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Structure of the Irish Health Service

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OBJECTIVES

- To provide a brief comparative analysis of health systems structures within other jurisdictions.
- To provide a broad overview of the role and structures of government and relevant departments in relation to health care.
- To provide a broad overview of the structure of the Irish health sector and the interrelationships between the main bodies and agencies.
- To provide a brief outline of the governance arrangements within the main health sector organisations.
- To provide an outline of key developments in relation to the ongoing restructuring of the health services.

INTRODUCTION

In many OECD countries the public sector assumes a dominant role in the structure and financing of health care, and determining an appropriate level of spending on health is an ongoing dilemma for governments. There are similarities across the OECD in relation to difficulties in ensuring access to health care and value for money; however, the challenges are manifested differently. In Ireland, health is heavily funded by the state and, as in other countries, there is a constant tension between the desire to provide a first world health system and the need to restrain costs and manage resources. Internationally, the provision of health care is an important political issue as countries respond to demographic changes, transformed consumer expectation and the proliferation in recent years of medical technology and capacity. The expectations of consumer organisations and individuals can conflict with attempts by government to change structures or limit medical expenditure in the interest of community need. The population of Ireland is 4,239,848 and it is estimated to rise to 4,900,000 by 2025 (DoHC 2007). Ireland's total fertility rate (a measure of the average number of children per woman) is, at 1.88, currently the second highest in Europe, the European average being 1.44 (OECD 2009). Therefore Ireland currently has a very young population and a significant increase in the ratio of older persons in the population is projected in the coming decades.

There are significant differences between countries as to how health care is funded, structured and delivered, and considerable differences in the percentage of gross domestic product (GDP) devoted to health care. The critical structural

difficulties faced by the Irish health service are a number of decades in the making, with an over-reliance on acute services, under-investment in community care and infrastructure contributing to fragmentation of care and inappropriate usage of acute services. These issues are all considered in this chapter, which seeks to illuminate the structure and governance of the Irish health service.

TYPES OF HEALTH CARE

In examining the structure of the Irish health system it is necessary to consider the types of health care that are provided in any health system.

Primary care: normally community based, primary care usually represents the first point of contact or access for individuals to health service providers. This type of care encompasses a wide range of health professionals including general practitioners, nurses, midwives, dentists, pharmacists, physiotherapists, occupational therapists and social workers. Primary care includes a myriad of activities: individual needs may include medical assessment, diagnosis, therapy, nursing, midwifery, health education, counselling and social services.

Secondary or tertiary care is focused on acute care services, maternity and specialist services and is primarily hospital based.

Chronic care involves all the ongoing care provided in long-term residential settings and homes. In the Irish health care structure, it encompasses social and continuing health care, for example day and long-term residential care services for care groups such as intellectual disability, psychiatry and older persons.

HEALTH SYSTEMS – AN OVERVIEW

There are a variety of health systems approaches. The organisational structure of a health system will, in the main, be determined by the funding structure that underpins it. This can create challenges, for example where the creation of an integrated primary care service structure to deliver multi-faceted services to patients and service users is developed within a care group-funded structure. Health care systems can be classified according to their funding arrangements, and they may lie anywhere on a continuum from free market with little or no government input to a government monopoly system funded by taxation (Blank & Burau 2004). Along this continuum are three models that represent aspects of health service provision in many countries.

Private insurance model: This system is defined by the absence of state involvement in the provision of service. It is derived from the assumption that the funding and provision of care is better left to market forces and is best represented by the United States and Switzerland, which are primarily private insurance models. Private health insurance is also significant in Germany and duplicates the universal access public provision in Australia, Italy, Spain and Ireland.

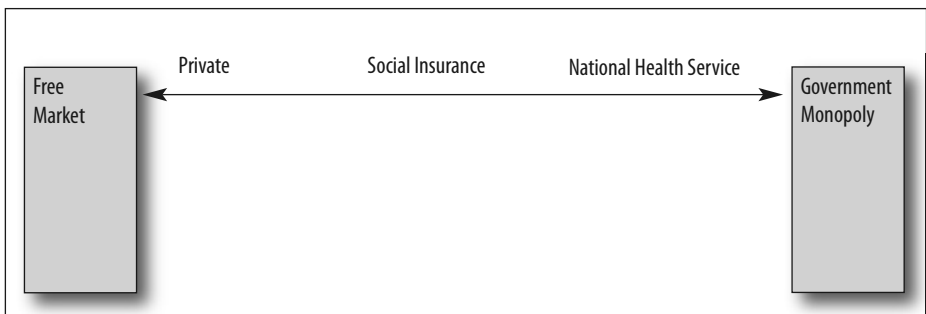
Social insurance model: The organisation of this model varies considerably across countries and may include social or state insurance. It is usually defined by universal coverage enabled through health insurance funded by a combination of

individual and government contributions. Examples are Germany, the Netherlands and Japan.

National health service: This model is defined by universal coverage funded by general taxation, best represented by the United Kingdom and New Zealand. It is often free at the point of use. It is reliant on budget finance and draws upon a number of salaried and private contractors to provide services. This system is good for ensuring access but can weakly incentivise improvements in efficiency.

All the systems described above may include elements of direct payment or co-payments by the user.

Figure 1.1: Types of health system by provision and funding



Source: Blank & Burau (2004)

DEVELOPMENT OF THE IRISH SYSTEM

The Irish health care system has developed in an ad hoc fashion over the last decades and is somewhat difficult to categorise as it is a mixed system of funding and provision structures. The system is an eclectic mix of elements of the private and the national health service models described above. Services are delivered through a combination of private, public and voluntary organisations and the system has been criticised for being fragmented.

The framework for the structure, governance and finance of the Irish health system is defined by a series of Health Acts 1947, 1970 and 2004. Before 1 January 2005, health care was governed, organised and delivered through the regional health boards, which were in the main organised and structured according to population size. The initial structure, laid down in the Health Act of 1970, formed the basis for the eight health boards and gave centralised responsibility for the running of the health services to the Department of Health. As the population of the east of the country grew, due to decreasing emigration and increasing migration from the rest of the country, the Eastern Health Board was renamed East Regional Health Authority (ERHA), which comprised three separate regions. (The current structure has been influenced by the local politics of the old health board arrangements.) Access to services was determined by income, with a portion of the population deemed eligible for GP, hospital and

prescription services that were free at point of service. GP services for eligible individuals was administered through the General Medical Scheme (GMS), which provided a capitation system for the provision of GP services to those citizens below a certain income threshold. The remainder of the population had to pay for GP and prescription services.

Under the health board system, services in Ireland were delivered through a complex set of organisations that spanned the statutory and voluntary sectors. The major criticism levelled at the health boards was related to their persistent budgetary over-runs and the negative effect of local politics on integrated health planning and appropriate resource usage. The Brennan (DoHC 2003a) and Prospectus (DoHC 2003b) reports identified the lack of accountability and fragmentation within the structures of the Irish health system. The Health Service Reform Programme (DoHC 2003c) and the Health Act (Government of Ireland 2004) heralded a major reorganisation of the structure of health care delivery in Ireland; and, indeed, the system has undergone significant change in recent years, in particular with the establishment of the Health Service Executive (HSE). Ongoing reforms recently announced are focused on reorganising health care organisational structures to achieve a more integrated model of service delivery.

OVERVIEW OF THE IRISH HEALTH SYSTEM

All OECD countries have some element of public finance in their health care provision but the Irish health care system has features which distinguish it from other health care systems. In a study of the Irish 'health basket', Smith (2009) explains that the structures that define entitlement in this country are complex and that the cost of access to primary care is higher than in other systems. It is estimated that 29 per cent of the population have medical cards and a further 75,589 people have GP visit cards (HSE 2007a). The Irish health system determines entitlement according to income: two main category classifications are used (see Table 1.1). The acute care sector is heavily funded by general taxation, as is Category I medical card provision. The system has been classified as a universal access and a socialised model, due to its provision of health care free at point of service to Category I (medical card) patients. As of 1 January 2009 the automatic entitlement to a medical card for the over-70s has been substituted with a means test system.

Table 1.1: Entitlement/access to care

Access to health care	Category I	Category II
GP care	100%	0
Prescriptions	100%	Excess above €120 per month
Public hospital in-patient	100%	€75 per night up to maximum €750 per annum
Public hospital outpatient	100%	100%
A&E attendance (referred by GP)	100%	100%

In the Irish health system, access to primary care services is, for the majority of people, determined by ability to pay (a notable exception being public health nurse (PHN) services) and is reliant on out-of-pocket payment for GP visits privately and co-payment of up to a €100 per month for drugs under the Drugs Payment Scheme. The potential avenue to access health care by bypassing the GP system and attending A&E directly is obstructed by the statutory requirement to pay a €100 attendance charge in the event of self-referral. This charge does not apply if the patient has a letter of referral from a general practitioner. Out-of-pocket charges also apply to in-patient stays; Irish Category II patients pay €75 per night to an annual maximum of €750. A unique element of Irish health care, and one that contrasts greatly with other countries, is the mix of private and public patients within publicly funded organisations receiving different standards of care. Ireland does provide universal access to specialist services, as hospital outpatient visits are free at point of service. However, this service may be provided by a non-consultant hospital doctor in training and therefore the standard of care can differ considerably from that enjoyed by patients who are able to attend privately.

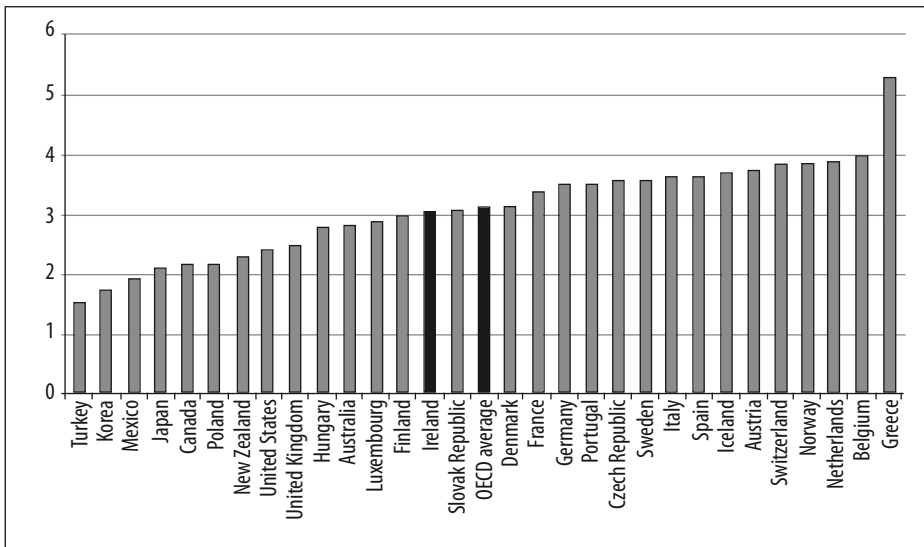
The percentage of Irish citizens who feel it necessary to supplement or duplicate the universal access supposedly already provided in the public sector is of interest, and it is estimated that 50 per cent of the Irish adult population have private health insurance. In some way it could be said that the country already operates a social insurance model, given the percentage of the population who deem it necessary to pay for duplicate cover for acute services. The structures that have evolved and underpin the system conspire to favour private patients over public and there has been considerable objection to the propensity of the system to advantage one over the other. Two waiting lists are in operation within public hospitals, with the result that private patients can access specialist care and services ahead of those most in need (Burke 2009; Wren 2003; Tussing & Wren 2006). Health expenses over €125 per annum are, with some exceptions, eligible for tax relief at the marginal rate of 20 per cent.

It is broadly understood that all OECD countries, with the exception of Mexico, Turkey and the United States, have achieved universal or near-universal health coverage (Docteur & Oxley 2003). In Ireland a large percentage (estimated to be about 78 per cent) of health expenditure comes from central government and the system has been described as a universal access system. Indeed, the structure of the system provides free acute and primary care service at point of access to Category I medical card holders. The majority of the population (approximately 70 per cent) who are described as Category II are also entitled to free access at point of service to specialist care in the acute sector. In contrast, access to primary care through GP services is determined by ability to pay: therefore the Irish system is not a complete system of universal access. As Ireland operates a gatekeeper structure, in which referral from a GP is required for access to specialist care in the acute sector, it follows that even access to specialist services is to some extent determined by ability to pay. A patient may access specialist services through the A&E system, but they will be required to pay €100 at point of service unless they have paid and received referral from a GP.

The public health service employs 111,062 people in total and comprises a complex set of organisational and professional structure, which would require considerable analysis. For the purposes of this book, two professions will be briefly considered: the medical and nursing professions.

Ireland has a lower number of physicians per capita than most European countries. There are fewer physicians in Ireland than in other OECD countries: Ireland has 3.03 per 1,000, compared to an OECD average of 3.1; and there are reports of fewer specialists in certain areas.

Figure 1.2: Practising physicians: density per 1,000 population (2007)



Source: OECD (2009)

The number of consultants in the country has increased but is falling short of demand, a result in some part of the process of cost containment since 2004. Prior to the establishment of the HSE the appointment of hospital consultants was determined by Comhairle na nOspidéal, an organisation upon which consultants had a majority representation (Burke 2009), and there was evidence of inadequate numbers even prior to 2004. The ESRI (2009) report on the impact of demographic change on the demand for and delivery of health care in Ireland suggests that a significant increase in the number of doctors will be needed to meet the growing demands of the Irish population. Access to specialist care can be obstructed due to a shortage of consultants in specialities such as neurology, rheumatology and dermatology.

The unique elements of the Irish consultant's contract enabled individuals to operate as salaried employees in the public service and also charge 'fee for service' for private work. The defining characteristic of consultant-led care in the Irish health structure is its reliance on junior doctors (who have varying levels of competence and experience, depending on their stage of education) to work long

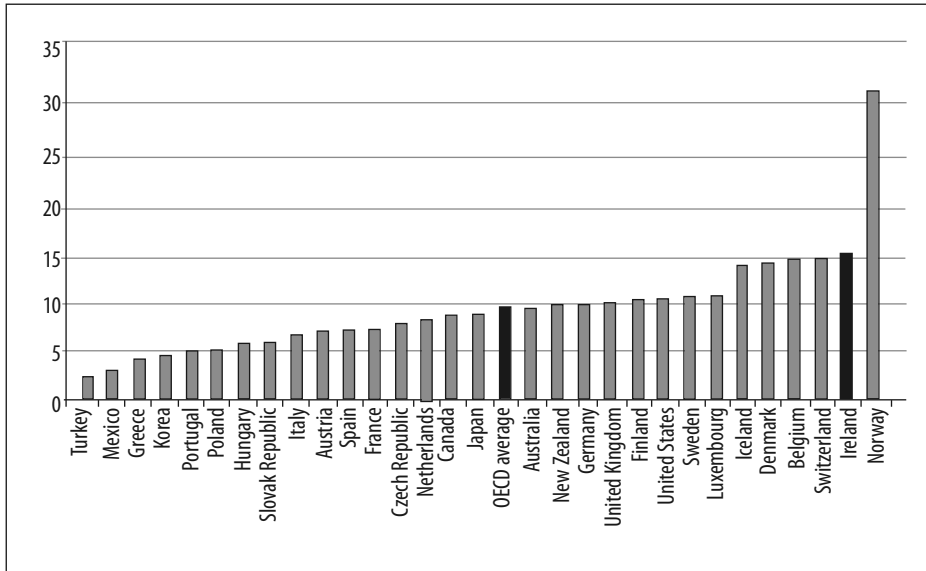
hours. The consultant contract in Ireland has been criticised for the relatively short number of hours that constitute the public commitment, enabling the individual to exercise their own discretion and judgment as to how much, if any, of their contracted hours are spent delivering care to public patients. While the system does result in adequate remuneration for individual junior doctors who work long hours, it does mean that there is a considerable overtime wages burden on the Irish taxpayer, which in terms of quality of patient outcomes does not always represent the best value for money.

There has been considerable comment in the Irish health literature of how the system incentivises consultants and organisations to favour private patients in terms of access and level of quality in service delivery. Burke (2009) argues strongly that there is apartheid in Irish health care and advances the argument that this two-tier system has been an insidious and habitual element of Irish health policy in recent decades. The Hanly Report (DoHC 2003d) sought to limit the practice of consultant-led care where care is delivered across a number of smaller hospitals by junior doctors at different stages in their training. The European Working Time Directive (DoHC 2004) has been a driving force in the move to increase the number and availability of consultants working in the public service. Traditionally only a small number of Irish consultants worked exclusively with public patients and they were usually found in specialities such as paediatrics, gerontology and psychiatry, where opportunities and incentivisation to operate a two-tier system are of course, while by no means absent, not as prevalent.

The recent increase in the consultant remuneration package has been referred to in some sectors as a 'sweetheart deal'. The purpose of the renegotiated contract is apparently to afford greater access to consultant-delivered care and improve access to specialist care. At the time of writing it is not clear if the new contract will deliver on the consultant-delivered care desired in the public health service. It is questionable whether the recently negotiated remuneration rates are sustainable and it remains to be seen how effective plans to limit the amount of private activity undertaken will be, given that it is such a well-established custom and practice in the Irish health service. Wren (2004) argued that more modest salary levels would enable the recruitment of more specialists. Indeed, basic economics would suggest that limiting the monopoly that underpins specialist care could also enable a reduction in salary costs. Under the terms of the renegotiated contract the HSE is making some effort to police the cap of 20 per cent of time spent with private patients. There is some scepticism as to how effective we have been to date in monitoring the 80/20 mix in care delivery which had always been an inherent element of the contract prior to renegotiations. It remains to be seen what nature of sanction will be possible if a consultant should be found to be non-compliant with the cap. Burke argues that the revised consultant contract continues to incentivise private work within the public system and that it 'reinforces rather than deconstructs the two-tier system of care' (Burke 2009:17). Indeed, increasing the number of consultant posts may enhance career pathway and expectations for indigenous Irish-educated doctors and may disincentivise these groups from patterns of emigration seen thus far. This may provide better

value for taxpayer investment in the education of doctors and provide the culturally attuned medical workforce desired by the public.

Figure 1.3: Practising nurses: density per 1,000 population (2007)



Source: OECD (2009)

The number of practising nurses in 2007 was 15.5 per 1,000, a proportion significantly higher than the OECD average of 9.56 (see Figure 1.3).

However, efforts to ensure comparability across OECD countries have limitations. Variations in skill mix and the low proportion of assistive personnel in the service are not taken into account. The numbers recorded in some countries may reflect whole-time equivalents rather than head counts registered (as recorded by An Bord Altranais). Many of the countries to which Ireland is compared in terms of numbers of nurses operate generic education courses, where numbers working in the various disciplines of psychiatry, general, learning disability are not recorded as they are here. Many Irish nurses are recorded on more than one part of the register, and in some countries midwives are not counted in nursing numbers. The numbers do not reflect whole-time equivalents engaged in the system and in Ireland up to 40 per cent of Irish nurses are working part-time. Therefore this relatively high nurse density may not be regarded as a full picture of the number of Irish nurses engaged in the health system.

HEALTH – THE BLACK HOLE

There is a negative public perception of Irish health care services (Burke 2009) and negative commentary in relation to health was even evidenced with an off-the-cuff remark of one prominent politician describing the Department of Health as ‘Angola’. Politically health is viewed as a poisoned chalice in some sectors, and sometimes described as a ‘black hole’ (Wren 2004). The Euro Health Consumer

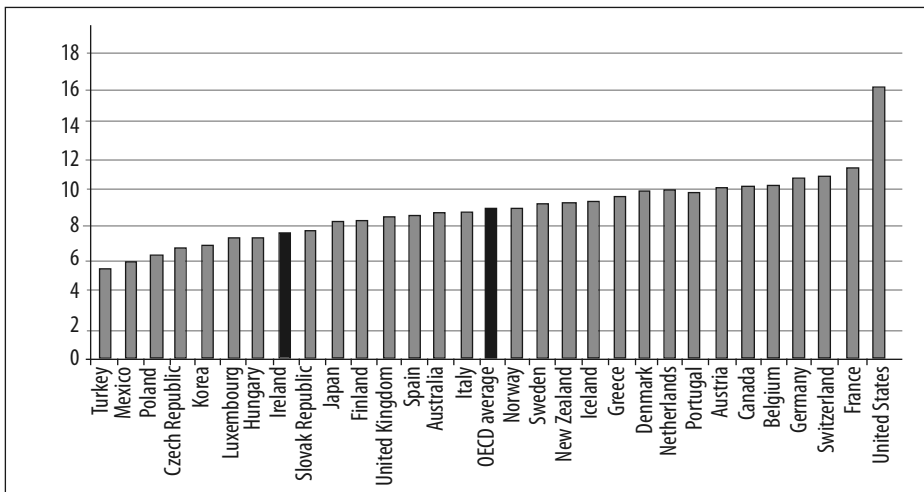
Index (EHCI) findings (Health Consumer Powerhouse 2009) suggest a ‘domestic marketing problem in Ireland’. Even though Ireland has moved up two places in the EHCI since 2008 and now ranks 13th out of 33 European countries, the findings of the patient organisation survey give a less positive picture than the official data (Health Consumer Powerhouse 2009). The Netherlands was the best performing country, with a total score of 875 out of a possible 1,000 points, followed by Denmark (819) and Iceland (811). Ireland generally performed well, with a score of 711, ahead of the United Kingdom and Italy; however, it scored poorly in the area of e-health. Ireland scored top marks in four of seven health outcome measures: infant deaths per 1,000; cancer five-year survival; preventable years of life lost per 100,000 in the 0–69 age group; and percentage of diabetic population of patients with HbA1c (the amount of glycated haemoglobin in your blood) levels above seven.

There is undoubtedly a public relations issue in relation to trust in the health service, no doubt fuelled by the myriad of scandals in relation to standards of care in recent years. Wren (2004) rejects the interpretation of Irish health spending as a ‘black hole’, arguing that Ireland’s expenditure on health in the early 2000s could not deliver the anticipated outcomes, given the level of capital deficiencies that had been the norm in previous years. There has indeed been a marked increase in capital spending on health care; however, it must be examined in the context of the underspend that occurred from the 1970s to the 1990s. The effect of reduced spending on health, particularly through the 1980s and in the early 1990s, is still felt in Ireland at a time when other OECD countries are increasing their spending on health (Wren 2004).

Health spending

Total health spending accounted for 7.6 per cent of gross domestic product (GDP), lower than the OECD average of 8.9 (see Figure 1.4).

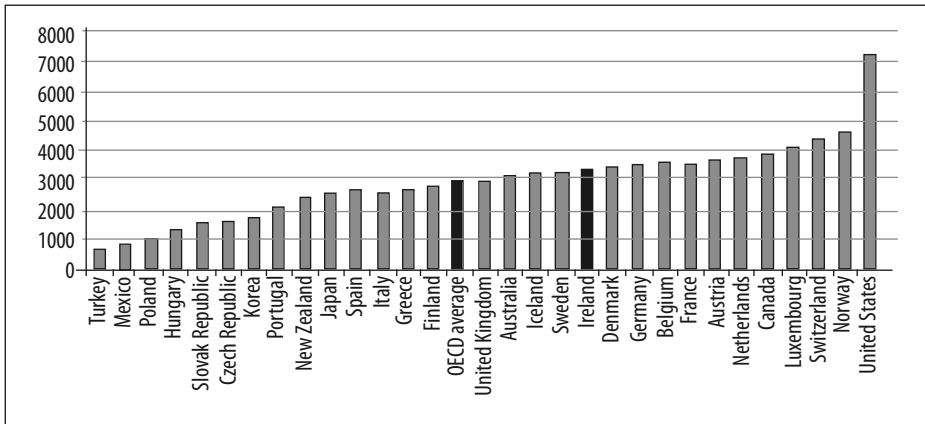
Figure 1.4: Health expenditure as % of GDP (2007)



Source: OECD (2009)

The USA spends the most on health, with 16 per cent of GDP allocated to health, followed by France (11 per cent) and Switzerland (10.8 per cent). Germany, Belgium and Austria also devoted in excess of 10 per cent. In terms of health spending per capita, Ireland is above the OECD average (€2,984) at €3,424, but we do rank significantly lower than some other European countries that spend in excess of €4,000 (see Figure 1.5).

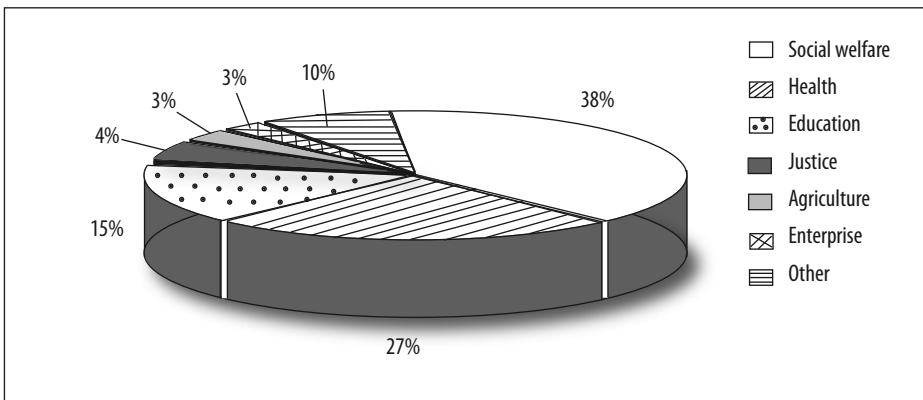
Figure 1.5: Total expenditure on health per capita, US\$ purchasing power parity



Source: OECD (2009)

The number of acute beds in Ireland in 2007 was 2.7 per 1,000, below the OECD average of 3.8 per 1,000. Worldwide, the number of beds has fallen due to shorter lengths of stay. Health estimates for 2009 record health spending in Ireland as 27 per cent of total gross expenditure, and the total funding for 2009 is estimated to be €14.79 billion.

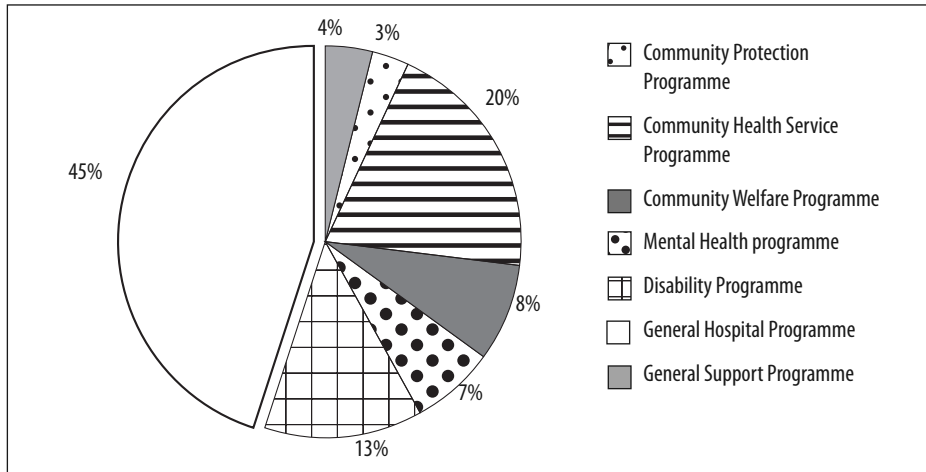
Figure 1.6: Gross voted current spending (overall €56.6 billion in 2009)



Source: Government of Ireland (2009)

Forty-five per cent of all health care spending is in the acute care sector, 20 per cent on community health services, general practitioner services and pharmaceuticals, and seven per cent on mental health services. The remaining 28 per cent is spent on a range of services that may be broadly described as social care.

Figure 1.7: Health service expenditure



Source: DoHC (2007)

Comparison with health systems internationally is complicated by the eclectic nature of the Irish health system and by the differences in the way different countries conform to the System of Health Accounts (SHA) introduced by the OECD in 2000. The estimate of health spending also necessitates an estimate of private spending on health. Private expenditure includes the purchase of health care service by insurance companies; out-of-pocket expenses by individuals for primary care; and expenditure on private hospitals and diagnostic facilities. Tussing and Wren (2006) explain that a significant portion of spending in health care actually funds social programmes. The OECD definition excludes the bulk of spending under the Community Welfare Programme, which funds services ranging from home help to contributions to patients in private nursing homes, and the Disability Programme, which funds residential care and home care for people with intellectual and physical disabilities.

DEPARTMENT OF HEALTH AND CHILDREN

The Department of Health and Children has responsibility for the overall organisational, legislative, policy and financial accountability framework of the health sector (see the organisation chart in Appendix 5 following this chapter). It has a statutory responsibility to support the minister in the formulation and evaluation of policies for the health services. It also has a role in the strategic planning of health services. This is carried out in conjunction with the Health

Service Executive, voluntary service providers, government departments and other key stakeholders. Its core objectives are to support the minister and the government by:

- advising on the strategic development of the health system including policy and legislation – its strategy statement sets out the high-level objectives of the department, and it takes account of the priorities of government
- supporting their parliamentary, statutory and international functions
- evaluating the performance of the health and social services
- working with other sectors, such as education, to enhance people’s health and well-being.

In accordance with the Public Service Management Act 1997, each government department is required to prepare a strategy statement every three years. (See www.dohc.ie for copies of strategy statements, including the 2008–2010 strategy statement.) The Department of Finance also plays an important role in relation to health care policy making and expenditure in terms of pay determination, allocation of expenditure and vote control (see www.finance.gov.ie for further information).

In addition to the Minister for Health and Children, there are four ministers of state attached to the Department of Health and Children:

- Children and Youth Affairs
- Disability and Mental Health
- Health Promotion and Food Safety
- Older People.

HEALTH SERVICE EXECUTIVE (HSE)

The HSE incorporates the former health boards and a number of former organisations and agencies including the Health Service Employers’ Agency, the Office for Health Management and Comhairle na nOspidéal.

The establishment of the HSE represents the beginning of the largest programme of change ever undertaken in the Irish public service. Prior to this our health care services were delivered through a range of different agencies, each of which was independently answerable to the Department of Health and Children. It was a complex structure that made it difficult to provide nationally consistent health services.

(HSE 2008a)

The HSE, which was established under the Health Act 2004, is the largest organisation in the state, employing over 111,000 whole-time equivalent staff, with an annual budget of €14.9 billion. The Health Act 2004 states that the objective of the HSE is to efficiently use the resources available to it in order to

provide services that improve, promote and protect the health and welfare of the public. Health and personal social services are delivered to the population living in the Republic of Ireland directly by the HSE and through the many voluntary hospitals and agencies that are funded by it. These will be described later in this chapter.

Prior to the establishment of the HSE, health and social personal services were planned and delivered through ten health boards (established under the Health Act 1970) and the Eastern Regional Health Authority (established under the ERHA Act 2000), and the agencies and hospitals that they funded. The health boards were accountable to the Department of Health and Children, and each health board had a board of elected and nominated representatives to whom it was also accountable. The HSE replaced the ten health boards and the Eastern Regional Health Authority in 2005, and a number of other agencies, including Comhairle na nOspidéal, the Health Service Employers Agency and the Office for Health Management, were also transferred to the HSE.

Under the Health Act 2004, the HSE is obliged to fulfil a number of requirements in relation to the planning and delivery of services. It must produce a corporate plan every three years and an annual service plan and submit these to the Minister for Health and Children for approval, who in turn submits them to the Houses of the Oireachtas for approval. The HSE delivers services directly and through the funding of voluntary agencies and hospitals. It enters into arrangements with these hospitals and agencies and provides direct funding for the delivery of agreed amounts of services through annual service level agreements. Community, residential and rehabilitative training services are also provided by a large number of voluntary organisations that receive grant aid from the HSE, as provided for under the Act. Since its establishment there has been a considerable reorganisation of the administrative structure of the HSE.

Governance

The role and functions of the board of the HSE, which are set out in detail in the Health Act 2004, are significant. Section 12 (1) of the Act defines the board of the HSE as ‘the governing body of the Executive with authority in the name of the Executive, to perform the functions of the Executive’. The board has responsibility under the Act to appoint a CEO, under the terms of the Public Service Management (Recruitment and Appointments) Act 2004. The board comprises 11 members and the CEO of the HSE (see Sections 11 to 16 of the Health Act 2004 for further information).

The respective roles and responsibilities of the board and CEO are also made clear in the Health Act 2004. Section 18 of the Act states that the function of the CEO of the HSE is to ‘carry on and manage and control generally the business and administration of the Executive . . . and perform any other functions assigned to him/her under the Health Act or as delegated by the Board. S/he is responsible to the board for the performance of his/her functions and the implementation of the Board’s policies.’ The significance of this role, which marks a change from the role of the CEO in the previous health board structure, is highlighted in Section 20

of the Health Act, which states that ‘the CEO is the Accountable Officer in relation to the Appropriation Accounts of the Executive for the purposes of the Comptroller and Auditor Generals Acts 1866 to 1998’. Prior to the establishment of the HSE, the role of accounting officer for the health vote lay with the secretary general of the Department of Health and Children. The appointment of the CEO as the designated accounting officer means that the postholder is ultimately responsible for the spending of public monies.

While further reform of the service delivery structures was initiated in October 2009, when the HSE was established in 2005 its structures were divided into three service delivery units: the Population Health Directorate; the Primary, Community and Continuing Care (PCCC) Directorate; and the National Hospitals Office (NHO). The structures also comprised core National Support Directorates including Human Resources, Finance, Estates and shared services. A Regional Forum was also established in each of the four administrative areas of the HSE, which are described below. These forums, which comprise representatives from city and county councils, make representations to the HSE on the health and personal social services in their area.

The structure of the HSE in mid-2009 was as follows.

Population Health, whose function is to promote and protect the health of the entire population.

Primary, Community and Continuing Care, responsible for delivery of health and personal social services in the community and other settings. These services include primary care, mental health, disability, child, youth and family, services for the elderly, community hospitals, continuing care services and social inclusion services. PCCC is divided into four administrative areas as follows:

- HSE Dublin Mid-Leinster – 28.7 per cent of the population
- HSE South – 25.5 per cent of the population
- HSE West – 23.9 per cent of the population
- HSE Dublin North-East – 21.9 per cent of the population.

The National Hospitals Office (NHO) is responsible for delivering acute hospital and ambulance services throughout the country through a structure of eight hospital networks. The hospital network manager in each network is accountable for the planning and delivery of services within agreed targets in the hospitals in their area. Service delivery is planned and agreed annually through service level agreements between the eight hospital network managers and the NHO and through agreements with individual public statutory and voluntary hospitals, for example in relation to national specialities (including heart, lung and liver transplants, bone marrow transplants, spinal injuries, paediatric cardiac services and medical genetics). The service level agreement process and how it differs according to the type of hospital involved is discussed in the next section.

Hospitals

Broadly speaking, there are three types of hospital in Ireland.

Statutory public hospitals are owned and funded by the HSE. (Prior to the establishment of the HSE, these hospitals were funded by the health boards.) These hospitals agree business plans with hospital network managers in order to receive funding. (See Appendix 3 at the end of this chapter.)

Voluntary public hospitals are funded through service level agreements made with the NHO as provided for in the Health Act 2004. Some voluntary public hospitals are owned by private bodies, such as religious orders. Other voluntary public hospitals are incorporated by charter or statute and are often run by boards appointed by the Minister for Health and Children. Prior to the establishment of the HSE, voluntary hospitals in the eastern region (Dublin, Kildare, Wicklow) received funding through the making of ‘service arrangements’ with the Eastern Regional Health Authority, while voluntary hospitals in all other counties made arrangements and received their funding directly from the Department of Health and Children.

Private hospitals. These independent hospitals can operate as for-profit or non-profit. These are a number of arrangements in place to increase the number of beds in order to alleviate some of the bed congestion caused by the private–public mix and a number of plans to increase the number of co-located hospitals in the sector. The system of co-location of private hospitals has been a central element of the political agenda advanced by the current administration and has been quite controversial.

Hospitals can also be categorised as acute general hospitals, single specialism hospitals (for example Cappagh Hospital, the Eye and Ear Hospital) or acute specialist hospitals (e.g. paediatric, maternity). They can also be further classified as providing secondary and/or tertiary (national) services.

A range of initiatives are under way within the NHO to improve services for patients, efficiency and effectiveness, including the development of a new national children’s hospital, the National Cancer Control Programme, and the development of clinical directorates and clinical networks.

Primary, Community and Continuing Care services

Primary care is the first point of contact that people have with the health and personal social services. Traditionally much of primary care services are delivered through general practitioner services. GPs operate as private and independent contractors, remunerated by capitated amounts for Category I patients or fee for service arrangements for Category II patients. GPs have a distinct role within the system as they act as a gatekeeper to specialist services. The approach to the award of GMS practices and the ability of GPs to practise independently has resulted in an ad hoc development of primary care services in the country. It has also contributed to duplication and small GP practices with insufficient investment in technology and infrastructure to support the needs of a modern health care system. In fact many GPs are geographically isolated and removed from the other members of the multidisciplinary team in the community. *Primary Care: A New*

Direction (DoHC 2001) set out a new direction for primary care as the central focus for the delivery of health and personal social services in Ireland. The strategy proposes a model of primary care team working, with teams providing services to a population of between 4,000 and 10,000. It is intended that the further development of primary care services will allow hospitals to concentrate on those who need more complex interventions in the hospital sector.

Members of primary care teams include GPs, nurses/midwives, health care assistants, home helps, physiotherapists, occupational therapists, social workers and administrative staff. A wider primary care network of other primary care professionals such as speech and language therapists, community pharmacists, dieticians, community welfare officers, dentists, chiropodists and psychologists is being developed to provide services for the enrolled population of each primary care team, which is between approximately 30,000 and 50,000. The HSE 2009 Service Plan sets an objective of having 210 primary care teams in place. It is making some efforts to increase the number of primary care centres in the country, although in reality many in urban areas are actually private enterprises. Because of the reductions that must, in line with government policy, be made to current workforce levels, the main focus of the reconfiguration of PCCC services and resources is on the redeployment of staff and the redefinition of existing roles and job descriptions.

PCCC services cover a wide range of areas, including:

- primary care services, including general practitioner services (which are privately provided by self-employed GPs)
- public health nursing
- community paramedic services
- speech and language services, etc.
- mental health services
- child care services
- disability services
- social inclusion services
- elderly/nursing home services
- dental services.

In addition to the direct provision of these services, there is also a range of voluntary agencies that provide services in these areas, for example in the area of physical, sensory and intellectual disabilities (see Appendix 2 to this chapter for a list of the main agencies).

In accordance with the Health Act 2004, PCCC enters into service arrangements with certain voluntary organisations, whose income is above a stipulated amount. The process of developing service agreements takes place at both national and local level, a reflection of the structures in many of the organisations concerned. It also provides funding to a large number of other voluntary organisations across the country. Details of these organisations can be found on the Department of Health and Children website.

RESTRUCTURING THE HEALTH SERVICES

There have been criticisms as to the success of the reformed structures. Burke (2009) argues that despite the attempt of the 2004 Health Act to clarify the distinct functions of the HSE and the Department of Health and Children, their roles remain blurred. The minister is accountable for national pay negotiations in relation to public service pay, conditions of service and superannuation. The Department of Health and Children (2009a) is also responsible for workforce planning and long-term strategic planning such as cancer control. ‘The Minister for Health and Children is accountable for developing and articulating government policy on health and personal social service, and for the overall performance of health service’ (DoHC 2008).

There are a total of 475 whole-time equivalent staff in the Department of Health and Children. There is concern about duplication of work between the Department and the HSE. The secretary general of the Department, in his address to the Dáil Public Accounts Committee (DoHC 2009b), reported that its main activities now incorporate parliamentary work, preparing legislation and statutory documents and representing the interests of the country to international organisations such as the WHO, OECD and other health organisations. The Department is linked to the Health Information and Quality Authority (HIQA), the Irish Medicine Board, the Irish Blood Transfusion Service, the Food Safety Authority, the Health Research Board, the National Treatment Fund and the various professional regulatory bodies.

The HSE’s Transformation Programme 2007–2010 (HSE 2007b) was launched in late 2007. The programme was prepared following consultation with staff and other key stakeholders. It sets out a vision for the HSE in which ‘everybody will have easy access to high quality care and services that they have confidence in and that staff are proud to provide’. It also sets out a core mission for the HSE: ‘to enable people live healthier and more fulfilled lives’. More effective integration of hospital and community services was identified as one of the organisation’s priorities when the HSE launched the Transformation Programme. In 2008 the HSE developed this priority further through the establishment of an Integrated Services Programme, the objective of which is to ensure that patients and service users can access and receive seamless services, regardless of their location.

The key objectives of the programme were to:

- empower front-line clinicians, other clinical staff and managers to make effective local decisions
- reduce the distance between local service providers and the leadership of the HSE
- ensure strong local accountability and adherence to robust national planning processes
- support high-quality clinical and business decisions
- support consistent management of performance, quality and outcomes.

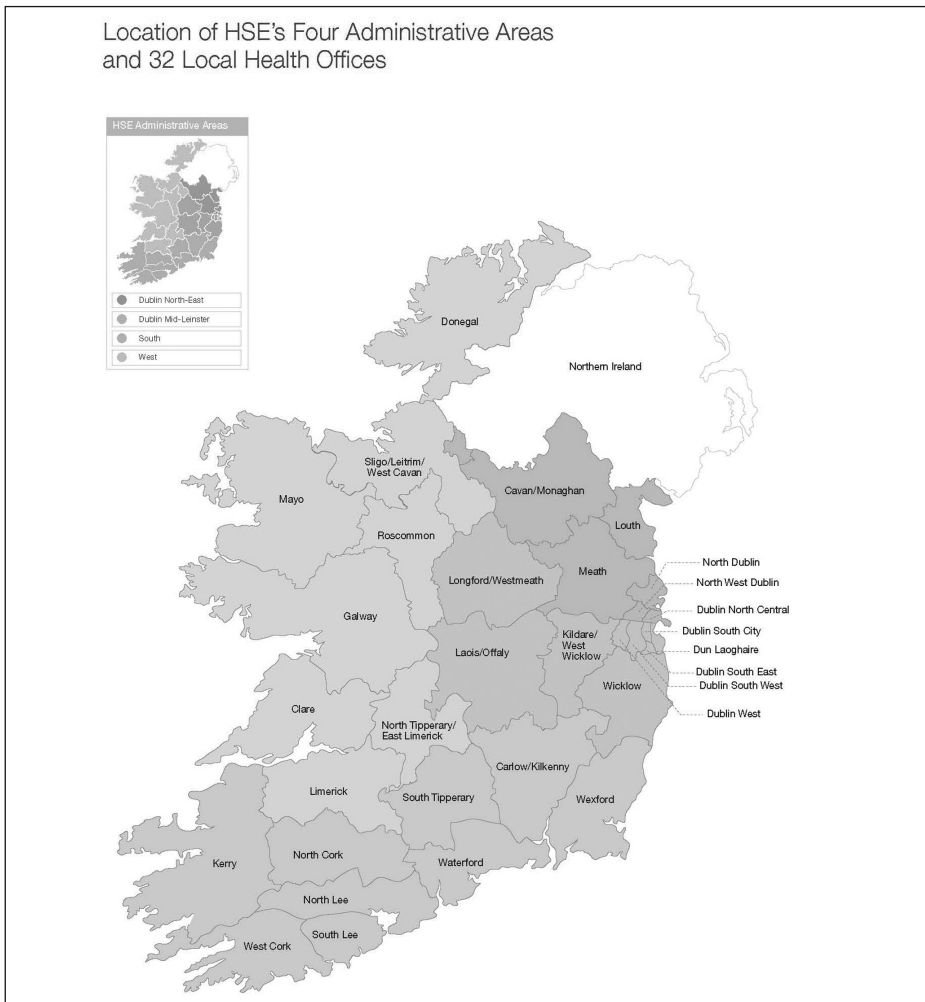
Work continues in relation to the restructuring of the HSE to enable the

achievement of these objectives. The most recent developments include: the creation of a National Directorate for Quality and Clinical Care; and the merging of the Primary, Community and Continuing Care Directorate and the National Hospitals Office into one National Directorate for Integration:

An integrated health and social care model develops services with the service user at the centre of services. Patient and clients in an integrated system are more likely to receive the type and quality of care they need, when they need it in the most appropriate setting and from the most appropriate health professional.

(HSE 2008b:17)

Figure 1.8 HSE regional operating units



Source: HSE press office

Work is under way to integrate the former Population Health Directorate into the Clinical Care and Quality Directorate and regional operating units. While various options were proposed during the restructuring programme regarding the creation of regions, as at October 2009 it is proposed that four regional operating units based on the existing administrative structures would be established, with a significant strengthening of integration and accountability (see Appendix 4 to this chapter for the new HSE organisation chart).

It is proposed to recruit four regional heads to have full accountability and responsibility for the delivery of all PCCC and hospital services in their region, within an overall national framework of objectives and policies. There will be four care groups nationally for services for children and families, older people, disabilities and mental health. Proposals to reconfigure local health offices and hospital networks to support this model are currently being developed.

OTHER BODIES

There are a number of agencies that are funded directly from the Department of Health and Children's vote allocation, including the National Treatment Purchase Fund, the Crisis Pregnancy Agency, the National Cancer Screening Service, the Mental Health Commission, the Health Information and Quality Authority and the Health Research Board (see Appendix 1 following this chapter). There is a Programme for Rationalisation of Agencies in the Health Sector, as outlined in Appendix 2. The Health Information and Quality Authority (HIQA) was established in 2007 as part of the ongoing reform of the health services. HIQA is an independent authority that reports to the Minister for Health and Children, and it has a broad range of powers and functions. It was set up to drive quality, safety, accountability and best use of resources in health and social care services, and its core functions are as follows:

- developing health information systems
- promoting and implementing quality assurance programmes
- overseeing accreditation
- developing health technology assessment
- reviewing and reporting on selected services.

CONCLUSION

The chapter has drawn attention to the structural and governance provision in the Irish health system. As illustrated in this chapter, the Irish health system is not easily classified as it has a mix of funding sources which define the structure and organisation of health care delivery. Ireland has embarked upon a wide-ranging series of reforms in recent years to advance the structure and governance arrangements that underpin the delivery of health care. Reforms in the public service have advocated stronger governance with devolution of authority and responsibility.

Since its establishment there has been considerable reorganisation of the administrative structure of the HSE. The National Hospitals Office and the Primary Community and Continuing Care Directorate have recently merged into the Integrated Services Directorate. It is anticipated that its regional sections will be required to operate performance contracts in relation to clinical quality, service volumes and service improvement.

The aspiration to achieve consultant-delivered care in the Irish health system has yet to be achieved. There are quarters which advocate a further restructuring of Irish health care so that universal access can be extended to primary care funded by a system of social insurance. A multitude of government reports underpinned the reform agenda that commenced in 2005; however, the under-investment in community care structures has been a major obstacle to streamlining and reorganising care delivery structures. The success of the health strategy is dependent on advances in the social care provision for older people and people with disability in the community. The coming years will be an interesting period in health care, with considerable changes to the structure of the Irish health service under way, which will no doubt require significant time to bed down.

REFLECTIVE EXERCISES

- 1 The HSE is currently developing structures to enable and empower the delivery of integrated care at regional and local levels. What do you see as the main challenges and critical success factors in relation to the delivery of integrated care?
- 2 Discuss how the functions of the Department of Health and Children and the HSE within the current health care structure influence your area of work.
- 3 The private/public mix is a distinguishing feature of the Irish health system. Discuss how this phenomenon compares internationally and its advantages and disadvantages for both health providers and consumers.
- 4 Conduct a SWOT analysis of the health care sector. What are the key challenges and how will they impact on the delivery of health care services? What are the opportunities and how might they best be maximised?

ADDITIONAL RESOURCES

An Bord Altranais: www.aba.ie

Capital Investment for Health. Case Studies from Europe, <http://pr4.netatlantic.com/t/1694353/2924751/103024/0/>

Department of Health and Children: www.dohc.ie

FÁS (2009) *Quantitative Tool for Workforce Planning in Health Care* (Report by the Skills and Labour Market Research Unit), http://www.forfas.ie/media/egfsn090617_healthcare_report.pdf

Financing Health Care in the European Union: Challenges and Policy Responses, <http://pr4.netatlantic.com/t/1694353/2924751/103025/0/>

Health Service Executive: www.hse.ie

Health Service Reform: www.healthreform.ie
 Institute for Innovation and Improvement: <http://www.institute.nhs.uk/>
 Leadership Qualities Framework, <http://www.nhsleadershipqualities.nhs.uk/>
 Medical Council: www.medicalcouncil.ie
 OECD Health Data 2009: <http://www.oecd.org>
 OECD (2008) *Public Management Reviews – Ireland: Towards an Integrated Public Service* http://www.oecd.org/document/31/0,3343,en_2649_33735_40529119_1_1_1_1,00.htm

APPENDIX 1: BODIES UNDER THE AEGIS OF THE DEPARTMENT OF HEALTH AND CHILDREN

Adoption Board
 An Bord Altranais
 Children Acts Advisory Board
 Crisis Pregnancy Agency
 Dental Council
 Food Safety Authority of Ireland
 Food Safety Promotion Board
 Health and Social Care Professional Council
 Health Information and Quality Authority
 Health Insurance Authority
 Health Research Board
 Health Service Executive
 Institute of Public Health
 Irish Blood Transfusion Service
 Irish Medicines Board
 Medical Council
 Mental Health Commission
 National Cancer Registry Board
 National Cancer Screening Service Board
 National Council on Ageing and Older People
 National Council for the Professional Development of Nursing and Midwifery
 National Haemophilia Council
 National Paediatric Hospital Development Board
 National Social Work Qualifications Board
 National Treatment Purchase Fund
 Office for Tobacco Control
 Opticians Board
 Pharmaceutical Society of Ireland
 Poisons Council
 Postgraduate Medical and Dental Board
 Pre-Hospital Emergency Care Council
 Voluntary Health Insurance Board
 Women's Health Council

APPENDIX 2: PROGRAMME FOR THE RATIONALISATION OF AGENCIES IN THE HEALTH SECTOR

Agency	Rationalisation Measure	Timeframe
National Council on Ageing and Older People	Integrate into the Office for Older People, Department of Health and Children	Merged 1 September 2009
Children Acts Advisory Board	Integrate into the Office of the Minister for Children and Youth Affairs, Department of Health and Children	1 January 2010
Women's Health Council	Integrate into the Department of Health and Children	2009
National Cancer Screening Service and National Cancer Registry Board	Integrate into the HSE	Target date 2010
Crisis Pregnancy Agency	Integrate into the HSE	1 January 2010
Drug Treatment Centre	Integrate into the HSE	1 January 2010
National Social Work Qualifications Board, Pre-Hospital Emergency Care Council and Opticians Board	Integrate into the Health and Social Care Professionals Council where functions are appropriate	Not possible to indicate accurate merge date but no sooner than 1 January 2011
Postgraduate Medical and Dental Board	Integrate with the HSE/Medical Council	Merged in January 2009
National Council for the Professional Development of Nursing and Midwifery	Integrate with the HSE/Bord Altranais	Bill to be published 2009
Food Safety Authority of Ireland, Irish Medicines Board and Office of Tobacco Control	Amalgamate into a new Public Health and Medicines Safety Authority, to be created	Target date 1 January 2011

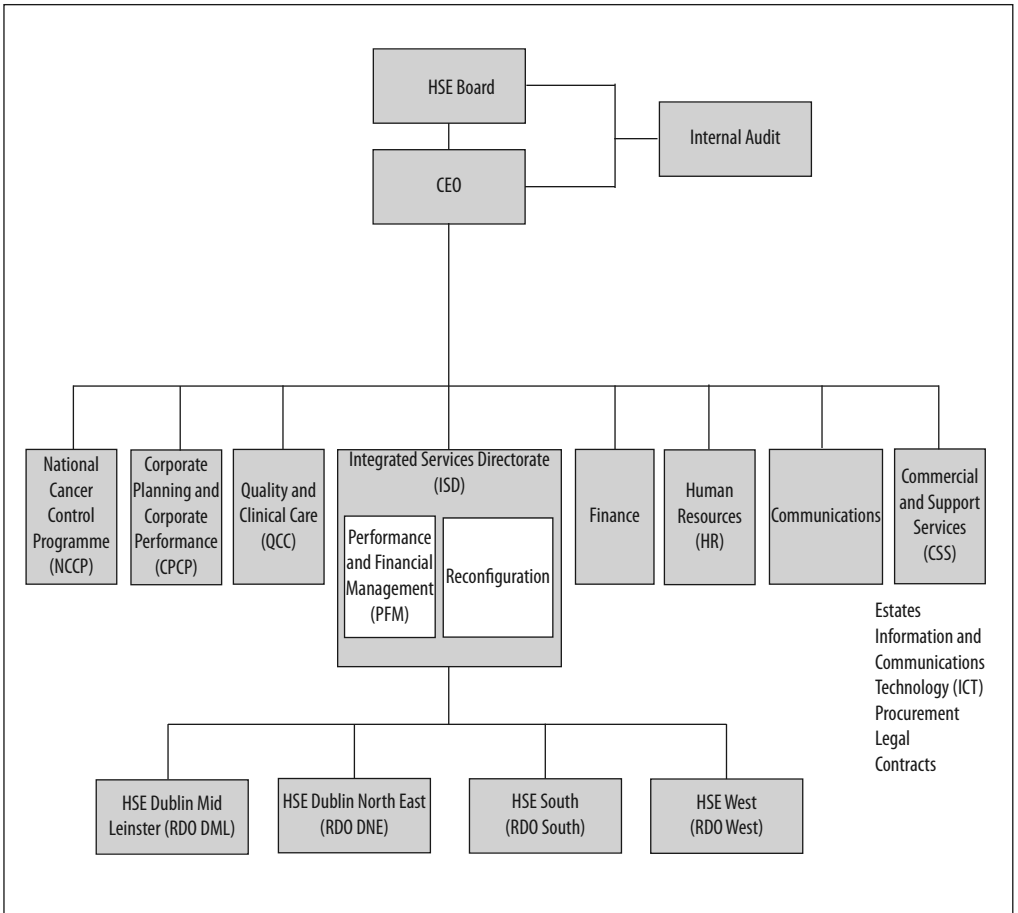
Source: DOHC (2009a)

APPENDIX 3: PUBLIC HOSPITALS

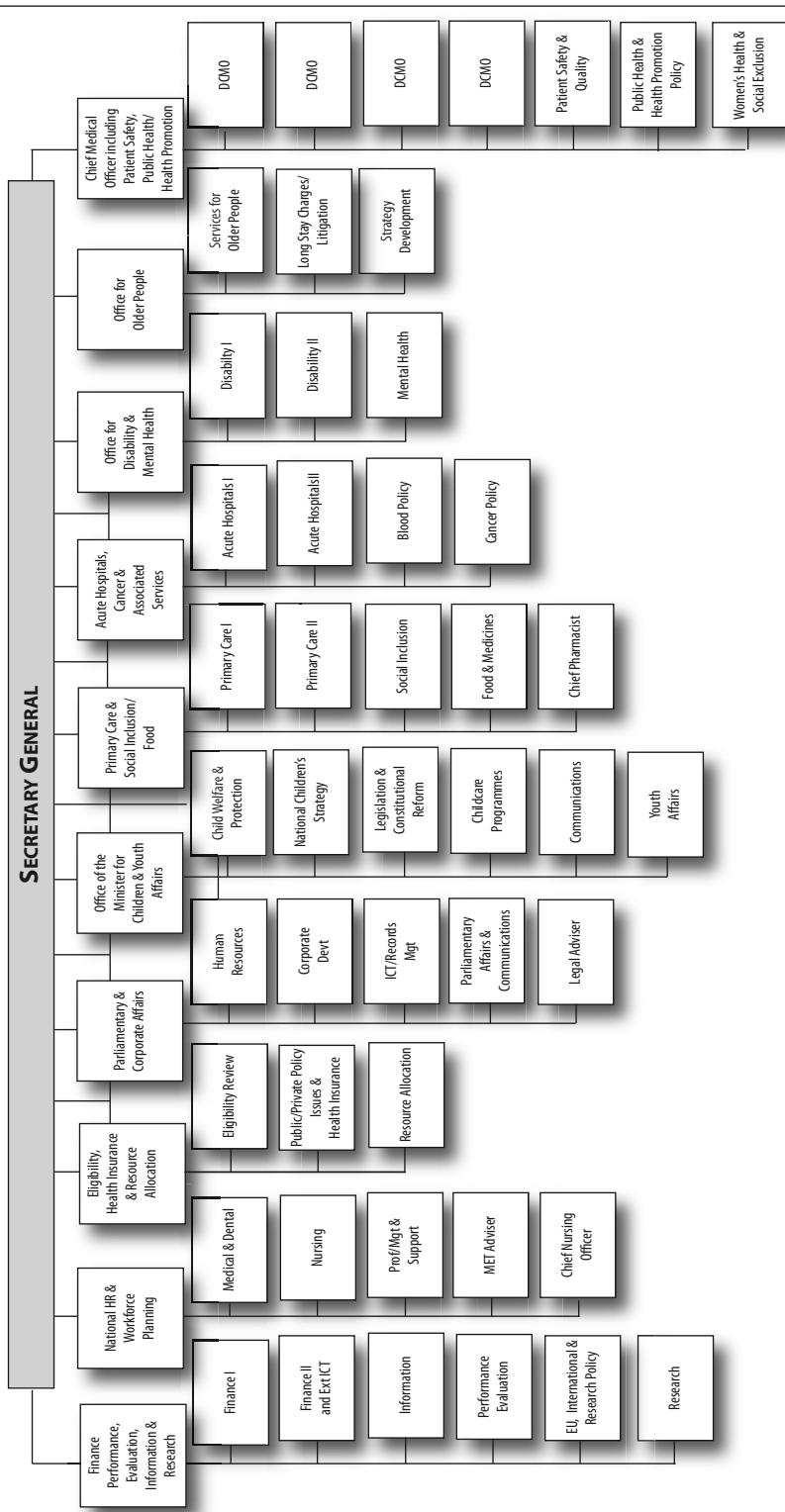
Bantry General Hospital
 Beaumont Hospital
 Cappagh National Orthopaedic Hospital
 Cavan/Monaghan Hospital Group
 Children's University Hospital, Temple Street
 Connolly Hospital, Blanchardstown
 Coombe Women's Hospital
 Cork University Hospital
 Cork University Maternity Hospital

Galway University Hospitals
Kerry General Hospital
Letterkenny General Hospital
Lourdes Orthopaedic Hospital, Kilcreene
Louth County Hospital, Dundalk
Mallow General Hospital
Mater Misericordiae University Hospital
Mayo General Hospital
Mercy University Hospital, Cork
Mid Western Regional Hospital, Dooradoyle
Mid Western Regional Hospital, Ennis
Mid Western Regional Hospital, Nenagh
Mid Western Regional Maternity Hospital Limerick
Mid Western Regional Orthopaedic Hospital Croom
Midland Regional Hospital Mullingar
Midland Regional Hospital Portlaoise
Midland Regional Hospital Tullamore
Naas General Hospital
National Maternity Hospital, Holles Street
Our Lady of Lourdes Hospital, Drogheda
Our Lady's Children's Hospital Crumlin
Our Lady's Hospital, Navan
Portiuncula Hospital, Ballinasloe
Roscommon County Hospital
Rotunda Hospital
Royal Victoria Eye and Ear Hospital, Dublin
Sligo General Hospital
South Infirmary–Victoria Hospital, Cork
South Tipperary General Hospital
St Colmcille's Hospital, Loughlinstown
St James's Hospital
St John's Hospital Limerick
St Luke's General Hospital Kilkenny
St Luke's Hospital, Rathgar (Cancer Services)
St Mary's Orthopaedic Hospital, Cork
St Michael's, Dun Laoghaire
St Vincent's University Hospital, Elm Park
Tallaght Hospital
Waterford Regional Hospital
Wexford General Hospital

APPENDIX 4: HSE ORGANISATION CHART



APPENDIX 5: DEPARTMENT OF HEALTH AND CHILDREN ORGANISATION CHART*



* As of the end of October 2009

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2

Health Policy and Economics

Michelle Butler

OBJECTIVES

- To provide an overview of health policy and economics.
- To provide an overview of the way in which health services in Ireland are financed.
- To situate the Irish health system in relation to health systems found in other countries.
- To identify trends in expenditure in Ireland and related economic factors.
- To examine the public/private mix in Ireland.
- To examine economic influences in health care.
- To identify issues of access and eligibility.
- To review recent health care reforms.

INTRODUCTION

Health policy is ‘agreement or consensus on issues to be addressed in order to achieve a desired result or change’ and ‘agreement on goals and objectives, the priorities between these objectives and the main policy directions for achieving them’ (Ritsatakis *et al.* 2000:1). Johnson-Lans (2006:3) suggests that health economics is about value, ‘more specifically, with maximising well-being in a world where choices must be made about the allocation of scarce resources’. Health policy can be linked very closely with health economics, where policy makers are concerned with how best to provide for the health care needs of the population in a time of burgeoning costs and ever-tightening fiscal constraints. Trade-offs may be required between equity, access, universal coverage, freedom of choice and cost containment (Weale 1988). Over time health systems become shaped by the cumulative effects of decisions made by policy makers. This chapter will examine how health care in Ireland is funded and will explore the impact of policy and economic developments in the health system at large on the delivery of care received by the individual.

HEALTH POLICY

The purpose of health policy is to ‘to clearly define measurable and obtainable objectives that can guide changes in health care delivery that will effectively and

efficiently produce a healthy society by improving the health of individuals' (Lancaster 1999:319). Health policy is inherently political in nature, involving multiple, diverse stakeholders, who very often may have very different, and sometimes competing, priorities and expectations. Weiss (1987:47) suggests that health care programmes themselves are 'the creatures of political decisions. They [are] proposed, defined, debated, enacted, and funded through political processes, and in implementation they remain subject to [political] pressures – both supportive and hostile.'

Policy is a cyclical process, and the policy cycle involves the identification of a problem or agenda setting, policy formulation, policy implementation and policy evaluation. Policy evaluation provides the information required to begin the cycle once again and this part of the cycle is often referred to as *closing the loop*. For further details of the policy process see Milstead (2004).

Over recent years those involved in health policy decisions have become concerned with economics in health care provision. Dobrow *et al.* (2004:207) suggest there has been greater recognition of and attention to 'the classic economic dilemma between the scarcity of resources and our potentially unlimited wants, raising difficult resource allocation, rationing and priority setting questions'. Even in Ireland's recent unprecedented period of economic growth, a cautious approach was promoted to funding health care, emphasising the need to demonstrate real returns for any increases in investment in health care (McCreedy 2003).

THE IRISH HEALTH SYSTEM

The Organisation for Economic Co-operation and Development (OECD 1997:116) described the Irish health system as a unique structure, comprised of a 'mixture of a universal health service, free at the point of consumption and a fee-based private system where individuals have to subscribe to insurance if they wish to be covered for medical expenses'. This 'mixture' relates both to the provision and to the funding of health services and the relationships between funders, providers and end users of health care. The Irish health system was also described as a social assistance model by the OECD (1992) in its comparative analysis of health care across countries, on the basis that the poorest one-third of the population are entitled to free services at the point of delivery (Wiley 2005). Wiley (2005) suggests that the Irish health system has evolved into the current 'mixed' system of provision and funding by drawing on a number of models. In 2006, 78 per cent of Irish health care expenditure came from public funding and the remainder through private funding (OECD 2008).

The World Health Organisation (WHO 2000:xi) describes a health system as 'comprising all the organizations, institutions and resources that are devoted to producing health actions. A health action is defined as any effort, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health.' In the Irish context the health system includes a range of public and private providers, providing a range of hospital and community curative, preventive and diagnostic services, funded by general taxation, private health insurance and direct payments. The Irish health system,

rather uniquely, also includes an element of personal social services which in 2005 accounted for just over eight per cent of non-capital publicly funded health expenditure (using data from CSO (2008b)).

Eligibility for health care

In Ireland, approximately one-third of the population are eligible for Category I ('medical card') cover on the basis of means testing, particular health needs and participation in approved government training and employment schemes (Nolan 2008). Providers of care for patients with Category I eligibility are reimbursed by the Primary Care Re-imburement Service (PCRS – previously the GMS (Payments) Board). The remainder of the population (Category II) must pay the full costs of family doctor consultations, all prescribed medications (costs in excess of €120 per month can from 1 January 2010 be reclaimed through the Drug Payment Scheme), and certain direct payments for hospital care (€66 for those attending for outpatient services, €100 for patients attending the emergency department without referral from a GP, and daily charges of €75 for in-patient care up to a maximum of €750 per annum (Department of Finance 2008)). Although Category I eligibility could be interpreted as the provision of cover for those most marginalised in Irish society, access to health care needs also to be considered separately from eligibility as access is determined by factors other than ability to pay. The proportion of the population covered by category/eligibility has fallen from 40 per cent in 1977 (O'Dowd 2007). Also, approximately 27 per cent of the Irish population have neither Category I eligibility nor private health insurance (CSO 2008a). This includes those who sit just above the means testing thresholds but who are on incomes well below the average industrial wage (see Nolan 2008).

Resourcing health care

In Ireland, resources for public health care are generated primarily through general taxation. Tax-financed systems are progressive, so long as the taxation system itself is progressive (i.e. tax liability is proportional to income, and those earning more make a greater contribution). However, in Ireland health care competes with other public services for a share of the resources generated through taxation. In the Irish context, 29 per cent of the €52.8bn of public spending (gross voted current spending) in 2008 was allocated to health. This was second only to social welfare (32 per cent). Almost €14bn was allocated to health care for 2009 (see Table 2.1). While this relatively high allocation to health care suggests health care is high on the agenda of government, this system of income generation for health care exposes the health system to changes in the economy which reduce the availability of public resources. Even in a stable economy, this system exposes health care financing to the relative value attached to health care and other public services by society, or more specifically, by the value attached to health care by individuals and groups with power within society.

Table 2.1: Voted expenditure for health care 2009 (€000)

Current expenditure	
Health Service Executive	12,149,325
Department of Health and Children	506,943
Capital expenditure	
Health Service Executive	20,450
Department of Health and Children	581,720
Total	13,258,438

Source: Department of Finance: Government Estimates 2009

One way to avoid this competition is to ring-fence health care funding. This happens in health systems funded through the social insurance model, which is common in several European countries. In the social insurance model, insured persons pay a regular contribution based on income or wealth, and not on the cost of the services they are likely to use. Health care is purchased on behalf of insured persons from public and/or private providers. Access to care is based on clinical need, not ability to pay. Participation is usually mandatory and contributions are paid by employees and employers. The size of pools varies from system to system and since social health insurance is separate from taxation and other publicly mandated systems, the income from contributions must cover the fees paid for the services to which members are entitled. Schemes may receive government subsidies and generally contributions for unemployed, disabled and elderly persons are collected from designated pension, sickness or unemployment funds or from taxation (Normand *et al.* 2006).

A third general approach to health care funding is the private finance system. Here health care is seen as a private commodity subject to market mechanisms, and individual choice of provider is a primary concern. Resources are raised individually and paid directly by users or through private health insurance. The most often cited example of a private finance system is the health system in the United States. Although Medicare and Medicaid provide cover for older Americans and those defined by each state to be poor, health care is seen as a private matter and individuals purchase care directly from private providers.

Several features of a private finance system are to be found in the Irish health system. The private health care sector in Ireland, also referred to as the 'independent sector', is mainly comprised of GPs, but the number of private hospitals and clinics has grown considerably over recent years (O'Dowd 2007). In addition, a number of new services have been introduced by the private sector, perhaps most notably the provision of emergency department services (although these are usually available only during business hours). In addition, private beds are provided in public hospitals, with the proportion of public to private beds set at approximately 80:20. The growth in private providers is mirrored by a growth in private health insurance from 17 per cent in 1977 to 50 per cent in 2005

(O'Dowd 2007). In 2007, 49 per cent of the population had voluntary health insurance (CSO 2008a) provided by four private health insurance companies.

Voluntary health insurance was first introduced in Ireland in the 1950s with legislation (the Voluntary Health Insurance Act 1957) to provide for the establishment of the Voluntary Health Insurance Board. This was to enable those who were not eligible for public hospital services, or who wished to avail of private or semi-private care, to make arrangements to cover the costs of private health care. The Health Insurance Act was passed in 1994 to open up the private insurance market in light of an emerging single European market. Premiums are linked to the range and levels of services available to subscribers from a range of public and private providers. Health insurance subscriptions are tax-deductible at the standard rate of tax and any health expenditure not reimbursed through the health insurance provider can be claimed against tax at the marginal rate (Wiley 2005).

Mossialos and Dixon (2002) suggest that health systems in which private health insurance is widespread generate a highly regressive pattern of distribution. In 2006, the US health care system was the most expensive of the 22 OECD countries, costing just over \$2 trillion. This equated to 15.3 per cent of gross domestic product (GDP) compared with the OECD average of 8.4 per cent. Despite this, 45 million Americans, as many as 30 per cent in some states, were uninsured (Alakeson 2008). In addition, in private health insurance systems, competition between insurers forces them to adjust the premiums of enrollees according to their relative risk, and individual contributions are linked to illness rather than to income. Such systems are also subject to the problem of adverse selection, where those who voluntarily take out health insurance tend to do so on the basis of known or anticipated need for health care. Thus they tend to cost more to insure than the average person.

Health insurers use various mechanisms to attempt to control adverse selection, such as underwriting, rating premiums according to individual risk, excluding pre-existing conditions from cover, and limiting coverage to members of groups formed for reasons other than to buy insurance coverage (e.g. union members). Insurers may also exclude certain expensive services or treatments or require patients to share the costs of treatment. Kutzin (2001) suggests that strong government involvement is required to regulate such markets to prevent segmentation of the population into different risk pools which would make it increasingly difficult to finance the premiums of people in sicker pools. Insurers may also provide packages which are more likely to appeal to younger, healthier subscribers (e.g. maternity care, health screening), aimed at limiting the risk in the pool.

In Ireland, several mechanisms have been applied to the private health insurance market. These include community rating, open enrolment, lifetime cover, minimum benefit and risk equalisation (Health Insurance Authority 2008). Community rating requires the same premium to be applied to all individuals regardless of personal characteristics. While premiums are related to the benefits available, the level of risk that a consumer poses does not affect the premium paid.

This is a mechanism to pool the health risks of the population; and revenues saved from healthy members cover the costs of sicker members.

Open enrolment requires all applicants to be accepted regardless of their risk status. Lifetime cover guarantees consumers the right to renew their policies regardless of age, risk status or claims history. Minimum benefit is provided for in regulations introduced by the Minister for Health and Children in 1996, which set out the minimum levels of benefit that must be provided by all insurance contracts sold in Ireland that provide cover for in-patient hospital services (Health Insurance Authority 2008).

Risk equalisation aims to protect community rating by ensuring that insurance providers who take on or have a higher proportion of older people (on the basis that they are more costly to insure) are compensated through a levy applied to insurance providers with a lower proportion of older people. In 2005, the Health Insurance Authority (the statutory regulator of health insurance in Ireland) recommended the commencement of the risk equalisation scheme (which had been provided for in the 1994 legislation). One of the providers (BUPA Ireland) took out a challenge to the introduction of risk equalisation in the High Court in May 2005, but the legality of risk equalisation was upheld under both Irish and EU law. However, the Minister for Health and Children (Mary Harney) held off on the introduction of the scheme until the government had started converting VHI (Ireland's largest provider) from a statutory body to a commercial body (Global Insight 2008).

Revenue collection, fund pooling and purchasing health care

The three elements of health care financing identified by Mossialos *et al.* (2002) are revenue collection, fund pooling and purchasing. Revenue collection in a health system funded through general taxation is always associated with prepayment and large pools. Individuals, households and firms pay direct taxes or indirect taxes levied on commodities and transactions. These can be levied at the national, regional or local level. Taxes can be general or earmarked for a specific area of expenditure. Prepayment provides protection against uncertainty and the risk of having to make large out-of-pocket payments, or not having the means to pay out of pocket to access services. However, most health care systems have an element of patient cost-sharing (direct payment), even those with universal coverage ('everyone in the population has access to appropriate promotive, preventive, curative and rehabilitative health care when they need it and at an affordable cost' (WHO 2005:1)). Direct payment may also be used where prepayment (insurance or taxation) is inadequate, to reduce demand, or to ration services. In the Irish health system, out-of-pocket charges apply to Category II patients using hospital services. Some of these direct charges (e.g. emergency department charges) are aimed at discouraging inappropriate use. Although income is generated through direct payments, charges tend to be notional and the income generated tends not to cover the economic cost of the service or treatment.

Risk pooling or fund pooling is the accumulation of prepaid health care revenues and the spreading of risk among the participants through cross-subsidies

from low-risk to high-risk individuals. Larger pools will benefit from economies of scale and will require lower contributions to protect against uncertain needs (Kutzin 2001). In private health insurance, funds are pooled between subscribers of the same insurance provider. However, the pool may not be shared equally to the same extent as in social insurance pools. Premiums may be related to an individual's risk and pooling may not be between high-risk and low-risk members unless community rating is applied.

Purchasing is 'the transfer of pooled resources to service providers on behalf of the population for which the funds were pooled' and involves the distribution of the funds pooled between competing claims to meet certain pre-specified goals (Kutzin 2001:180). Traditionally in the Irish health system an incrementalist approach had been adopted to purchasing: health boards received funding based on what had been allocated the previous year with some adjustments for agreed new developments, increases in pay costs, service-specific items relevant to each health board and projected inflation rates. Using Rice and Smith's (2002) paradigm, Wiley (2005) describes the Irish approach to resource allocation as prospective funding based on expected future expenditure using fixed budgets. Wiley (2005) identifies a significant historical dimension which generally underlies the determination of health service budgets in Ireland and the absence of formula-based resource allocation approaches.

However, over recent years there has been a 'conscious move' away from this approach towards the development of 'more systematic decision-making tools' for the allocation of health care resources (Lynch 1998:104). The introduction of case-mix budgeting in acute hospitals is one example of such tools, which aim to link funding more closely to agreed levels of service. The Health (Amendment) (No. 3) Act 1996 provided for the introduction of service planning in the Irish health system. The Act required the eight health boards at the time to enter into an annual cycle of planning, through which they would set out in a service plan the services to be provided over the following year for the funding received by the Department of Health and Children. The legislation set out very specific requirements for health boards in relation to the service planning process and their interaction with the Department of Health and Children. With the subsequent establishment of the Eastern Regional Health Authority (ERHA), provider plans were introduced to clarify funding and service arrangements between the ERHA and hospitals and other agencies providing care to the population in the Eastern Region. With the abolition of the eight health boards and the ERHA and the establishment of the Health Service Executive (HSE) in 2005, service planning continues between the HSE and the Department of Health and Children and between the HSE and agencies providing care on its behalf.

TRENDS IN HEALTH EXPENDITURE IN IRELAND

Current expenditure on health care in Ireland is 8.9 per cent of gross domestic product (GDP) (OECD 2008). However, measuring health expenditure as a proportion of GDP has its limitations where there are sudden fluctuations in growth. This can be seen in the Irish context. In the recession of the early 1980s,

when growth was less than two per cent (Fitz Gerald and Kearney, 2000) health expenditure as a proportion of GDP was 7.72 per cent. In contrast, in the late 1990s when growth in GDP was about 10 per cent, health care expenditure was about 6.5 per cent. However, in 1980, expenditure on health care was €890.10m, whereas in 1995 it was €2.9bn. A more stable comparative measure of expenditure is expenditure per capita. Total expenditure (public and private) on health care in Ireland in 2006 was US\$3,082 per capita. This is just above the OECD average of US\$2,824. Health care expenditure in the United States is the highest of all OECD countries whether measured as a proportion of GDP (15.3 per cent) or expenditure per capita (US\$6,714).

Ireland experienced an unprecedented period of economic growth between 1995 and 2007, peaking at more than 10 per cent in 1997 and 1999 (ESRI 2008). Public expenditure on health care has changed dramatically over the last twenty years, primarily related to dramatic changes in economic growth. In the mid-1980s, when Ireland experienced negative growth in GDP, this resulted in contraction in public investment in health care and significant retrenchment in health services. The impact of the period of retrenchment in the 1980s is still to be found today, particularly in relation to bed capacity. Savings during this time of contraction were found mainly by reducing hospital expenditure. Between 1980 and 1988 expenditure on hospital services declined by 15 per cent, comprising: a reduction in acute hospital beds by 20 per cent; a reduction in average length of stay of 19 per cent; a 25 per cent reduction in hospital bed days; and a five per cent reduction in discharges from acute hospitals (Wiley and Fetter 1990). In 2007 Ireland had 20 per cent fewer hospital beds per capita than the OECD average and it is estimated that there were 1,118 too few beds in the system (PA Consulting 2007).

In contrast, health expenditure (in constant terms) increased by 23 per cent between 1990 and 1996, and by 86 per cent between 1996 and 2002 (Wiley 2005). However, the recent period of economic growth was short-lived: in 2009 the Irish economy declined by 7.5 per cent and a further contraction of 1.5 per cent is predicted for 2010 (Department of Finance 2009). In his Pre-Budget Outlook (Department of Finance 2009) the Minister for Finance announced the need to make an adjustment to the budget of €4 billion in 2010 in order to stabilise the budget deficit. This is likely to be reflected in significant cutbacks in all public expenditure.

ECONOMICS AND THE DEVELOPMENT OF IRISH HEALTH POLICY

Prior to 1947 health services in Ireland were financed largely through local taxation, but there was growing concern about the increasing burden being placed on local sources of finance due to increasing costs and a growing range of services; and also about disparities in services provided from county to county (Commission on Health Funding 1989). A White Paper published in 1966 proposed that ultimate responsibility for health service financing should rest with the state and that there should be changes in the administration of the services. A modern health system would require services that would span county boundaries

to provide the concentration of population required to support these services (Wiley 1998).

The 1966 White Paper on Health and the Health Act 1970 that followed were the first real attempts to change the service radically since the Poor Relief Act of 1838. They also tried to address one of the main criticisms at the time that there was a two-tier system in place with persons using the dispensary system having no choice of doctor and being separated from private medical patients. This led to the introduction of the General Medical Services (GMS) scheme in 1972. This scheme was administered jointly by the eight health boards, which provided for a choice of doctor and pharmacist for those eligible, based on a means test (O'Hara 1998).

The next key policy document, *Health, the Wider Dimensions*, was published in 1986 (DoH 1986). At the time of the review, the health board system had been in place for some time (and there had been considerable development and expansion of the system in the wake of the 1970 Health Act), and it was considered an opportune time to review the whole approach to health and to consider modifications in health policy required to meet the needs of the 1990s and beyond. There were particular concerns about trends in the utilisation of services and the potential mismatch between demands and resources in the future, and international developments needed to be reflected in national policy. Equity was defined as 'The distribution of available health services over the population on the basis of need and an equitable sharing of the cost of providing such services' (DoH 1986:18) and concern was noted about how access could be guaranteed to the whole community with individuals being required to pay on the basis of their financial means. Equality of health was noted as a concern – that each individual should have the same opportunity to enjoy good health. The document noted the existence in Ireland of clear inequalities based on age and sex groups, socio-economic groups and the need to recognise that these inequalities do exist and to frame policy responses that would promote equality in health based on an analysis of the differences. It also identified that a mix of national and local-level responses would be required. It reported that the traditional view of efficiency in terms of 'squeezing the fat out of the system' was too narrow and that changes in the basic design of the system needed also to be considered. It also highlighted the need for fundamental analysis of the value for money of services and how this could be improved through economic incentives in the system. It stated that a system of a public/private mix had evolved over a long period of time and should be opened up to debate. A range of issues was identified in relation to management and planning, in particular accountability at health board level and the lack of integrated planning due to the programme structure. It identified the need to adopt a new approach to planning and information and financial management that would involve measurement of health needs in local populations and the identification of health goals and a formal planning cycle.

The Commission on Health Funding was established in 1987 in the wake of public concern and dissatisfaction with a range of across-the-board cuts undertaken in response to economic difficulties at the time, which were seen as rather crude and in need of rigorous review. In its report (Commission on Health

Funding 1989) the commission identified a range of weaknesses in the planning, organisation, management and administration of the system which reduced its efficiency, effectiveness and responsiveness. It noted the strong focus on hospital systems and inequities and rationing in the system.

The key theme in *Shaping a Healthier Future*, introduced in 1994 (DoH 1994), was the need to reorientate the Irish health system towards improving the effectiveness of health and personal social services. It proposed that prevention, treatment and care services should be more clearly focused on improvements in health status and quality of life. It highlighted the importance of equity and quality of service, and the need to focus on the provision of a positive outcome rather than on the provision of a level of service.

The latest health strategy, *Quality and Fairness: A Health System for You* (DoHC 2001b), builds on many of the priorities set out in 1994. In terms of resourcing health, it states that the strategy outlines the largest concentrated expansion in services in the history of the Irish health system. Proposals are set out over the full range of services and it is stated that these proposals are the result of detailed research and expert input addressing system-wide as well as programme-specific issues. There is a strong focus on implementation and the document concludes with an implementation plan. The strategy sets out four national goals (see Table 2.2) and six frameworks for change.

Table 2.2: Four national goals set out in the 2001 Irish health strategy

<p>1 Better health for everyone</p>	<ul style="list-style-type: none"> • Health of the population at centre of public policy. • Promotion of health and well-being intensified. • Health inequalities reduced. • Specific quality of life issues targeted.
<p>2 Fair access</p>	<ul style="list-style-type: none"> • Eligibility is clearly defined. • Scope of eligibility framework broadened. • Equitable access for all categories of patient.
<p>3 Responsive and appropriate care delivery</p>	<ul style="list-style-type: none"> • Patient at the centre in planning care delivery. • Appropriate care in the appropriate setting. • The system – capacity to deliver timely and appropriate services.
<p>4 High performance</p>	<ul style="list-style-type: none"> • Standardised quality systems – best patient care and safety. • Evidence and strategic objectives underpin all planning.

Source: DoHC (2001b)

Key themes in the six frameworks for change are: the need to strengthen primary care and to reform the acute hospital system; the need to target investment using an evidence-based approach and prioritised programmes; and the need for transparent funding systems where funding is linked to service plans, outcomes and incentives for efficiency. Also highlighted are the need to develop approaches

to human resource management, the need for organisational reform, the establishment of the Health Information and Quality Authority (HIQA) and the need to invest in and develop information available for planning and organisation. The strategy sets out 121 targets to be achieved over specified timeframes. The 2001 strategy is also underpinned by the primary care strategy, *Primary Care: A New Direction* (DoHC 2001a). Although this was published alongside the *Quality and Fairness* strategy, the primary care sector remains underdeveloped and under-resourced.

Three major reviews of health services have been conducted since the 2001 strategy: the Brennan Report (DoHC 2003a); the Prospectus Report (DoHC 2003b); and the Hanly Report (DoHC 2003c). The key issues identified are summarised in Table 2.3.

The Brennan Report (DoHC 2003a) is the *Report of the Commission on Financial Management and Control Systems in the Health Service*. In its detailed review, the commission noted the absence of any organisation responsible for managing the health service as a unified national system. It also noted that financial management and control systems were not designed to develop cost consciousness among those who make decisions to commit resources and provided no incentives to manage costs effectively; insufficient evaluation and analysis of existing programmes and related expenditure; and inadequate investment in information systems and management development.

The aim of the Prospectus review (DoHC 2003b) was to audit the extent to which the structures and functions of the health system are organised to deliver on the ambitions of the health strategy *Quality and Fairness* (DoHC 2001b). The review found the complex and fragmented structures in the Irish health system an obstacle to achieving improvements. It noted the continued involvement of the Department of Health and Children in operational matters, reducing clarity around organisational accountability, and overlap between specialist agencies and other bodies. It recommended the rationalisation of certain agencies through mainstreaming or merging and the need for standardisation and co-ordination across the system. The review identified particular gaps in relation to governance and accountability and highlighted the need to strengthen service planning and to align resource allocation and planning cycles; the need to strengthen service evaluation; the absence of a consistent focus on the consumer; and the need for a clearer focus on stakeholder participation required at each level of the system.

The Hanly Report (DoHC 2003c) is the *Report of the National Task Force on Medical Staffing*. The task force recommended the development of acute hospital services that are consultant-provided rather than consultant-led and the reconfiguration of acute hospital services to provide patients with access to specialist staff. It also highlighted the need for high volumes of activity in order to maintain consultants' expertise and quality care, and the need to ensure access to appropriate diagnostic and treatment facilities. It recommended the development of integrated hospital networks and supra-regional and national specialist services.

Table 2.3: Summary of issues identified in Irish health policy

Health system	Outcomes Equity Integration Patient focus and stakeholder participation Emphasis on acute services Capacity and funding Decision-making and strategic planning Quality systems and information management Human resource management No one organisation managing a unified health system Need to streamline organisations Accountability, evaluation and cost-consciousness Medical education and training
Hospitals	Configuration of acute hospital services Consultant-led rather than consultant-provided Shortage of non-consultant hospital doctors (NCHDs) Critical mass to sustain consultants and for quality care
Community services	Underdeveloped Under-resourced

Source: DoHC (2001b, 2003a, 2003b, 2003c)

CHALLENGES TO HEALTH CARE FINANCING

In a review of health policy across countries, Saltman *et al.* (1999) identify five common key economic challenges facing health policy makers. The first of these is dealing with scarcity. As the resources required to pay for health care become more constrained, pressures on health expenditure increase. Certainly scarcity of resources has been a recurrent theme in Irish health policy. Saltman *et al.* (1999) suggest that this leaves policy makers with two basic options that may also be complementary. One is to move funds from other areas of public sector expenditure or to increase taxation or social insurance contributions. The other option is to control health expenditure by influencing either demand for or supply of health services. In Ireland, a relatively high proportion of public expenditure is allocated to health and this has continued to be the case as economic circumstances change. There has also been a trend to reduce taxation over the last decade or so. However, there are several examples of attempts to reduce demand for and supply of health services. These include the direct payments required of Category II persons who use acute hospital services and GP services, and the use of waiting lists to control numbers seeking elective services. While these direct charges reduce inappropriate use of such health services, they also deter necessary use. Waiting times and overcrowding experienced by patients when they attend for outpatient and emergency department services also act as deterrents to using publicly funded services and provide an incentive to opt for

private health care (Tussing & Wren 2006) or to purchase private health insurance.

The second major economic challenge is in relation to funding systems equitably and sustainably and balancing equitable and sustainable funding for services with scarce resources. In Ireland, approximately one-third of the population has Category 1 eligibility, meaning they have full access to all publicly funded health services, on the basis of means testing. While the proportion of the population eligible has remained at approximately one-third, the threshold for access changes over time. For example, the expansion of Category I eligibility to include those over 70 years of age in 2001 (without means testing) came at a time when the government was moving the income-based eligibility line downward by failing to increase it in line with rising incomes, thus taking free medical care away from the poor. Tussing and Wren (2006) estimate that in November 2005, 350,000 lower-income people were not covered by medical cards who would have been covered had coverage remained at its 1996 level. Eligibility does not ensure access to care when it is required and significant differences are reported in the length of time public and private patients wait for elective procedures and to see a consultant (Tussing & Wren 2006). Aside from waiting list times, other factors may limit access to services for those eligible to use them, such as the geographical location of services, the availability of services outside normal business hours, waiting times and the acceptability of services. Differences are also reported in the level of service received between public and private patients, for example whether they receive consultant-led or consultant-provided care, and in the standard of accommodation (Tussing & Wren 2006). Equity also relates to equality, or the opportunity that each individual in society has to reach their full potential in relation to health. Significant inequalities in health have been noted in Ireland, including differences between occupational groups; those less well off or marginalised having poorer health outcomes; geographical differences and particular geographical hot spots; and significant differences in healthy lifestyles between socio-economic groups (CMO 1999). Differences have also been noted in relation to gender and urban–rural locations (Balinda & Wilde 2001).

The third challenge is to allocate resources effectively, and Saltman *et al.* (1999) identify instruments such as contracting that have been developed in countries to provide stronger links between funding and the achievement of policy objectives. There are several examples of such approaches in Ireland over recent years. These include the development of service planning, which links funding with the services to be provided by the HSE and service providers over the coming year, and case-mix budgeting which aims to link acute hospital funding to activity levels based on diagnosis-related group (DRG).

The fourth key challenge is to deliver care efficiently. Difficulties here relate to inefficiency at the micro level, poor co-ordination among providers, lack of incentives for efficient service provision, lack of adequate information on the cost and quality of services, inadequate management of capital resources and the quality of services. Several of these issues have been identified in recent reviews of health services in Ireland.

The fifth key challenge is to implement change. Saltman *et al.* (1999:13) suggest that ‘Reform failures have little to do with the relative merits of the reform programme but rather reflect inadequate understanding of the process of reform implementation and the management of change.’ They report that policy implementation is influenced by a range of contextual factors and the implementation process is directly affected by the system of government and the distribution of authority as well as the way in which the process itself is conducted. The pace of implementation – whether to go for a ‘big bang’ or incrementalist approach – and the involvement of stakeholders are seen as key determinants of policy change. The development of the latest Irish health strategy (DoHC 2001b) involved nationwide consultation with key stakeholders. In addition, the strategy itself included an implementation plan and the 121 targets included are reasonably specific and time-bound. Regular reviews of progress have been undertaken over the eight years since the strategy was first launched. In addition, corporate and service plans produced by the HSE reflect the targets set out and the progress made year on year towards achieving the objectives. There is no doubt that the approach adopted was a ‘big-bang’ approach and the health system in 2010 is considerably different from that in 2001. However, further bedding down of the reforms is required before the full effects of the reforms can be evaluated fully.

CONCLUSIONS

Several economic concerns have influenced the development of health policy in Ireland since the 1960s. These include the availability of resources in the light of increasing demands and changing population demographics. There has also been significant concern about the lack of transparency in relation to financing health services and the need to adopt more systematic and analytical approaches to planning. The service planning process and case-mix funding provide a stronger link between funding provided and the services provided. However, further developments are required to more closely match services to the assessed needs of the population as a whole and the different groups within the population. Issues such as cost containment, equity, efficiency, effectiveness and accountability prevail despite a range of policy statements over the years highlighting the need to address these concerns. Examples of specific experiences and concerns continue to feature regularly in the Irish news media. The Irish health system has undergone a sustained and progressive programme of reform since the Health Act 1970, which has been renewed regularly through subsequent health strategies. However, the most recent wave of reforms has involved a major restructuring of the health system itself. Although these reforms are based on wide consultation and expert reviews, it will take some time for the reforms to become properly established and for their effects to impact on health outcomes. In addition, the sudden downturn in the economy will prove to be an additional challenge to the reform programme itself.

REFLECTIVE EXERCISES

- 1 In your own experiences as a health care provider, manager, patient, relation or citizen, how does economics affect health services in Ireland?
- 2 How equitable is the Irish health system?
- 3 What are the options available to health policy makers in Ireland to increase investment in health care?
- 4 Would a social insurance model be more appropriate for the Irish health system?

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