needs for services and should also be more closely related to incomes.

Timeline: A project on the development of a coherent framework and related systems of fees and capitation should be initialled before the end of 2010, with a completion date no later that the end of 2011.

RECOMMENDATION 25

The Group recommends that, as resources allow, user fees in primary and community care should be lowered where they are likely to deter use of services, where they place a heavy burden on sick people, where they make it more difficult to put in place integrated models of care or where they incentivise inappropriate use of hospital care where primary care would be appropriate. This should be done by moving groups into higher categories of subsidy within a coherent financing framework (see Recommendation 24).

Timeline: This recommendation should be implemented in the context of the project recommended under Recommendation 24.

RECOMMENDATION 26[108]

The Group recommends that, as part of the reform of user fees and entitlements in primary care, the current tax reliefs on health care use be withdrawn to release resources to be targeted on capitation payments to primary care providers for registered users.

Timeline: This recommendation should be implemented in the context of the project recommended under Recommendation 24.

RECOMMENDATION 27[109]

The Group recommends that tax reliefs on private health insurance be phased out over time and that the resources released be made available for more targeted health policies, such as the creation of an integrated and coherent medical card framework as outlined in the funding framework in Chapter 4.

Timeline: This recommendation should be implemented in the context of the project recommended under Recommendation 24.

Principle 7

All aspects of the health-care system should be sustainable.

5.3.9 Recognising that sustainability applies to all aspects of health care, economic as well as fiscal, means that all new and existing funding should be evaluated in terms of its cost to the population at large, not just the costs that fall on government. Therefore, Ireland needs health accounts which indicate clearly the full costs of health care, both public and private.

5.3.10 To ensure sustainability, the Group believes that there should be a greater focus on measures that enhance the capacity of the health-care system to convert resources into value. In contrast to other countries there is a very wide range of staff contracts currently operating within the Irish health-care system, a legacy from the independent Health Boards that operated different systems. As health-care professionals are the key health-care resource, the Group believes that it is important that comparisons across grades and areas are possible. This ultimately requires a standardisation of contracts.

[108] The Department of Finance notes that various significant tax expenditures have been restricted or terminated in recent years. All revenues raised by such tax base broadening measures have been absorbed into general government revenues. There is no direct link between tax expenditures and expenditure programmes, allocations for which are determined as part of the annual Estimates process.

[109] As in Recommdation 26 the Department of Finance notes that various significant tax expenditures have been restricted or terminated in recent years. All revenues raised by such tax base broadening measures have been absorbed into general government revenues. There is no direct link between tax expenditures and expenditure programmes, allocations for which are determined as part of the annual Estimates process.

5.3.11 As the data in the Evidence Report, ESRI (2010), Chapter 12 make clear, controlling the pharmaceutical budget is key to ensuring the sustainability of the health-care system. The Group welcomes the recent changes to the structure of pricing and reimbursement of publicly-funded pharmaceuticals – they indicate the types of measures that need to be applied across the board in ensuring greater value for money. The Group believes that further immediate steps can be taken to reduce pharmaceutical costs and to ensure that they are more inline with international norms.

5.3.12 The Group believes that the control of drugs, in terms of what is prescribed, how it is prescribed (generic or other), and the volume prescribed is best controlled by implementing guidelines and protocols and increasing consumer awareness about drug prescribing. The Group noted the unfavourable cost implications of the low prescription rates for generics in Ireland and that the Irish Medicines Board has recently published an information leaflet on generics. Notwithstanding recent developments in generic substitution and reference pricing, this is an area requiring further attention by the HSE. To deal with the growing numbers of new drugs/ treatments, the DoHC/HSE and HIQA need to consider how Ireland should address these issues, drawing on the experiences of other countries.

5.3.13 The Group believes that for overall economic sustainability of the health-care system, there should be an economic evaluation underpinning decision-making at every level of activity. This type of analysis was referred to in 5.2.11 above. It is central to engaging both health-care professionals and managers in taking responsibility for the need to have the most effective use possible made of all available resources. In terms of pharmaceuticals, the Group believes that there should be an economic evaluation of all existing high-cost items on the GMS and DP lists to ensure that only cost effective treatments are reimbursed, drawing on international evidence in this area. At present, evaluations typically relate to new drug products only.

5.3.14 The Group believes that performance management tools are essential to measure outcomes, ensure consistent data collection (including financial information), and to monitor adherence to contracts. Systematic performance management requires clear statements of roles, responsibilities and accountabilities, and must be supported by efficient management and information systems. This will require investment in ICT in the HSE and in provider institutions.

5.3.15 The Group notes, for example, the evidence that has become available that in a significant number of cases there is not a satisfactory level of adherence to the new consultant contract. The Group believes that transparency in the system is vital to both patient safety and the optimal use of the resources at our disposal, and that a system of penalties should be imposed where professionals are found to be in breach of their contracts.

5.3.16 The Group recognises that the current arrangements for allocating capital funds to health-care providers imposes inappropriate constraints on developments that would meet objectives as outlined in the Guiding Principles. A new system should recognise that capital resources are not free, but also that capital represents only a small part of health-care costs and should not constrain important service developments. It may be possible to solve some current physical capacity constraints by public providers renting surplus facilities from private providers or by entering other leasing agreements. In the long run the best models for acquiring and managing capital resources are likely to be through the prices paid for service delivery, thereby incentivising the appropriate balance of capital and revenue spending, but this would require new systems to be put in place.

RECOMMENDATION 28

The Group recommends that in order to ensure full costs in relation to health care are fully counted, data on health accounts should be placed in the public domain by the DoHC at an early date, and backdated where possible.

Timeline: Data for 2009 should be made available by the end of 2010, and backdated where possible to 2000.

RECOMMENDATION 29

The Group recommends that, in line with the proposed government modernisation plans for the health-care sector, staff contracts within the health and social care sector should be simplified and standardised, as well as configured to ensure the delivery of health-care services that are accessible and integrated across all sectors.

Timeline: This process of standardisation and simplification should commence by the end of 2010.

RECOMMENDATION 30

The Group recommends that an evaluation be undertaken of all high-cost, high-use drugs on the current GMS/DP lists, based on Irish costs and international experience of their outcomes, and that the HSE and DoHC engage immediately in the development of official guidelines and clinical protocols on the use of new technologies.

Timeline: This process should begin as soon as possible, and no later than April 2011.

RECOMMENDATION 31

The Group recommends that the DoHC/HSE create immediate plans to

(i) develop further the recently announced reference pricing system

(ii) review critically the comparator countries currently used for setting ex-factory price of pharmaceuticals with a view to adjusting these as soon as possible, and no later than March 2012

(iii) extend tendering for sole supply contracts for additional pharmaceutical products

(iv) establish treatment and prescribing protocols that promote the use of generics

(v) introduce regulations to mandate that all prescriptions for public and private patients must contain the generic name of the drug prescribed

(vi) introduce regulations to mandate all pharmacists to dispense the lowest cost version of the drug unless the patient specifically requests a particular brand (in which case the patient is responsible for the additional cost)

(vii) extend information on generics more widely among doctors, pharmacists and patients.

Timeline: This process should begin as soon as possible and no later than April 2011.

RECOMMENDATION 32

The Group recommends that the DoHC clarify the roles of different bodies in relation to regulation and oversight to ensure that procedures are in place to deal with wrongdoing, and that there are no gaps in the system of governance that could leave the health system exposed.

Timeline: This process should begin in 2010 as part of the overall review of governance.

RECOMMENDATION 33

The Group recommends that there should be an evolving performance management system with a manageable number of Performance Indicators to allow managers to focus on what is considered priority and the key cost and service drivers.

Timeline: Final agreement on the set of key performance measures should be agreed by mid-2011 at the latest.

RECOMMENDATION 34

The Group recommends that a task force be established to develop a new approach to the management of capital resources, looking at best practices in other countries and focusing on removing barriers to efficient use and management of capital resources.

Timeline: This should be established in 2010 and should come back with proposals by end 2011.

CHAPTER 6 | Implementation Challenges

Chapter 6

Implementation Challenges

6.1 Introduction

Chapter 5 of this Report indicated some practical steps that can be taken towards a more rational and transparent resource allocation system in the health-care sector and an improved method of financing health care. In addition, Chapter 5 also set out some of the ways in which the Irish health system can be made more sustainable.

This Group was appointed at a time of growing health-care demands, falling incomes and falling tax revenues. This combination has led to the recognition among health-care stakeholders and the society at large that

- resources must be utilised to maximum effect
- access to care must become more equitable
- costs must be kept as low as possible.

At the same time there is also growing recognition in Irish society that the pace of change in health service provision must increase if we are to get quickly to a point where we have a health-care system that is centred on planned, integrated services linked explicitly to national priorities and focused on maintaining health and well-being, rather than one which is reactive, episodic, fragmented and financially unsustainable.

While concepts like 'integration' and 'better resource allocation system' may sound abstract and unexciting, they are crucial to helping Ireland deliver health-care services more effectively and to improving the sustainability of the system.

In the context of an ageing population and recent challenges in areas like child protection, it may be timely for Ireland to have an informed and rational debate or the whether the benefits (such as inclusiveness and continuity of care) of having a wide range of resources linked to a broad definition of health care outweigh the costs (e.g. challenges for leaders and managers from having to run such a large and complex system). This issue was outside the Group's Terms of Reference but it was a recurring theme in many of the submissions received.

6.2 Changes

As discussed in Chapters 2 and 3, health-care reform in Ireland and internationally is being driven by new models of integrated care. The potential of successful reform is very considerable, as is the cost of not adopting these new models of care.

The change in the way that health care is delivered needs to be reflected in new resource allocation mechanisms – what we have no longer fits our requirements for the delivery of safe, effective and efficient health and social care services. Consequently, these new resource allocation mechanisms must be aligned with the new care protocols and pathways that guide the delivery of care. If the system is to work well, the pathways within the protocols must be mirrored in the incentives created by the resource allocation models. For example, if integrated care is mandated by newly-defined protocols then the resource allocation mechanism must ensure that professionals and institutions are rewarded for behaviour that promotes integration through the design of payment systems. While some individuals and institutions may not be strongly influenced by financial incentives which are perverse in the sense that they run counter to the objectives of good health care, international evidence suggests that such responses need to be taken into account in the design of system changes.

Well defined protocols and compatible metrics for allocating resources are required to ensure that new methods of care provision promote individual health and wellbeing in a cost-effective manner, integrated across sectors and peopled by a plethora of skilled personnel (doctors, both GPs and consultants, nurses, dentists, allied health-care professionals, and social care workers).

6.3 Challenges

Professionals operating in teams and professionals functioning as solo operators require different behaviours, with a different system of management as well as delivery. In terms of hospitals, this requires the integration of the role of the Clinical Director into every aspect of care delivery, meeting the cultural challenges that this requires. Alongside this, it means that all professionals must see themselves as part of discipline-specific and cross-disciplinary teams, and operate accordingly. In the primary care sector and crossing into the continuing and community care sector, co-ordination of the development of teams will need to be supported by Health Service Executive (HSE) local offices at the 'macro level'. At the 'micro level', health and social care workers will have to learn to work together as partners of a health-care team, focussed on the health and well-being of the patient as she/he moves along the care pathway. Essentially, better health-care delivery requires all professionals to recognise, understand, respect and utilise their different but complementary roles in health-care delivery.

Ultimately, the success of the new methods of delivery will require changes to how health and social care professionals are trained initially, and the ongoing training of currently practicing health and social care professionals. To ensure that health-care delivery is cost effective as well as safe, training is required to ensure that all professionals also understand the potential benefits and costs of their own and their team-members' proposed actions. This means that they become more connected with the cost base in health than has been the case historically.

The new approach will also require

- external monitoring and audit to ensure best practice is being implemented
- team meetings to ensure care is effectively coordinated
- IT systems so that all team members can be fully informed, have input into, and be kept up-to-date about the care the patient is receiving.

Ireland will only reap the potential benefits from what modern health care has to offer if its professionals can successfully make the transition to the new modes of working. This transition will not happen seamlessly and requires careful planning, training and the commitment of professionals, individually and collectively, to the health and well-being of Irish society.

6.4 Potential Barriers to Implementation

All societies find transformations challenging, and failure to acknowledge these challenges sometimes means that the successful implementation of programmes of transformation takes too long. In this section we identify some of the potential barriers that could stand in the way of changes that are needed to improve health-care delivery, so that they can be addressed during the implementation process.

Society: While one might expect that there should be widespread public support for and commitment to the integrated model of care, it cannot be taken for granted that there will be such support. We have seen considerable resistance to change in modes of health-care provision in the very recent past, for example, in relation to cancer care. The key to getting public support is to increase our collective understanding that safe care must dominate convenient care in driving the allocation of resources. This requires a political commitment at local level, often lacking in the past, to promoting the integrated model of care that is centred on patient safety, rather than on the interests of maintaining the status quo in local institutions. Those organising services need to demonstrate that they are responsive in their planning to what should be centralised and what can be delivered safely and cost-effectively at local level. Those delivering services must also take responsibility for explaining why services must be delivered in safe setting. Without these efforts, barriers will emerge which will counteract the potential benefits being achieved.

Service Providers: Just as there are challenges to be faced in moving patients to safer and more cost effective methods of delivery, there are challenges to be faced in ensuring the providers adjust. There are many instances where services can be brought closer to the patient, but this requires changes in how service delivery is organised, and may involve professionals in moving to the patient rather than the patient moving to the professional. As in any change situation, there can be barriers to change from stakeholders who have either a vested interest in maintaining the current situation or who fear that they do not have the competencies to meet the new requirements. It is to be hoped that the greater flexibility associated with the 'Croke Park' agreement will assist in arrangements for delivering services that focused more on the patient/user than the provider(s).

Changes are clearly needed to the contracts of many involved in delivering care. In relation to publicly employed health professionals, many of these contracts are currently under discussion in the context of public sector modernisation, and others, such as the GP contract (dating back to 1989), need to be overhauled in order to reward the creation of teams and team working within primary care, and provide incentives for improved care. These new contracts need to reflect the integrated model of care and provide career trajectories for professionals within the health-care sector and for enhanced mobility where skills are transferable to other sectors.

One recently revised contract is the new consultant contract. It represents considerable progress and provides an opportunity to progress developments further. The contract has put multidisciplinary teams at the heart of hospital-based medical provision, increasing the potential for better safety standards and greater efficiency in hospitals. It has also fundamentally changed the governance structure within hospitals by establishing a clear line of accountability as consultants are managed by their clinical director who is directly accountable for ensuring that the terms and conditions of the contract are fulfilled by all. However, the contract as it stands does not promote/support the kind of cross-sectoral linkages needed for the fully integrated model of care to which policy is committed. For example, consultants need to be mandated to liaise with potential team members in primary or social care to ensure patients a smooth progression along the care pathway.

Training: Medical training is currently under review and must inculcate fully new methods of working to replace the old independent/sole practitioner model of medical practice. Medical students have to be taught about the costs of interventions, including the cost of drugs, so that they can participate as part of a responsible health delivery system in an era of reduced resources, both of the State and of the patients. Ongoing training of the existing medical professional is essential if Ireland is not to have to wait for two generations to reap the benefits of the more integrated health-care models. Similar changes in training are required in all other areas of health care. As in the case of all of the professions, there is a need for all areas of health-care practice to be properly regulated and to be answerable for their use of resources.

Governance: Governance in the health system needs to develop so that there is a clear line of accountability linking Clinical Directors in hospitals to care professionals in the primary and social care sectors. For the patient care pathway to be secured, the connection between these Clinical Directors and the primary and social care sectors must be two way, i.e. Clinical Directors need to be connected locally, and this should happen through their links into the local HSE offices. Furthermore, structures within the hospital sector need to link financial and care decision-making so that managers and clinicians can work effectively together to achieve safe, high-quality, cost-effective provision of health care. In addition, if there is not adequate investment in training to realise fully the potential of the contract (for example, joint training for clinicians and managers), especially for clinical directors, then this will act as a barrier to realising the expected improvements in both patient safety and the cost effectiveness of the sector. As noted in Chapter 4, there needs to be a planned development of governance structures in both the primary care and community/continuing care sectors, so that they can play the role required of them if Ireland is to make the transition successfully to a model of integrated care.

Institutions: The integrated medical models involve the delivery of more care in the community rather than in hospitals. This creates new challenges for the health-care system as there are fewer promotion opportunities for other health-care professionals outside of the hospital sector.[110] Consequently it is to be expected that these changes will not be greeted with enthusiasm by certain health-care professionals, notwithstanding their acceptance that the changes are clearly in the interests of the society at large, and especially the most vulnerable and needy in that community. Over time, as with any structural adjustment, new roles will emerge, especially as services develop locally to meet and match local need, and considerable management expertise will be required to effect these changes.

Structures: The move from medical to social models of care for certain groups in the community (e.g. individuals with a disability) also creates new challenges for the sector. In the Irish context, as the provision of services shifts from institution-centred settings to person-centred settings, HSE personnel at local level will have a major role in co-ordinating care provision. Furthermore, the local HSE personnel will have to work in a systematic way on developing multidisciplinary primary care teams, a project that is estimated to take some time to complete, as it has done in other countries.

The Group's intention in drawing attention here to potential barriers to change is to highlight the need for these barriers to be addressed systematically. Without their being addressed, it will not be possible for Ireland to reap the potential benefits of its investment in health care. Either the health of the population will suffer and/or the costs of health care will rise beyond what we can afford.

[110] In some ways, this mirrors what has happened in some high technology sectors, where average company size has reduced with consequences for the promotion possibilities of those employed in the sector.

6.5 Implementing Changes

Some thirty four recommendations for action were proposed in Chapter 5. Because these have been drawn up within the framework of the guiding principles, the Group is confident that significant progress can be made on these over the coming three years, and that the impact of these individual changes will move the health system in Ireland in the right direction. The benefits in terms of reduced health costs cannot readily be measured, but there are clear efficiency gains inherent in the system and good management will realise the cost savings from them.

The approach taken by the Group was holistic, and hence its recommended actions run right throughout the system. The connecting thread between the recommended changes in resource allocation systems and the methods of financing health care is the need for Ireland to realise the full potential of integrated health-care delivery centred on the patient. The adoption of the integrated model is central to the safety of patients and the sustainability of the health-care system. The changes are not dramatic, but over a very short period, they will serve to reduce the gap between the aspirations of Irish health-care policy and what is delivered on the ground.

In presenting its report to the Minister, and in providing 600 pages of evidence to support a better and fairer health-care system, the Group sees paths to its implementation process: one related to the resource allocation model and one in relation to financing.

Since the resource allocation model introduces changes to how the Department of Health and Children, the HSE, and all practitioners and providers of health and social care operate, it is essential that an implementation body of experienced, disinterested, non-partisan, and independent experts be set up to ensure that recommendations in this report that are accepted by government are implemented. Given the seriousness of Ireland's fiscal challenges and the growing demands for increased safety and quality in the delivery of health care, it would be important that this body would get full compliance with its implementation plans and be in a position to deal with any obstructive behaviour in relation to the implementation process. This implementation body should be supported by representatives of the hospital, primary care, and social care sectors, by HSE financial, human resources, and general managers, and by representatives of the professional bodies and the patient/client advocacy groups.

To be able to operate effectively, the implementation body need access to accurate and timely information from the HSE, and the HSE's full co-operation in undertaking its various tasks. The agreed plan for the health system should be launched publicly, a set of milestones announced, and compliance monitored and reported publicly on a quarterly basis. If milestones are missed, a full accounting of why must also be reported, and an adjusted timeline announced. The spirit of transparency that is associated with HealthStat augurs well for the success in using information to

drive change. As the health and social care system is being restructured to become patient centred, the transition to this system should be monitored by those same patients, so they too can evaluate progress.

In relation to the future financing of the health-care system, the Group suggests that the first step is to create an understanding among health policy makers that the key issue is not whether Ireland has a social health insurance model or continues to fund health care out of taxation, but rather how to structure the financing system so that it supports the stated health-care objectives. The Group developed a framework to illustrate how a rational and integrated structure can be used to achieve greater fairness in access to care and to support greater use of primary care services for those with chronic diseases. The illustrative framework involves moving to a simpler more coherent system from the present system, which is highly complex and incoherent in terms of meeting stated health objectives, consequently resulting in perverse incentives and inequities. The Group believes that moving to a more rational framework would be of considerable benefit, recognising that the speed of implementation will depend on available resources.

6.6 Future Potential

The Group believes that its recommendations, building on earlier reports contributing to health-care reform, can assist in improving Ireland's health-care sector to deliver on the publicly stated objectives of the health-care system. The approach to improved resource allocation should deliver better value for expenditure on health care. The proposed changes to financing health care should improve access to health care for those most in need. The changes proposed in relation to payments for pharmaceuticals, building on welcome progress in this area in recent times, should help to improve the sustainability of the Irish health-care system. The increased flexibility linked to the 'Croke Park' agreements should see significant productivity gains within a short period, which will again support sustainability.

Health-care reform is an ongoing process. There is no single 'solution' to what people perceive as the challenges of meeting demands for a better health-care system, and these challenges are increased in a period budgetary constraints. While there is no such thing as the 'perfect health-care system', in that things will go wrong from time to time, the target must be to ensure that these are the rare exceptions and to provide appropriate responses when they do. The better the system of care in place, and the better the use made of the resources available, the fewer these exceptions will be.

The Group believes that the guiding principles for resource allocation, financing and sustainability in this Report provide a pathway to support Ireland in meeting its national health objectives.

REFERENCES

REFERENCES

Ayanian, J. Z., Guadagnoli, E. & Cleary, P. D. (1995) Physical and Psychosocial Functioning of Women and Men After Coronary Artery Bypass Surgery. *Journal of the American Medical Association,* 274(22)**,** 1767-1770.

Baumol, W. (1996) Children of Performing Arts, the Economic Dilemma: The Climbing Costs of Health Care and Teaching. *Journal of Cultural Economics,* 20(3)**,** 186-206.

Brennan, N. (2003) *Commission on Financial Management and Control Systems in the Health Service.* Dublin, Stationery Office.

Central Statistics Office (2007) SILC Microdata File. Government of Ireland.

Commission on Patient Safety and Quality Assurance (2008) *Building a Culture of Patient Safety. Report of the Commission on Patient Safety and Quality Assurance.* Dublin, Stationary Office.

Dail Eireann (2006) *Seanad Debates.* Available at:

http://debates.oireachtas.ie/Xml/29/DAL20060221.PDF [last accessed 29 May 2010].

DoHC (2001) *Quality and Fairness: A Health System for You.* Dublin, Stationery Office.

DoHC (2010) Health Service Reform Programme. Available at:

www.healthreform.ie/background/purpose.html [last accessed 09 May 2010].

Fulop, N., Protopsaltis, G., Hutchings, A., King, A., Allen, P., Normand, C. & Walters, R. (2002) Process and Impact of Mergers of NHS Trusts: Multicentre Case Study and Management Cost Analysis. *British Medical Journal,* 325(7358)**,** 246-249.

Green, L. A., Fryer, G. E., Jr. , Yawn, B. P., Lanier, D. & Dovey, S. M. (2001) The Ecology of Medical Care Revisited. *New England Journal of Medicine,* 344(26)**,** 2021-2025.

Langham, S., Basnett, I., McCartney, P., Normand, C., Pickering, J., Sheers, D. & Thorogood, M. (2003) Addressing the Inverse Care Law in Cardiac Services. *Journal of Public Health,* 25(3)**,** 202-207.

Layte, R. (Ed.) (2009) *Projecting the Impact of Demographic Change on the Demand for and Delivery of Healthcare in Ireland,* Dublin, Economic and Social Research Institute.

McCarthy, G., Tyrrell, M. P. & Cronin, C. (2002) *National Study of Turnover in Nursing and Midwifery.* Dublin, Department of Health and Children.

McGrail, K., Green, B., Barer, M., Evans, R., Hertzman, C. & Normand, C. (2000) Age, Costs of Acute and Long-Term Care and Proximity to Death: Evidence for 1987-1998 and 1994-1995 in British Columbia. *Age and Aging,* 29(3)**,** 249-253.

PA Consulting Group (2007) *Acute Hospital Bed Capacity Review: A Preferred Health System in Ireland to 2020.* London, PA Consulting Group.

PCRS (2010) Medical Card and Expenditure Data. Primary Care Reimbursement Service.

Revenue Commissioners (2008) *Office of the Revenue Commissioners Statistical Report (Year ended 31st December 2008).* Dublin, Irish Revenue Commissioners.

Smith, S. (2010) The Irish 'Health Basket': a Basket Case? *European Journal of Health Economics,* 11(3)**,** 343-350.

Staines, A., Vega, A., O'Shea, S. & Murrin, C. (2010) *Towards the Development of a Resource Allocation Model for Primary, Community and Continuing Care in the Health Services.* Volume I Executive Summary. Dublin, Health Research Board.

Staines, A., Vega, A., O'Shea, S. & Murrin, C. (2010) *Towards the Development of a Resource Allocation Model for Primary, Community and Continuing Care in the Health Services.* Volume II Technical Report. Dublin, Health Research Board.

Thomas, S., Normand, C. & Smith, S. (2008) *Social Health Insurance: Further Options for Ireland.* Dublin, The Adelaide Hospital Society.

Thomas, S., Ryan, P. & Normand, C. (2010) *Effective Foundations for the Financing and Organisation of Social Health Insurance in Ireland.* Dublin, The Adelaide Hospital Society.

Ulrich, R. S., Zimring, C. M., Zhu, X., DuBose, J., Seo, H.-B., Choi, Y.-S., Quan, X. & Joseph, A. (2008) A Review of the Research Literature on Evidence-Based Health Care Design. Georgia Institute of Technology. Available at:

www.healthdesign.org/hcleader/HCLeader_5_LitReviewWP.pdf [last accessed 01 July 2010].

Wanless, D. (2004) *Securing Good Health Care for the Whole Population: Final Report* London, HM Treasury.

WHO Europe (2008) The Talinn Charter: Health Systems for Health and Wealth. Available at: http://www.euro.who.int/__data/assets/pdf_file/0008/88613/E91438.pdf [last accessed 09 May 2010].

Wren, M. A. (2010) *The Influence on Acute and Long-Term Care Utilisation of Female Labour Force Participation and Converging Life Expectancies.* Unpublished, PHD Thesis Chapter.

APPENDIX

APPENDIX

(Prepared by the Department of Health and Children)

A.1 Previous Reports/Studies on Resource Allocation in Irish Health Care

A number of key reports/studies have been undertaken in the past on resource allocation in Irish health care and are relevant in the context of this current examination. The key relevant reports focused on here are:

- Report of the Commission on Health Funding, published September 1989
- Quality and Fairness, A Health System for You, Health Strategy, published November 2001
- Audit of Structures and Functions in the Health System - the 'Prospectus Report', published June 2003
- Commission on Financial Management and Control Systems in the Health Service - the 'Brennan Report', published June 2003

A.1.1 The Report of the Commission on Health Funding

The Commission on Health Funding was established in June 1987 under the Chairmanship of Miriam Hederman O'Brien and published its report in September 1989. The Commission was asked by the Government '*to examine the financing of the Health services and to make recommendations on the extent and sources of the future funding required to provide an equitable, comprehensive and cost-effective public health service and on any changes in administration which seem desirable for that purpose*'.[111]

The Commission examined the rationale for the collective funding of the health services and considered the implications of '*a market allocation contrasted with a public allocation of resources for such services*'. It recommended inter alia[112] that:

- the Irish Health Services should continue to be primarily tax funded and publicly regulated (a majority of the Commission made this recommendation; a minority saw advantages in a system based on ear-marked tax)
- the lowest income group should remain eligible for all necessary health services free of charge
- non-medical cardholders should be eligible for a group of publicly -funded core services comprising specified acute hospital care, long-term care and person social services
- modest user chargers may have a useful role to play in a public funding system provided that they are regulatory in nature and do not impose hardship on patients.

[111] Report of the Commission on Health Funding, Government Publications, September 1989; 1.

[112] Report of the Commission on Health Funding, Government Publications, September 1989; 99-100.

A.1.1.1 Status/Implementation

- Health Services in Ireland continue to be primarily tax funded, in accordance with the findings of the Commission
- the lowest income group remain eligible for all necessary health services free of charge[113]
- modest user charges (medical card-holders and some other groups are exempt from these charges)[114], are applied to the public health service in Ireland as follows:
    - Emergency Department (A&E) = a standard charge of €100 (no charge if referred by GP)
    - In-patients - charged a standard fee of €75 per night, up to a maximum of €750 in one year
    - Long-stay patients – charges may be imposed on long-stay or extended care patients in HSE public care, up to a maximum of €153 per week[115]
- Nursing Homes Support Scheme, A Fair Deal – since 27 October 2009 all new entrants to long-term residential care in 'public nursing homes' pay contributions to their care.[116]

A.1.2 Quality and Fairness, A Health System for You Health Strategy, 2001

The National Health Strategy, 'Quality and Fairness: A Health System for You' was published by the Department of Health and Children in November 2001. It provides a vision and strategic direction for the provision of the health and personal social services and sets out the key objectives for the health system up to 2010.

In regard to resourcing health, a full range of options for funding methods was considered in the preparation of the Strategy. Having considered the alternatives, the Strategy concluded, '*it is clear that none would deliver significant improvements over the present tax-based method, while each would undermine the ability of the system to delivery the expansion of capacity required both immediately and across the next decade*'.[117] The Strategy also stated that the reforms to the existing funding system, which it outlined, would address clear deficiencies without diverting resources away from the needs of core services.

[113] To address rising costs in both the GMS and Long Term Illness schemes, and to influence to some degree demand and prescribing patterns, Budget 2010 provided for a 50 cent charge per prescription item to be introduced, subject to a monthly ceiling of €10 per family. The details will be set out in new legislation which is required to give effect to the introduction of prescription charges.

[114] This charge is not applicable if your are in one of the following groups: Medical card holders; People admitted to hospital after attending the emergency department (you will then be subject to in-patient/day service charges);People receiving treatment for prescribed infectious diseases; People who are entitled to hospital services because of EU Regulations.

[115] The Regulations provide for different charging arrangements, depending on the level of nursing care being provided. www.hse.ie/eng/services/Find_a_Service/Older_People_Services/Benefits_and_Entitlements/Hospital_charges.html

[116] www.hse.ie/eng/services/news/Campaigns/nhss.shortcut.html

[117] Quality and Fairness, A Health System for You, Health Strategy, Department of Health and Children November 2001; 11

The Health Strategy also identified two main problems in the resource allocation system[118]:

- The perceived inflexibility and uncertainty of the current allocation system, which is centred on the annual estimates and budgetary cycle is seen as a weakness and highlights the need for longer term planning
- Concerns about capacity and the configuration of services underline the need for ongoing capital investment, expansion in acute hospital services and substantial strengthening of primary and community care services.

The report highlighted a clear need to ensure that funding is allocated based on implementing sound strategic plans and that funding clearly relates to service outcomes. Performance measurement and transparent, evidenced-based allocations are essential elements of this. A key action set out in the report (action 96) states '*it is important to reduce the dependency on incremental approaches, which are influenced significantly by the allocation given in a previous year. The amounts allocated by the Department to each health board must take full account of all relevant local factors so that the available funding is distributed fairly and to the best effect. In particular, account must be taken of the specific needs of the population, which may vary between boards, depending on age profile, morbidity and income levels. The Department of Health and Children will examine the current system for allocating funding to health boards with the aim of taking as much account as possible of specific local factors.*'[119]

Quality and Fairness also recognised the importance of allocating funding based on sound strategic plans via two actions 95 and 98, which would relate funding to service outcomes:

- Action 95 – Multi-annual budgeting will be introduced for selected programmes
- Action 98 – Annual statements of funding processes and allocations will be published.

[118] Quality and Fairness, A Health System for You, Health Strategy, Department of Health and Children November 2001; 52

[119] Quality and Fairness, A Health System for You, Health Strategy, Department of Health and Children November 2001; 113

A.1.2.1 Status/Implementation

Immediately after the adoption of the Health Strategy, the Government acted by commissioning major reports on the health system (i.e. Prospectus Report, Brennan Report), the Health Boards were abolished and the HSE established, representing the biggest transformation of health services in the history of the state.

The Expert Group on Resource Allocation and Financing in the Health Sector has addressed some of the problems in the resource allocation system identified in the Health Strategy, but yet to be implemented, by its recommendations on

- national priorities determined and planned on the basis of population health needs
- prospective funding for acute hospitals
- population based health funding
- shifting of capital investment from acute care to primary and continuing care.

A.1.3 Audit of Structures and Functions in the Health System - the 'Prospectus Report', June 2003

The central theme of this report is the need to consolidate fragmented structures and functions to enable the health system deliver sustained value for money and a high quality of service for consumers. This report highlighted the impact of the public/private mix as a funding model in Ireland. It acknowledged '*attempts to plan, deliver and evaluate public services are complicated by this mix at a number of levels*'.[120] In order to address this, the report suggests that the '*complementarity of the public and private systems referred to in the Health strategy*' *need to be taken account of in order to promote opportunities for joint planning and shared delivery of services or facilities*'.[121]

The report goes on to describe the system of resource allocation as incremental, almost in its entirety; sectoral, with each programme or service being considered individually; developmental, focussed on 'new money'. The report summarises that this '*compounds the fragmentation of service planning from the top of the system all the way through to the patient*'[122].

[120] Audit of Structures and Functions in the Health System – Prospectus Report, June 2003; 47

[121] Audit of Structures and Functions in the Health System – Prospectus Report, June 2003; 47

[122] Audit of Structures and Functions in the Health System – Prospectus Report, June 2003; 47

The report also identifies key factors that are fundamental to ensuring that financial management and control processes support coherent planning[123]:

- The need to inject strategic coherence and evidenced based analysis into the funding process
- The need to ensure that both strategic and operational planning functions are present within the health system
- The need to incentivise behaviour in support of system priorities, with funding seen as an important mechanism to achieve this aim
- The need to quantify and measure more clearly exactly what outcomes are anticipated from the totality of resources available.

A.1.3.1 Status/Implementation

The DoHC and HSE have embarked on a wide range of planning initiatives to tackle some of the issues identified in this report, examples of which can be found in primary care, reconfiguration of hospitals and the cancer care programme.

The HSE National Service Plans are clear on the output expected for funds provided each year; measurement of outcomes has proved difficult, reflecting the experience in other health systems.

A.1.4 The Commission on Financial Management and Control Systems in the Health Service - the 'Brennan Report', published June 2003.

The 'Brennan Report' is undoubtedly the most relevant previous report in the context of this Groups' deliberations. It carried out a detailed examination and review of the financial management and control systems in the Irish health service and made recommendations on improving the effectiveness of those systems. It addressed structural and organisational issues that it felt to be necessary to improve the management of public expenditure.

The Commission found problems in the existing systems, including[124]:

- the absence of any organisation responsible for managing the health service as a unified national system
- systems are not designed to develop cost consciousness among those who make decisions to commit resources and provide no incentives to manage costs effectively
- insufficient evaluation and analysis of existing programmes and related expenditure
- inadequate investment in information systems and management development.

[123] Audit of Structures and Functions in the Health System – Prospectus Report, June 2003; 64

[124] The Commission on Financial Management and Control Systems in the Health Service - the 'Brennan Report', published June 2003; 5

The Commission adopted four core principles in addressing the problems:

- the health service should be managed as a national system
- accountability should rest with those who have the authority to commit the expenditure
- all costs incurred should be capable of being allocated to individual patients
- good financial management and control should not be seen solely as a finance function.

The Commission made 136 recommendations including:

- the establishment of an Executive to manage the Irish health service as a unitary national service
- a range of reforms to governance and financial management, control and reporting systems to support the Executive in the management of the system
- the designation of Clinical Consultants and GP's as the main units of financial accountability in the system
- substantial rationalisation of existing health agencies
- all future Consultant appointments to be on the basis of contracting the Consultants to work exclusively in the public sector; more transparent arrangements for existing Consultants
- reform of the medical card scheme to include a Practice Budget for each GP, monitoring of activity and referral patterns etc
- strengthening the process of evaluation of clinical and cost effectiveness for publicly funded drug schemes.

A.1.4.1 Status/Implementation

Many of the recommendations have been put into effect. However, a number of important recommendations have not yet been implemented.

These include:

- the Role of the Executive should include the resource allocation process (R3.7 (v)) – The HSE does allocate resources but largely on an incremental budget basis. As stated above this issue is being tackled by this Group through its recommendations
- integrated financial and non-financial data. Formal and clear inter-connections are needed between cost (approved determination) and activity (level of service being provided) (R4.3 (ii))
- annual Reports and Financial Statements should specifically link back to financial and activity performance envisaged in the Service Plan (R.4.4 (iii))
- funding of regional health boards should be evidence based and prioritised across identified needs (R.4.6/R4.7)
- multi Annual Budgeting - Service Plans should be framed on a multi-annual basis, structured to allow for annual adjustments to the funding base. Each year's plan should be adjusted accordingly to fit the letter of determination. (Not done for revenue side; in progress on capital side) (R4.8)

- Recommendations on the Public Private Mix and Service Planning - (R5.20/ R5.22/R5.23/R5.24) – While these recommendations have not yet been fully implemented, some progress has been made in tackling related issues as follows:
    - **R5.20** – Under the HIPE system, patients can be identified as in-patients and day cases based on the patients admission and discharge dates; the patients status of public or private is coded (this refers to the public/private status of the patient on discharge and not to the type of bed occupied during their stay in hospital).
    - **R5.22/R5.23** – The full cost of treating private patients in public hospitals is being assessed by a group established by the DoHC under the Value for Money and Policy Review Initiative 2009-2011 for the Health Services. An interim report has been produced with the final report being finalised shortly. This work will inform the implementation of these recommendations.
    - A central objective of the new consultants' contract is to improve access for public patients to public hospital services. The contract sets out clear new rules on the mix of public-private practice that may be undertaken by consultants and new measures to manage these rules by newly appointed clinical directors.[125] The HSE has put a monitoring system in place to report on public/private activity as provided for in the new contract.[126] These contractual features complement the existing bed designation arrangements.
- Service Planning in non-hospital programmes – in all other areas of the health service (i.e. non-hospital), the individual responsible for the budget (whether clinical or non-clinical personnel) should be held formally accountable for financial performance. (R5.27)
- Information Technology - recommendations R10.1 – R 10.6.

[125] These include a total prohibition on consultants undertaking private practice (Type A contract holders) and a cap of 20 per cent of private activity for newly appointed consultants (Type B) (A cap of up to 30 per cent may apply in the case of certain existing consultants).

[126] Following a pilot testing phase the system is being used to monitor individual consultants actual level of private activity against the level allowed under his or her contract. The monthly report is given to the individual consultant as well as to the Hospital Manager and Clinical Director concerned. This information provides the basis to follow up with individual consultants who are exceeding their specified private practice ratio.

A.2 Summary of Findings of Submissions to the Expert Group on Resource Allocation and Financing in the Health Sector

A.2.1 Introduction

As part of its deliberations, the Expert Group sought submissions from the public and relevant interested groups/parties on the issues within its remit. The Call for Submissions was advertised in the national and medical press with a closing date of 19 June 2009, extended to 30 June 2009. Submissions were asked to focus on:

- suggestions for change in the resource allocation system to enhance delivery of the core objectives of health reform
- providing access to the care/treatment that people need as quickly as possible
- equity of access and
- ensuring this is done in a sustainable way.

Over sixty written submissions were received (see Annex for a list of those who made submissions). While many of the submissions made did not concentrate on the above brief (some were not relevant to the remit, others focused largely on issues specific to their own areas and few addressed sustainability) some common themes and useful insights have emerged. As would be expected, many of the submissions speak in general terms about the importance of equity, access, transparency and the amount of health funding, to the public health-care system.

A.2.2 Main Themes

The main themes in the submissions related to the following issues:

A.2.2.1 Strengths and Weaknesses of the Current Resource Allocation System

Most of the submissions focused on perceived weaknesses in the current system, i.e.

- annual budgets and block grant application of funds
- current resource allocation based on historical arrangements rather than population needs
- absence of quality management and activity information systems
- resources do not follow the service user/patient
- lack of access to a GP at primary care level.

A.2.2.2 Recommendations for Changes to the Resource Allocation System

The submissions received included the following recommendations:

- adopt multi-annual budgets
- funding should follow the service user rather than being allocated to particular service provider
- only core health services should be included in the health budget
- eliminate duplicate payments to NTPF for services provided by public system
- need to move to population health based funding incorporating casemix funding on a phased basis
- need for significant investment in PCCC
- link payment to quality and outcome measures
- introduce a split between payer and provider of services
- need for incentives to encourage the delivery of care in manner consistent with goals of public health-care system
- need to utilise health technology assessment (HTA) to ensure VFM (Value for Money)
- need for flexibility in resource allocation to facilitate person-centredness
- resource allocation needs to be based on a long-term perspective involving health promotion and disease prevention initiatives.

A.2.2.3 Changes in Existing Financing Arrangements

The submissions that commented on financing arrangements suggested the following:

- consider the introduction of social health insurance
- universal health insurance needs to assessed
- reduce exchequer funding on health from 77 per cent to 60-65 per cent with a shift to citizens via co-payments or greater insurance coverage.

A.2.3 Areas of Agreement

There are a number of areas of agreement in the submissions regarding the current resource allocation system, recommendations for changes to that system and financing arrangements. These are considered in turn.

A.2.3.1 Current Resource Allocation Arrangements

The main areas of agreement, which centre on perceived weaknesses in the current system, concern the use of annual budgets and block grant application of funds and resources not following the service user/patient. The issues raised in the submissions to the Expert Group on these points include:

- inadequate health services and regional disparity in the allocation of funding for services as a result of historical funding arrangements;
- annual budgeting and the subsequent delays in business planning, results in a less efficient and effective system for service users and a negative impact on value for money;

- block grant funding to service providers does not support an individual's choice of provider; money does not follow the patient, it follows the service;
- lack of transparency in terms of the allocation method and as a result of there being no national system of accounts or activity information systems;
- difficulties in terms of tracking resources and a lack of information on output/ outcomes particularly in the PCCC sector;
- concern that PCCC funds being sidetracked to meet the needs of acute care;
- current funding model creates an incentive for older people to remain within the public secondary care system, as there is a huge difference in cost between it and long-term care;
- there is no incentive for PCCC to provide timely services to patients who have been clinically discharged, which results in delayed discharges and a knock on effect throughout acute sector.

A.2.3.2 Recommendations for changes to the resource allocation system

The main areas of agreement in the submissions were on the need for multi-annual budgeting, that funding should follow the service user and the inclusion of only core health services in the health budget. Other areas of agreement were the need for information activity systems and the sustainability of health services. The issues raised on these points include:

Multi-Annual Budgeting:

- the introduction of multi-annual budgeting would allow for detailed long term planning, enabling services to run efficiently and meet the needs of patients
- ensuring the system could plan over a medium timeframe would in itself deliver efficiencies and effectiveness
- business plans should be agreed before the start of the year for more fluid service provision
- the importance of good work force planning
- a move to population/needs based funding would ensure funds are targeted at care groups and regions where they are most needed and should result in a more equitable and transparent distribution of funds.

Funding should Follow Service User:

- money should follow the patient rather than the service user having to fit into a system that does not meet his/her needs
- such a funding model would facilitate different elements of service being sourced from different service providers, and maximise the choice available to the individual
- a system that rewards for completion of care (avoiding admission or referral) would bring more efficiency.

Only Fund Core Health Services from Health Budget:

- separate the funding and provision of health and social services which is due to historical reasons as opposed to being the most effective way of allocating resources
- the Expert Group should assess the appropriateness of social services being part of its remit and deliberate on the desirability of transferring them to a separate entity.

Activity Information Systems:

- introduction of activity information systems would be integral to the planning process, enabling resources to be more focused on individuals' needs and aid the tracking of resources and highlight where there may be service deficits
- activity information systems are thought to be a prerequisite to ensuring an effective system of resource allocation and would greatly facilitate an individual's journey through the health services.

Sustainability:

- assess the drivers of growth in health-care expenditure and develop policy on the basis of what will deliver greatest return in terms of building efficient and effective health-care;
- good chronic disease management (CDM) would result in a much more cost effective system overall and improved health care for the many patients with such conditions;
- CDM should be GP based where possible, some citing HeartWatch as an example of this in practice;
- further developments are needed in formalised share care models between primary and secondary care in key disease areas such as diabetes and asthma to maximise the use of resources;
- priority should be given to investing in prevention and health promotion, as it is far cheaper to prevent than to cure illness;
- prompt access to diagnostic services was recommended as earlier identification results in less hospitalisation.

A.2.3.3 Changes in Existing Financing Arrangements

Many submissions recommended considering universal or social health insurance as a way of ending a perceived two-tiered system in terms of access. One submission recommended the introduction of co-payments. The arguments made in the submissions supporting ***social health insurance*** include:

- that it provides a ring-fenced form of funding that is much more acceptable to the population as a means of raising funds specifically for health purposes (if experience of other European countries were to apply
- social health insurance model funding will follow patient in a manner that will encourage closer and more cost-effective working arrangements between GPs, community care and hospitals.

The arguments made in the submissions supporting ***Universal Health Insurance*** include*:*

- universal health insurance is required to ensure that money follows the patient and that local governance is improved
- some felt that a move away from funding health services from general taxation would put an end to diverting public funds to private health care i.e., private health insurance and NTPF.

Co-payments:

- consideration should be given to introduction of co-payments as individuals currently fund circa 2 per cent of cost of care, which means that they are unaware of cost of care.

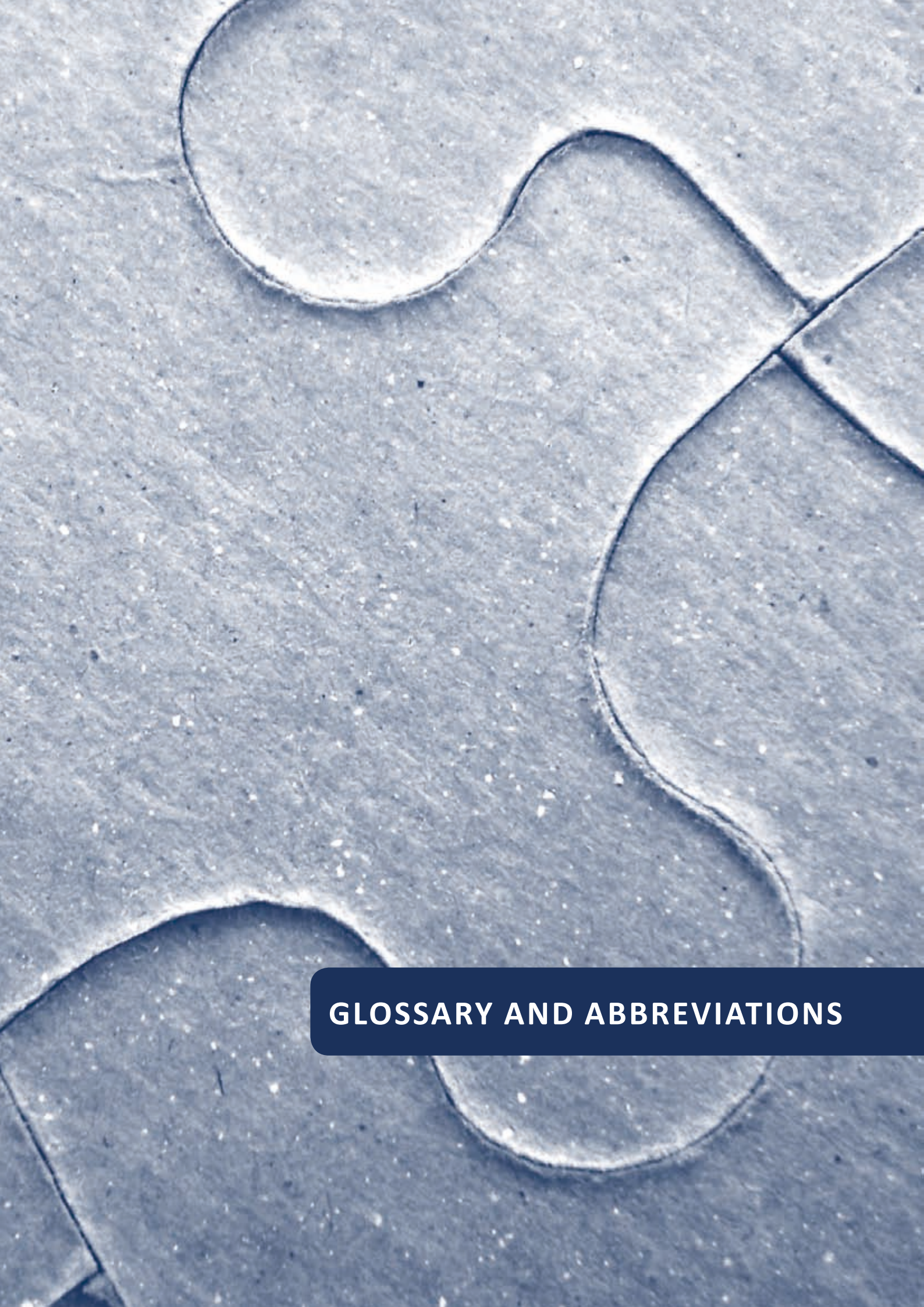
A.2.4 Areas of Disagreement

The submissions received did not reveal strong areas of disagreement, nevertheless there was some apparent difference regarding what model of funding might best suit integration of health care. Some advocated the transfer of funding and resources from the acute hospital sector to primary care, with the reduced demand on secondary care being accompanied by a reduced budget. Others argued for better chronic disease management and integration of health-care services to be provided by a redistribution of funds from the acute sector to primary care.

Annex: Submissions to Expert Group on Resource Allocation and Financing in the Health Sector

ORGANISATIONS:	
1	Adelaide and Meath Hospital, Dublin
2	Aspire
3	Barnardos
4	Boston Scientific
5	Caring for Carers Ireland
6	Competition Authority
7	Cúram
8	Diabetes Federation of Ireland
9	Disability Federation of Ireland
9	Enable Ireland
11	Euromedic
12	Health Insurance Authority
13	Health Management Institute of Ireland
14	Highfield Hospital Group- St Patrick's University Hospital-St John of God's Hospital
15	HSE Inequalities Steering Group
16	Impact
17	Inclusion Ireland
18	Independent Hospital Association of Ireland
19	Intensive Care Society of Ireland
20	Irish Association for Emergency Medicine
21	Irish College of General Practitioners
22	Irish Commission for Justice and Social Affairs
23	Irish Consultant Orthodontic Group, representing HSE orthodontic services
24	Irish Dental Association
25	Irish Hospice Foundation Also; St Francis Hospice
26	Irish Medical Organisation
27	Irish Mental Health Coalition
28	Irish Nurses Organisation
29	Irish Pharmaceutical Healthcare Association
30	Irish Platform for Patients' Organisation, Science and Industry
31	Irish Rural Link
32	Irish Society for Quality and Safety in Healthcare

ORGANISATIONS:	
33	Jesuit Centre for Faith and Justice
34	Mallow Primary Healthcare Centre
35	Mental Health Commission
36	National Disability Authority
37	National Federation of Voluntary Bodies
38	National Parents and Siblings Alliance
39	National Treatment Purchase Fund
40	National Women's Council of Ireland
41	Neurological Alliance of Ireland
42	Not for Profit Business Association
43	Pharmaceutical Society of Ireland
44	St Francis Hospice
45	St Vincent de Paul Society
46	Talbot Associates, Management Consultants
47	Vhi
48	Women's Health Council
49	Zehnacker Healthcare Providers
Individuals:	
50	Alice Gormley, Occupational Therapist, Cavan General Hospital
51	Chief Pharmacists, Our Lady of Lourdes and Louth County Hospitals
52	Consultant Neurologists, St Vincent's University Hospital
53	Dr Fergus O'Farrell
54	Dr Liam O'Siorain, Consultant in Palliative Medicine, Our Lady's Hospice and St James's Hospital
55	Dr Pascal O'Dea
56	Edel McGinnity, GP, Riverside Medical Centre, Mulhuddart
57	HSE Childcare Managers, HSE Dublin South and Wicklow
58	Michael Fitzpatrick, Chief Pharmacist, Our Lady's Childrens Hospital, Crumlin
59	Prof Dermot Power
60	William Dunne
61	Aine Ennis, Research, Registration and Inspection, Regional Child Care Development Unit, HSE South.



GLOSSARY AND ABBREVIATIONS

GLOSSARY*

Acute Care	Health care in which a patient is treated for a brief but severe episode of illness, such as an emergency or other trauma, or during recovery from surgery. Acute care is usually provided in a hospital and it may involve intensive or emergency care.
Acute Hospital	A hospital providing medical and surgical treatment of relatively short duration.
Advanced nurse practitioner/ advanced midwife practitioner	Advanced nursing and midwifery practice is carried out by autonomous, experienced practitioners who are competent, accountable and responsible for their own practice. They are highly experienced in clinical practice and are educated to masters degree level (or higher).
Allocative Efficiency	Combining inputs and/or outputs in the best possible proportions given prevailing prices.
Bed Designation	The assigning of beds in public hospitals for sole use by public or private patients.
Bundled Payment	A single payment for all services related to a specific treatment or condition (for example, *coronary artery bypass graft* surgery), possibly spanning multiple providers in multiple settings.
Capitation Fee	A method of payment for health services in which the provider is paid a fixed, per capita amount.
Casemix	A method of quantifying hospital workload by describing the complexity and resource-intensity of the services provided. This differs from a simple count of total patients treated or total bed days used.
Chronic Disease Management (CDM)	An approach which is designed to address the systemic barriers to effective care and establish evidence based standards of care for particular conditions.
Chronic Disease/ Illness	A long-term condition, lasting more than 6 months, that is non-communicable and involves some functional impairment or disability and that is usually incurable.
Clinical Nurse Specialist	A nurse specialist in clinical practice who has undertaken formal recognised post-registration education relevant to his or her area of specialist practice at higher diploma level. Such formal education is underpinned by extensive experience and clinical expertise in the relevant specialist area.
Community Rating	Requires that the same premium is charged for a particular insurance product to all individuals, regardless of individual characteristics (e.g. age, sex, health status).
Co-Insurance	The user pays a fixed proportion of the total cost, with the insurer paying the remaining proportion. See also cost sharing.
Co-Payment	The user pays a fixed fee (flat rate) per item or service. See also cost sharing.

* Since this Report is directly linked to the Evidence Report, the same glossary is used in both. Consequently there are some terms in this glossary that are not used in the Expert Group Report itself.

Cost Sharing	Requires the covered individual to pay part of the cost of care received. This can take a number of forms including co-insurance, co-payments and deductibles.
Cream Skimming	The practice of selecting only those patients who are expected to generate a low workload.
Creaming	The overprovision of services to low severity patients.
Day Patient	A patient admitted to hospital for treatment on a planned (rather than an emergency) basis and who is discharged on the same day.
Deductible	The user bears a fixed quantity of the costs, with any excess borne by the State/insurer; deductibles can apply to specific cases or to a period of time.
Delayed Discharge	A patient whose treatment has concluded and who is medically fit to be discharged, but who cannot or will not leave the hospital for other reasons.
Diagnosis-Related Group	A group of cases with similar clinical attributes and resource requirements.
Discharge Planning	The active planning of discharge and post-discharge services for patients.
Dispensing Fee	A fee paid to pharmacists in respect of a prescription filled.
Dumping	The explicit avoidance of highly complex patients.
Economic Sustainability	Refers to the growth in health-care spending as a proportion of national income.
Economic Cost	Includes the direct and indirect costs of providing a service.
Elective Treatment	A planned or non-emergency admission or procedure that has been arranged in advance. This differs from emergency treatment that is urgently required.
Eligibility	Refers to whether or not an individual qualifies to avail of services.
Entitlement	A right to benefits or services granted by law or contract.
Evidence-based Practice	Practice which incorporates the use of best available and appropriate evidence arising from research and other sources.
Ex-Factory Price	The manufacturer's posted price, in some countries also referred to as the list price.
Ex-Wholesale Price	The ex-factory price plus wholesale mark-up, also known as the ingredient cost.
Fee-for-Service	A method of provider payment where providers receive a payment for each item of service provided.
Fiscal Sustainability	Refers to the ability of public revenue to meet public expenditure on health care.
Fixed System of Reimbursement	A payment system where the reimbursed amount does not change as activities increase or decrease.
Generic Drug	The bioequivalent of a branded original pharmaceutical whose patent on the active ingredient has expired.

Generic Substitution	The substitution of a generic drug for an identical brand-name drug that has lost its patent protection.
Global Budget	A budget at the hospital level set in advance to cover the aggregate expenditures of a hospital over a given period (usually one year) to provide a set of services that have been broadly agreed on by the hospital and the purchaser.
Ingredient Cost	Ex-factory price plus wholesale mark-up, also known as the ex-wholesale price.
In-patient	A patient admitted to hospital for treatment or investigation who stays for at least one night.
Interdisciplinary or Multidisciplinary Approach	The term used to describe professionals from more than one discipline working together in a co-ordinated way.
Multi-Annual Budgeting	A system of budgeting where money is allocated for more than one year.
Off-Patent	A product not covered by a patent or supplementary protection certificate.
Out-of-Pocket Fee	A direct payment by the user at the point of use. See also user fee.
Out-patient	A patient who attends a hospital clinic for treatment and is not admitted to the hospital.
Parallel Importing	The legal importation of a patented product from one country where it is legally marketed into a second country where the patent holder also markets that product, but without the authorisation of the patent holder.
Pay for Performance	In the context of provider payment, the payment of providers according to achievement on structure, process or outcomes of care.
***Per diem* Payment**	A payment (generally determined in advance) per day.
Pharmacoeconomic Assessment	Health technology assessment for drugs and medicines.
Pre-Payment	Payment in advance of use.
Preventive Care	Refers to measures to prevent disease, rather than treatment and cure.
Primary Care	An approach to care that includes a range of services designed to keep individuals well, from promotion of health and screening for disease to assessment, diagnosis, treatment and rehabilitation as well as personal social services. The services are usually directly accessible by individuals and are generally their first point of contact with the health service.
Progressivity	A payment is progressive if richer individuals pay more as a proportion of their income relative to poorer individuals.
Proprietary Drug	The first version of a pharmaceutical developed and patented by an originator pharmaceutical company which receives exclusive rights to market the product for a specified period of time.

Prospective Reimbursement	A payment system where the provider's payment rates or budgets are determined *ex ante*. Contrary to retrospective systems, there is no link with the individual costs of the provider.
Protocol	A plan specifying the procedures to be followed in providing health and social care. Protocols specify who does what, when and how.
Purchaser–Provider Split	The separation of purchasing and providing roles in health care.
Reference Pricing	A system whereby the public subsidy for drugs within a particular subgroup is set at a level determined by low cost alternatives within that subgroup (with patients required to pay the excess cost if they wish to use drugs priced above the reference-based subsidy).
Regressivity	A payment is regressive if poorer individuals pay more as a proportion of their income relative to richer individuals.
Retrospective Reimbursement	A system in which the provider's own costs are fully (or partially in certain systems) reimbursed *ex post*.
Risk Adjustment	In the context of provider payment, the process whereby payments are adjusted for characteristics of the individual that are associated with need for health care (e.g. age, sex, chronic illness, etc.).
Risk Equalisation	The transfer of funds within an insurance market to compensate companies for less favourable risk profiles.
Risk Management	The prevention and containment of liability by careful and objective investigation and documentation of critical or unusual patient care incidents.
Salary	A method of provider payment where providers receive a fixed payment for a defined period of time (usually per annum).
Skimping	The underprovision of services to highly complex patients.
Technical Efficiency	Maximising output produced for given inputs and within existing technology (or conversely, by using the minimum amount of input possible to produce a given level of output).
Upcoding	The systematic misrepresentation of patient data to receive higher reimbursements.
User Fee	A direct payment by the user at the point of use. See also out-of-pocket fee.
Variable System of Reimbursement	A payment system where variation in activities induces changes in payment.
Whole Time Equivalent	A measure of the number of individuals working in an organisation which takes into account the number of hours worked by both full- and part-time staff and expresses this in terms of the number of individuals working full-time that it would take to carry out the same work.

ABBREVIATIONS*

ACCEA	Advisory Committee on Clinical Excellence Awards
ACE	Angiotensin-converting Enzyme
ADRG	Adjacent Diagnosis-Related Group
AfC	Agenda for Change
AFS	Annual Financial Statement
APMI	Association of Pharmaceutical Manufacturers of Ireland
AR-DRG	Australian Refined Diagnosis-Related Group
ATC	Anatomical, Therapeutic and Chemical Classification
AWBZ	Exceptional Medical Expenses Act (Netherlands)
BMI	Body Mass Index
CAG	Comptroller and Auditor General
CCM	Chronic Care Model
CDM	Chronic Disease Management
CDS	Community Drugs Schemes
CEA	Clinical Excellence Award
CEO	Chief Executive Officer
CIC	Community Interest Company
CMS	Centers for Medicare and Medicaid Services
CPI	Consumer Price Index
CPU	Corporate Pharmaceutical Unit
CQUIN	Commissioning for Quality of Innovation
CRS	Constant Returns to Scale
CSO	Central Statistics Office
CUH	Cork University Hospital
CUMH	Cork University Maternity Hospital
DBC	Diagnose Behandelings Combinaties (Netherlands)
DEA	Data Envelopment Analysis
DFLE	Disability Free Life Expectancy
DHB	District Health Board
DMP	Disease Management Programme
DoHC	Department of Health and Children
DP	Drugs Payment

* Since this Report may be read in tandem with the Evidence Report, the same abbreviations are provided for both reports for convenience. Consequently there are some abbreviations in this list that are not required for this report.

DQTC	Drug Quality and Therapeutics Committee
DRG	Diagnosis-Related Group
DTS	Dental Treatment Services
EAG	(Mental Health) Expert Advisory Group
ECG	Electrocardiogram
ED	Emergency Department
EEA	European Economic Area
EHR	Electronic Health Record
EPC	Enhanced Primary Care
EPP	Expert Patients Programme
EPR	Electronic Patient Record
ERHA	Eastern Regional Health Authority
ESRI	Economic and Social Research Institute
EU	European Union
EURONHEED	European Network of Health Economic Evaluation Databases
FAMA	Frequent Adult Medical Admission
FHT	Family Health Team
FMG	Family Medicine Group
FTE	Full Time Equivalent
GDP	Gross Domestic Product
GDRG	German Diagnosis-Related Group
GMS	General Medical Services
GMSPB	General Medical Services (Payments) Board
GNI	Gross National Income
GNP	Gross National Product
GP	General Practitioner
GST	Goods and Sales Tax
HAA	Health (Amendment) Act 1996
HCC	Hierarchal Condition Code
HCP	Home Care Package
HEDIS	Health Plan Employer Data and Information Set
HHS	(Department of) Health and Human Services
HICP	Harmonised Index of Consumer Prices
HIPE	Hospital In-Patient Enquiry
HIQA	Health Information and Quality Authority

HMO	Health Maintenance Organisation
HPSG	Hospital Procurement Services Group
HR	Human Resources
HRG	Healthcare Resource Group
HSCN	Health and Social Care Network
HSE	Health Service Executive
HSE-COS	HSE Community Ophthalmic Services
HTA	Health Technology Assessment
HTD	High Tech Drug
HUHC	High Use Health Card
ICER	Incremental Cost-Effectiveness Ratio
ICGP	Irish College of General Practitioners
ICT	Information and Communication Technology
ICTU	Irish Congress of Trade Unions
IDTS	Indicative Drug Target Scheme
IHF	Irish Heart Foundation
IMB	Irish Medicines Board
IMO	Irish Medical Organisation
INDC	Independent National Data Centre
INN	International Non-Proprietary Name
IPHA	Irish Pharmaceutical Healthcare Association
IPU	Irish Pharmaceutical Union
ISA	Integrated Services Area
ISD	Integrated Services Directorate
ISER	Incentivised Scheme of Early Retirement
ISIC	International Standard of Industrial Classification
IT	Information Technology
JES	Job Evaluation Scheme
KFH	Kaiser Foundation Hospital
KFHP	Kaiser Foundation Health Plan
KPNC	Kaiser Permanente North California
LDL	Low Density Lipoprotein
LHIN	Local Health Integration Network
LHO	Local Health Office
LTI	Long Term Illness

MBS	Medicare Benefits Schedule
MoHLTC	Ministry of Health and Long-Term Care
MS-DRG	Medicare Severity Diagnosis-Related Group
MT	Methadone Treatment
MVZ	Medizinische Versorgungszentren (Germany)
NCCP	National Cancer Control Programme
NCHD	Non-Consultant Hospital Doctor
NCPE	National Centre for Pharmacoeconomics
NEMU	National Employment Monitoring Unit
NESF	National Economic and Social Forum
NHO	National Hospitals Office
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NSW	New South Wales
NTPF	National Treatment Purchase Fund
NUI	National University of Ireland
ODB	Ontario Drug Budget
OECD	Organisation for Economic Co-operation and Development
OOH	Out-of-Hours
OTC	Over- the-Counter
PA	Programmed Activity
PAYE	Pay As You Earn
PBC	Practice Based Commissioning
PBS	Pharmaceutical Benefits Scheme
PCCC	Primary, Community and Continuing Care
PCG	Primary Care Group
PCRS	Primary Care Reimbursement Service
PCT	Primary Care Team
PDF	Pharmaceutical Distributors Federation
PEA	Pharmacoeconomic Assessment
PGP	Physician Group Practice (Demonstration)
PHO	Primary Health Care Organisation
PHQID	Premier Hospital Quality Incentive Demonstration
PIP	Practice Incentives Program
PLICS	Patient-level Information and Costing System

PMG	(Kaiser) Permanente Medical Group
PMS	Personal Medical Services
PMP	Performance Management Programme
POM	Prescription-only Medicine
PPMI	Performance Management and Management Information
PPP	Purchasing Power Parity
PPRS	Pharmaceutical Price Regulation Scheme
PRD	Pension Related Deduction
PRSI	Pay Related Social Insurance
PSI	Pharmaceutical Society of Ireland
QCC	Quality and Clinical Care
QNHS	Quarterly National Household Survey
QOF	Quality and Outcome Framework
RDO	Regional Director for Operations
RGN	Registered General Nurse
RHA	Regional Health Authority
RRMA	Rural, Rural and Metropolitan Area
RSC	Risk Structure Compensation
RVU	Relative Value Unit
SAHRU	Small Area Health Research Unit
SCB	Social Code Book
SHA	System of Health Accounts
SHI	Statutory Health Insurance (Germany)
SIP	Service Incentives Program
SLA	Service-level Agreement
SPHERE	Secondary Prevention of Heart Disease in General Practice
SWPE	Standardised Whole Person Equivalent
VA	Veterans Administration
VAT	Value Added Tax
VFM	Value for Money
VRS	Variable Returns to Scale
VTE	Venous Thromboembolism
WHO	World Health Organization
WTE	Whole Time Equivalents
ZVW	Health Insurance Act (Netherlands)

AUS	Australia
CAN	Canada
DEU	Germany
IRE	Ireland
NLD	Netherlands
NZ	New Zealand
SWE	Sweden
UK	United Kingdom
USA	United States

AUD	Australian Dollar
CAD	Canadian Dollar
NZD	New Zealand Dollar
SEK	Swedish Krona
USD	United States Dollar

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Published by Government Publications, Dublin

To be purchased from the
Government Publications Sales Office
Sun Alliance House
Molesworth Street, Dublin 2

or by mail order from
Government Publications
Postal Trade Section
51 St. Stephen's Green, Dublin 2
[Tel: 01 647 6834; Fax: 01 647 6843]

or through any bookseller

Design and Printed by Brunswick Press Ltd, Dublin 12

ISBN 978-0-7557-7638-2
9 780755 776382 >