



Implementing Social Health Insurance in Ireland

*Report of a meeting and workshop held in Dublin, on
December 6th 2010*



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Sponsor :- School of Nursing, DCU.

Summary

We considered two basic questions, '*Is it possible to implement Social Health Insurance in Ireland?*', and '*How can this be done?*'.

Can Social Health Insurance be implemented in Ireland? Our answer is a very definite *yes*. Furthermore, there would be many opportunities, while working towards this end, to improve the performance of our health care system.

How can it be implemented? This process will need to be actively managed. There are many difficulties in the Irish health services, but also many opportunities. The greatest strengths are the talented, well-trained and very committed staff. Getting and keeping the support of these staff, for the necessary changes in service delivery, will be critical. Ireland has the capacity to make these changes, but without high quality management, a detailed focussed plan for change, and political support, little will happen. Each step in the change needs to be planned to maintain services, improve service delivery, improve service accountability, and improve service governance. Each sector of the service will need someone to lead the change, and mind that service during the change.

- Primary care remains under-developed. The HSE plan to develop primary care teams (PCT) has not succeeded. There are several established PCTs which work well. In other areas there are informal arrangements for collaboration, which work well. Overall, there are many useful lessons to learn from the experience so far. Future developments will need to place general practice at the centre of primary care. The mechanisms for doing this will vary from place to place, but need to be developed urgently.
- Acute hospitals face a crisis of governance. Maurice Hayes' (1) recent report on Tallaght hospital gives an idea of the scale of the changes needed. Tallaght is, we believe, not atypical, and is reputed to be by no means the worst governed hospital in the system. This, alone, should provide a pressing motive for change. Redesigning Irish hospitals to a new mission of supporting primary care, of supporting care in the community where possible can, and must, be done.
- Long-term care for older people is also a challenge. We advise moving to an integrated needs based system with smooth transitions between different degrees of support at home, and different degrees of support in specialized housing facilities including nursing homes. A similar model should apply to other forms of long-term care, for example for people with a substantial disability.
- Information systems and management processes both need a major overhaul. The health service remains strikingly under-managed, and fixing this will need a substantial culture change within the services. Wide use of standardized formal project management processes will be vital. There is a separate plan being developed to improve health service IT systems, and implementing this needs to be a high priority.
- We have not considered other key sectors, for example mental health, disability services, and social services. This does not mean that these are unimportant, merely that we had limited time, and a great deal to cover.

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1 Background

A meeting was held on 6th December 2010 in Dublin to consider strategies for implementing Social Health Insurance in Ireland. We were generously supported by the School of Nursing, in DCU, and we are grateful to Catherine McGonagle, the head of school, for all her support. The attendance included practitioners, managers, administrators, civil servants, and academics. The Chatham House rule applied (<http://www.chathamhouse.org.uk/about/chathamhouserule/>).

We had talks from four speakers, Prof. Peter Groenewegen, director of Nivel, a health services research institute in the Netherlands; Prof. Orla Hardiman, a consultant neurologist in Beaumont and clinical researcher; Dr. Steve Thomas, a health economist from TCD; and Dr. Martin White, a general practitioner from Nobber, Co. Meath. We then divided into four groups, working respectively on primary care, acute hospital care, long-term care, and raising and allocating resources. The speakers' presentations and related materials are available on the editor's website, (<http://astaines.eu/meetings/shi>).

Responsibility for this report lies with the editor, the speakers and the named contributors, but I gratefully acknowledge the invaluable inputs of the speakers and all the other participants at the meeting.

1.1 Basic principles

The Irish health care system has been extensively analysed in many recent books, papers, and the mass media. The woes of the Irish health services are also well known, and have been reported in a lengthy series of bad news stories in the Irish media.

However, the more fundamental issues are also well understood. Recent books by Sara Burke (2), Maev-Ann Wren (3), and Dale Tussing and Maev-Ann Wren (4), have identified these with great clarity. Two recent reports on resource allocation, one, on primary, community, and continuing care, from Anthony Staines and colleagues in DCU (5,6), and a major report (7), from a committee established by the former Minister for Health, Mary Harney TD, and chaired by Prof. Frances Ruane of the ESRI, have explored the financing of the Irish system in great depth.

Our health care system is, we believe, fundamentally flawed, and further tinkering around the edges will get us nowhere. A radical revision of how we deliver, pay for and organize health care is needed; a system which eliminates, once and for all, the two-tier system of health care; a system which puts patients at the heart of the service; a system which builds out from primary care.

The most coherent policy proposal made, so far, is to introduce some form of Social Health Insurance (SHI) (8). There are several models of SHI in Europe, but their common features include tight state regulation, healthcare funded by income related contributions, healthcare arranged by insurance bodies which may act as purchasers or providers, with a strong emphasis on equity and social solidarity(8). Recent work, from Stephen Thomas, Charles Normand and colleagues in TCD, funded by the Adelaide Hospital Society, has outlined the feasibility and the affordability of SHI in Ireland (9-11). We now wish to consider some of the practical issues which will probably arise when implementing this in Ireland.

1.2 Values and Principles

Our aim is to support the development of a service which :-

- Provides equity of access to all services
- Guarantees reasonable access to decent services for health care, and social support¹
- Is built around patients

¹ We distinguish between equity of access – which implies that access to services does not depend on ability to pay, or having private insurance cover, and access to decent services, which is a measure of the quality of the bundle of services provided.

- Is built up from primary care
- Is built up from the many positive developments within HSE

We propose the following principles for the running of a future health service :-

- We will manage by the numbers – build an analytical approach to monitoring and evaluating services and allocating resources
- Services are national - parallel initiatives are needed to support balanced resourcing and balanced workloads on a local, regional and national basis.
- Patient at the Centre – a fundamental change from the current Provider Centred approach (somewhat pioneered by the Cancer Control Programme)
- Transparent and responsive – reducing the frustration of a public caused by poor information on service availability and quality – also reducing the frustration of providers who are meeting and exceeding their service levels.

1.3 Structure and Function in health service change

In any reform of health service provision, two issues must be balanced. The first is the structure which manages the system, delivers the resources, and guides service delivery. The second is what actually gets done in the millions of clinical encounters where healthcare is delivered. The first lends itself to grand intellectual principles, elegant economic and administrative structures, and other intellectually attractive activities. The second involves a lot of painstaking work with staff, building professional teams, analysing activities, rolling out support infra-structures and so on. Perhaps understandably, politicians, civil servants, and academics may prefer the first. Both are essential, but the work on and support for clinical encounters is the more important.

1.3.1 Health care - a dynamic system

Any health care system has to balance health care quality, health care access, and health care costs. Any effective healthcare system must balance these three, and the balance is not static. Think of a tightrope walker, walking on a high line, balancing a pole, with costs to the right, access on their back, and quality to the left. They must constantly shift their balance. If they stop, they fall off. There is no static steady-state system which will work, only a dynamic balance. Exactly the same is true for healthcare systems. Any regulatory system, any set of incentives must be constantly reviewed, to see if it still works, and changed if it does not.

2 Capacity

Change requires that the organizations changing have the capacity and the skills to change, and to continue service delivery while changing. It is appropriate to consider capacity for change in each of several key agents in the Irish health care system.

2.1 Change management in the health services (HSE and DoHC)

There is a significant issue of credibility for both the Health Service Executive (HSE) and the Department of Health and Children (DoHC), in putting forward proposals for large scale change in health service delivery. Both organizations have long track records of highly publicized failures in change management. Reviewing reporting of such topics as PPARs, co-located hospitals, national roll-out of breast cancer screening, will confirm this assertion. If the public, and health service staff, are to have faith in any plan of change, there will need to be clear and credible plan for effective change management in both organizations. This ought to include training and support for staff in management practice, and especially in project management. A credible structure for managing change will be needed.

- Formal training in project management processes will be needed for HSE and DoHC

2.2 Social health insurance - new roles for the services

Implementing an SHI system requires the introduction of a number of roles which do not exist in our current system. Each of these tasks is essential, and while some might be best done by health insurers, for others this might be very undesirable.

2.2.1 The initial definition, costing, and updating, of a basic package of care to be delivered to all subscribers.

In our view this is primarily a political decision. There are technical inputs, which are very important, but the key choices here ought to be made by elected representatives. The technical inputs are evidence on the range of services to be provided, and costings for these.

2.2.2 Monitoring the quality of care delivery to subscribers.

Three parties need to do this. Service providers, for internal management need to record a lot of details of activities and outcomes. These need to be available to their own staff, managers, regulators and the public. The next party is/are the insurers. They need access to a great deal of data on the performance and outcomes of the treatments offered to their clients. Without such data they will not be able to enforce contract terms, or make rational decisions about awarding or withdrawing contracts. These data need to be publicly accessible. Finally there needs to be an independent system, perhaps run by HIQA or the insurance regulators, monitoring overall quality of care.

2.2.3 Arbitrating conflicts between subscribers, insurers, and providers when disputes arise, and dealing with exceptions and marginal decisions.

This is a key role for the insurance regulator, and one which will test their skill, the soundness of their enabling legislation, their independence, and their political support.

2.2.4 Managing and controlling the system wide costs of health care.

There is a political role in setting overall budgets; there is a technical role in maximizing efficiency and effectiveness of care; and there is a regulatory role in pushing down costs. Markets do not have a good track record in controlling health care costs.

2.2.5 Managing risk equalization between insurers.

As the recent sharp rise in VHI charges demonstrates, effective risk equalization is vital if there is community rating, and more than one insurer working in a market. If it is decided to have more than one insurer, it will be essential to have legally sound, coherent, fair and effective risk equalization working first. This might be a further role for an insurance regulator.

- Definite decisions will be needed on each of the new roles required for SHI, and who will fulfil these roles

2.3 Health insurers

In an SHI system, the role of health insurers changes radically. In our current system, they take in money, invest it, and pay for services against receipts on a more-or-less fixed tariff. In no real sense do they manage care for their clients. As Relman (12) explains, this type of insurance system does not lend itself to cost containment, to quality health care, or to health care planning. In an SHI system, the primary responsibility for quality and value-for-money assessment will lie with the insurers. Do the current crop of Irish insurers have the ability to do this? It would mean a radical shift in their focus, and would require them to develop a very wide range of new skills. Allowing companies lacking the necessary skills to take part would risk significant failure.

- Devise clear criteria to be met by insurance companies participating in the SHI

A second question is how many insurance companies should be involved. Ireland is a small country, with a population of just over 4.5 million people. Bearing in mind that these insurance companies will cost more to run than the current companies, it is not certain that there is an affordable system which can give sufficient incentives to investors to move into this sector. This is a question which will need careful investigation.

- Assess the economic basis, costs and benefits of single vs. multiple insurance providers in the Irish SHI system

2.4 Health service regulators

Irish health care is not strongly regulated, although things are changing quickly. HIQA have a major role in relation to long-term care, and are rapidly developing a role in acute hospital care. HSE have just appointed a new National Director of Risk, Quality and Clinical Care, suggesting a move towards a more formal safety culture in that organization. This is an area where support for clinicians and managers, from the regulators will be essential. Any SHI system requires tight regulation of the whole system, if costs are to be controlled while quality is maintained, without very tight, and very tough, regulation, costs will rise or quality will fall, or both.

- A clear, transparent system for regulation of all health-care providers will be needed.

2.5 Health service providers

The Irish health care landscape includes several thousand providers, most of whom are in general practice, pharmacy services, and small voluntary bodies. There are about 80 'hospitals' of whom some 55 provide acute medical and surgical care. This landscape of providers will need to be effectively managed to deliver any sort of health-care reform. Some of these bodies are directly run by HSE, and most derive the large bulk of their resources from HSE, on the basis of contracts, or payments for demand-led services. Managing and developing open, frank, trusting and verified relationships with these providers is a key piece of managing change. It will not be easy to do this, but with sufficient clarity of purpose, and a strong management of the process, it can be done. It will be very important to make effective use of the skills and experience of existing HSE staff, and HIQA. Recent developments like the new cancer control program, and the clinical care pathways,

show just what the capabilities of HSE staff are.

- Providers will need to be engaged with the process of change early, and will need clear information, early on, as to where they might fit into a new structure of services.

Quality can also be a vexed issue. As we write this, the Dutch system is disturbed by a row between insurers, certain service providers, and the central quality office. The quality office has approved a range of providers for surgical services. One of the big insurers wishes to add a volume rule, so that providers who do only a few procedures a year will not be reimbursed. In a nutshell the question is who approves providers – a quality assessment from the regulator, or the insurers. A related issue, is whether each insurer is obliged to cover services provided by each provider. Is it possible for an insurer to require their subscribers to choose amongst certain providers, both for specialist care, and for primary care? If so, what are the limits of this? If a provider wishes to develop a service what is the process by which they negotiate this, and with whom? There are some very basic issues of system level governance to be considered here. It is likely that the best answers will vary depending on the services to be provided. Market mechanisms will *not* fill these gaps.

- Basic principles for approving services will need to be agreed at the start

2.5.1 Clinical staff

Clinical staff might find the changes proposed very disruptive. Keeping a tight focus on clinical activity, building and strengthening the work in HSE on care pathways, firmly rooting and connecting the care pathways from primary care, and providing staff with ready access to information should all prove helpful. Staff will need to know, as quickly as possible, where they will fit in the new system. It will be essential to develop the details of the process of change sector by sector with them.

- Clear process, sector by sector, for engaging clinical staff with the process of change in their sector

2.5.2 Administrative staff

It is an open question if HSE and DoHC staff presently have the capacity to introduce and manage large scale change. Both organizations have many skilled, talented, and dedicated people. Both have extensive records of repeated serious failure in implementing change. Both will be required to deliver sustained and effective effort to introduce a new health care funding system.

To achieve this several things need to be in place. Staff will need access to training and support. The co-ordination and leadership of the senior management in both organizations will be crucial. Formal management processes, especially formal project management, and audit of service delivery will be critical.

- Clear plan for change management in HSE and DoHC
- Support and training for managers and administrative staff

2.6 Future of HSE

One of the likely parties in the next government (Fine Gael) proposes to get rid of HSE, in a staged way, over a reasonable time. Managing this process will be an extra challenge. Crucial to a successful transfer of the role to a new organization is clear communication both at organization and individual level. The many failures in originally establishing the HSE must serve as an object lesson. The NHS in England also provides many examples of how not to do this.

- The role and responsibilities of the successor to HSE need to be clearly defined as early as possible

- Existing HSE staff need to know, as quickly as possible, where they will fit in the new systems, and what role(s) they will have. This is particularly important for middle managers.

2.7 Information

The defects of the information systems in HSE have been extensively reviewed (6,13). It may not be as well appreciated that HSE has had considerable success with using these poor systems to provide effective tools for planning services. It will be very important to build on the successes of the Health Intelligence unit in HSE, notably the Health Atlas, and to integrate new information systems into this framework. There are systematic proposals being developed elsewhere to greatly improve information systems in HSE, and these need to be implemented (see page 21 for more details).

3 Pieces of the service

In our work we were only able to review a selection of the services provided by HSE. This does not imply that services not included here are not important, but we suggest further work similar to this be done.

3.1 Integration of care - a patient centred service

If we are to make our health system patient-centred we need a chronic disease management strategy that is not disease focused. The current HSE single disease programmes led by specialists do not reflect the clinical reality that most people, particularly as they get older, have more than one condition. This is referred to as 'multi-morbidity' (13-16). We need interventions that work across conditions and focus on outcomes that matter to patients such as their daily functioning, well-being and ability to manage symptoms. If these improve we may also reduce emergency admissions, which is one of the greatest problems facing most health systems in industrialized countries. The HSE have been quoting USA based research to suggest that self-management programmes can reduce these admissions by up to 50% e.g. (17), whereas the UK studies of similar programmes found no significant reduction e.g. (18), so further research in this area is desperately needed.

- Realistic care pathways, starting in primary care, will be needed for major chronic illnesses and people with multi-morbidity

3.2 Patient registration

Patient registration is a key IT and management issue for primary care. To make any likely SHI system work, patients will be required to register, with a primary care practice, before using most healthcare. This does not diminish patient choice - which is a reasonable concern for many patients - but patient registration is the entry ticket to the health care system. An SHI model means, if managed properly, that registering with a practice will be the basic entrée to primary health care. Work is under-way exploring IT options to support this. We note that IT systems must also support urgent care, and care by providers other than the patient's usual provider, e.g. to cover care while on holidays.

- Patient registration for primary care will be required, and must be well supported by IT systems.

3.3 Acute Hospital Care

The key issues in developing acute hospital care are :-

- equity of access,
- accountability (including governance),
- support for primary care.

For equitable access we need a single queue for services, inpatient and outpatient, and reasonable capacity in emergency care services. For accountability we need more effective governance processes in the acute hospital sector, and information systems which support this. To support primary care we need a re-purposing of acute hospitals, to put the patient at the core of all their activities, and to view primary care as their key intermediaries with the patient. 'Money following the patient' will provide a strong incentive for this change to a patient focussed service. The incentive will need to be tightly controlled, because if it is not, the health budget will get out of control very rapidly.

A key strategic goal of the SHI process is to provide equitable access to GP services and, in turn, ensure that GP referrals to acute services either for diagnostics or specialist appointments will be based on need, not private insurance status – 'all patients will look the same' to the hospital. SHI will not increase the resource base, but it should ensure a better use of current acute resources, e.g.

better new to return ratio for OPD, if there is no benefit to patients or GPs (i.e. none of the current set of perverse financial incentives) in having ongoing treatment in hospitals. Theatres are often underutilized in public hospitals, and the facilities in the privates are used mainly for uncomplicated work, so there is some capacity.

There will remain a requirement for the government/HSE to have an overall plan for disposition of acute resources and ensuring primary care adequately resourced. There will need to be 'centres of excellence' as per current plans – a competitive free for all will not work, but there will be scope for efficiencies based on speciality or patient based funding. The current processes for ensuring quality – licensing, audit etc. – must remain in place. One route to this might be to set up eight or ten hospital networks, with common managements, boards and budgets, combining the existing fifty odd acute hospitals. This has already started, but the process needs to be completed. Hospitals will need to know that the new networks will be a permanent feature of the Irish health care system, and a commitment to a 'voluntary hospital style' of management, independent of HSE would be needed. In due course these facilities might move to an independent public ownership model, something like the Trust hospitals in the British NHS.

- Acute hospitals need to refocus on servicing primary care
- The framework for independently governed hospital networks should be established as soon as possible
- It is essential to make full use of the current processes, within HSE, on developing pathways to care, clinical effectiveness, and so on.
- All of these processes will need to start, and be rooted, in primary care.

3.4 Long Term Care

Several groups in our society require long term care, for example certain people with severe mental health problems, moderate or severe learning disability and severe physical disabilities. The largest group in long term care are the frail elderly. Our review focuses on this group, but we emphasize that the same principles apply to the other groups.

The guiding principles of such care are

- client centred care, with the wishes and needs of the clients determining placement
- provided equitably, transparently, and accessibly
- provided on a stepped, graded basis according to need
- integrated with community services
- sourced from a common budget for the care group to avoid perverse incentives

At present there is no effective integration between the various services provided to elderly people. Community based services, like general practice, and public health nurses, have separate budgets, separate management, and separate planning systems from the acute services. Service availability varies greatly between areas, primarily for historical reasons. Long term care facilities have been built, often in isolated areas, and driven largely by tax breaks. The long-term facilities are not integrated in any meaningful way into a health care system. Indeed provision of effective health and social care to residents of these facilities remains a problem. Furthermore the overall effect of the services is largely invisible. There is nowhere in the system that has an overall view, supported by data, of what is actually happening to this client group.

A second issue is the funding of these services. At present long-term care is largely funded through the Fair-Deal mechanism. The economic sustainability of this mechanism is unclear – it may be viable in the long term, but it may not. Other funding in this sector comes from a complex mix of state provision, out-of-pocket payment, and voluntary effort.

Service provision seems to be largely driven by the historical pattern of service provision, and the

private effort of individual entrepreneurs. Following on the 'Leas Cross' scandal, the long-term care sector is regulated by HIQA. A very recent Prime Time investigation, broadcast on RTE on December 13th [http://www.rte.ie/news/2010/1209/blog-ptihomecare_primetime.html] suggests that there may be similar needs in home care.

A sustainable common funding system for long-term care is urgently needed. There are models in other European countries, for example a levy of all income, similar to our universal social charge. These ought to be investigated. One of the potential strengths of our current system is the integration between health and social care. This ought to be developed in a more systematic way, and should cover all long-term care services. Logically funding ought to be based on a needs assessment. This is a much simpler and cheaper process than a full diagnostic assessment.

- As a matter of urgency, a sustainable system for paying for long-term care is needed. Different models should be urgently investigated, and an effective model implemented,
- The integration of health and social care is a fundamental strength in the Irish health care system, and should be exploited fully.
- Care should be based primarily on need, not on diagnosis.

3.5 Primary Care

Irish primary care comes from two groups, with very limited integration. First is general practice care, provided by GPs, practice nurses, community pharmacists, and an modest, but expanding array of other professionals who work in general practice. Some of these are actually HSE employees, some have salaries paid by HSE, and some work in a combination of capitation and fee per item. Second is the care provided by the former community care areas and the community mental health teams, this includes public health nurses, social workers, speech and language therapists, community occupational therapists, physiotherapists, psychologists, and psychiatrists. These groups have separate management structures, separate record systems, separate funding systems, and, largely, separate goals. This divergence make no sense at all.

It is proposed to move to a patient centred service, with equitable access for all clients. This is much less of an issue in primary care services, where almost all facilities treat patients regardless of the mechanism by which their care is paid for, than in secondary care services, where many facilities only treat private patients. What is needed is a clear process to move towards a general practice led primary care service. Equity of access includes access to diagnostic evaluation and treatment, but also equity of access to such services as physiotherapy, and occupational therapy. This is one major benefit of an SHI system.

This does not suggest a single model for these general practices. The needs and requirements of general practice in, for example, Dublin's Sheriff Street, Foxrock, Kilkenny, rural North Cork, and the Arran Islands, are not the same. A range of models will be needed. What all will have in common is a much greater level of care and service co-ordination provided at general practice level. There are several good models working now, which can be copied and adapted in other places. Patients will be required to register with their practice. Irish general practice is, largely, already organized into GP co-ops which will provide a natural frame for these developments. There should be an emphasis on organic development, with local solutions being developed, growing out of existing local partnerships, to meet local needs.

- An urgent decision is needed on the general mechanisms, both managerial and financial, for merging currently HSE provided services into general practice
- Different models of GP care will be needed in different places, and this will have to be supported.

- Building on the existing commitment, and innovation of Irish GPs and other primary care providers will be vital

3.6 Health Insurers and the 'Basic package of care'

A key element of most SHI systems is the 'basic package of care'. This is the key mandatory component of the SHI system. The vast majority of users will have this package. It will be subsidized for clients on lower incomes. Its safe, efficient and cost-effective provision is the core business of any SHI system. How the contents of this package are selected, and the processes for updating it, are critical choices. These are not simply technical choices, but deeply political choices.

- Systems to develop, update, and deliver, the basic package of care are the core of SHI

Health insurer(s) will need to be able to deliver a basic package, roughly similar to VHI plan B, to be carefully regulated, to be allowed to drive efficiencies by having an element of choice as to which care providers they purchase from and what rates are charged. It will be important that insurers monitor quality, and act on their findings. They need to be able to de-list providers for cause. The expertise of the HI provider(s) will develop over a years as the system evolves. Risk equalization will be a key issue and will need to be carefully worked out.

- The health insurer(s) is/are key to the effective running of the SHI system

3.7 Raising and Allocating Resources

It cannot be over-emphasized that these are secondary issues. The goal of any funding system is to encourage the provision of good accessible health care, to pay for that care, and to sustain the system of funding into the future. It would be quite possible to invest immense effort in a better system for funding our existing services, but this would be quite pointless.

Ireland's funding systems have had two very detailed examinations in the last year, and it is not proposed to review the system in any detail here. In summary, it is not possible to satisfactorily account for most Irish health care spending. The money provided is spent to provide services, but it is almost impossible to answer very basic questions, such as to whom are the services provided. The limited data suggest that service provision varies greatly between areas, and is not noticeably related, at area level, to any measures of need for services. National financial reporting is also notably poor, making comparisons with other countries very hard. This cannot continue, and it is now proposed to develop a national health accounts system.

- A national financial system is an absolute requirement for future service changes.
- The DOHC must prepare future reports using the OECD System of Health Accounts

With an insurance funding system there are several risks which need to be faced and addressed. First, the insurers have several strong perverse incentives, for example, to select providers on the basis of cost only, to deny useful, but expensive services, to promote pointless, but cheap services, for marketing reasons. They have a particularly strong incentive to select low risk clients. If there is more than one insurer, effective risk equalization will be needed from the start.

- Very clear regulation of the insurance sector will be needed.
- An effective, legally secure, agreed system of risk equalization will be needed.

There are several possible methods of raising the funding for services. Some services will need to be top-sliced, and these might be funded from general taxation. Other services are probably best funded by clearly hypothecated taxes, whether raised as a levy, by direct payment of premia, with subsidies for those on low incomes, or by some other means. The impact of these, and their interaction with the existing welfare system will need careful examination. The benefits to the system of clear public visibility of the flows of money for healthcare are probably significant.

- An early analysis needs to be done of the costs, progressiveness (or otherwise) sustainability, and acceptability of the various possible funding systems

Allocating resources is also a challenge. At present there are no intelligible allocation systems in use in Ireland. Service provision is dominated by historical accident, and budgets for existing services are usually simply increased, or, latterly, decreased year-on-year. This is wholly unacceptable. Taking a view of the services as being required to provide patient centred care, within a model where the money follows the patient, simplifies many of the choices around resource allocation. An individual based, needs driven model of resource allocation is entirely possible for Ireland .

4 Change management

The introduction of SHI in Ireland is a vast change management exercise. Any such exercise is risky. This risk is inherent, it cannot be removed, but it can and must be managed. The principles for this are well known (19). Effective leadership at every level, starting with the political level, will be necessary. Good communication of both the goal of the change, and of the impact of the change on individual services, individual clients and individual staff will be essential. Comprehensive use of formal management procedures, including project management will be needed, and staff will need support and training to use them. Most fundamentally HSE and the DoHC will have to adopt a culture of open and rigorous evaluation of their work.

Each part of the service must continue to work while being changed. The change must begin where the staff are, services are, where the management systems are, where the funding systems are, and where the information systems are, not where organizational desire might wish them to be.

Current hospital funding structures should not be altered too rapidly – a gradual change can be worked out over a number of years. Similarly, there cannot be a rapid change in contractual and remuneration arrangements without destabilizing the system.

4.1 Barriers and Facilitators of change

The biggest barrier to change, and the greatest facilitators of change, are the staff currently working in the system. It would seem that many staff are profoundly dissatisfied with the system, which makes them valuable agents for change. At the same time, many staff are tired, and cynical about the possibility of change. Mobilizing their energy, getting their commitment, making full use of their skill and knowledge, will all be necessary for change. This cannot be simply a screen, unless staff have a real sense of ownership of the proposed change, unless they can see how it will impact on their working lives, they will not support it. Unfortunately a series of badly considered, and poorly implemented changes over the last decade have discouraged staff. Keeping the staff focus on changes impacting on clinical care will help to overcome cynicism.

4.1.1 Clinical leadership

Effective use of clinical leadership at every level of the change will be vital. The goal of change is to change what happens in the clinical encounter. This will not happen without leadership from clinicians. A quick win for staff might come from giving all staff ready access to performance data, as these become available. All too often in HSE, data are kept secret, and used as sources of managerial power.

4.1.2 Public engagement

The general public will also need some persuasion. During the week when this paper was being drafted, (Jan 3rd to 11th, 2011) every single weekday brought another story of major failure, or apparent failure, on the part of HSE. This is not atypical. HSE gets terrible press, partly deserved, and partly because of major weaknesses in presentation. It will be necessary to communicate very clearly to the public what will happen. For example, many people may fear losing their medical card, and it needs to be explained that no-one will lose the card, but that it will provide access to a wider set of services. Public support will come if services improve. Our view is that the public cares much less about how services are paid for, than they care about their experiences, and those of their families in the health care system.

4.1.3 Management issues

A more basic barrier is management inertia. Many mid-level managers in HSE and the hospital sector are capable people, and their hearts are in the right place. However, they fear to make changes, they fear to rock the boat. Our experience of decision making at senior levels within HSE,

is that it is an intensely political organization, not in any party-political sense, but in the sense that every decision is dominated by the question – 'What will other people think'? Shifting this culture to one where the key question is 'How will this affect our patients?' will not be easy, but must be done. The key to success here will be leadership from the CEO down inside HSE. There are models of successful culture change in organizations, Ericsson and British Airways are two good examples, and we will need to learn from the successes of others.

4.1.4 Political will

One well known previous Minister for Health described working in the Department of Health as resembling Angola, because land-mines could detonate with no warning. While the analogy may be unfair, there is an element of truth. Health is popular with the media, and provides them with many opportunities for good photographs and strong stories. Without a clear political focus, and a firm schedule for change, nothing will happen.

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6 Appendix - Notes on IT systems

There is a lot of work being done, inside (and outside) HSE, to review options for future health-care IT systems. Common elements being considered in several of these projects include :-

1. Core Registries (client index, service directory of clinical providers etc).
2. Interoperability with existing systems, such as PAS and GPS systems, but using open standards and agreed protocols, so that we do not need to remove and replace all the existing systems, to interconnect the main systems.
3. Standard pricing, using an agreed costing process, for procedures (will take a few years and agreement).
4. Framework needs to track movement of clients and what they have done between services and hospitals.
5. Framework needs to integrate with HSE financial systems and external insurance company systems to allow for effective payment which will map to new resource allocation, money follows the patient and UHI.
6. For reconfiguration we need to have a comprehensive data warehouse solution that allows for multidimensional analysis to be able to view the service as an integrated and interdependent system, than silo structures.
7. Must adequately support community care involvement and future progression e.g. early diagnosis and prevention and help maintain treatment of clients in the community.

List of recommendations

Formal training in project management processes will be needed for HSE and DoHC.....	5
Definite decisions will be needed on each of the new roles required for SHI, and who will fulfil these roles.....	6
Devise clear criteria to be met by insurance companies participating in the SHI.....	6
Assess the economic basis, costs and benefits of single vs. multiple insurance providers in the Irish SHI system.....	6
A clear, transparent system for regulation of all health-care providers will be needed.....	6
Providers will need to be engaged with the process of change early, and will need clear information, early on, as to where they might fit into a new structure of services.....	7
Basic principles for approving services will need to be agreed at the start.....	7
Clear process, sector by sector, for engaging clinical staff with the process of change in their sector	7
Clear plan for change management in HSE and DoHC.....	7
Support and training for managers and administrative staff.....	7
The role and responsibilities of the successor to HSE need to be clearly defined as early as possible	7
Existing HSE staff need to know, as quickly as possible, where they will fit in the new systems, and what role(s) they will have. This is particularly important for middle managers.....	8
Realistic care pathways, starting in primary care, will be needed for major chronic illnesses and people with multi-morbidity.....	9
Patient registration for primary care will be required, and must be well supported by IT systems.....	9
Acute hospitals need to refocus on servicing primary care.....	10
The framework for independently governed hospital networks should be established as soon as possible.....	10
It is essential to make full use of the current processes, within HSE, on developing pathways to care, clinical effectiveness, and so on.....	10
All of these processes will need to start, and be rooted, in primary care.....	10
As a matter of urgency, a sustainable system for paying for long-term care is needed. Different models should be urgently investigated, and an effective model implemented,.....	11
The integration of health and social care is a fundamental strength in the Irish health care system, and should be exploited fully.....	11
Care should be based primarily on need, not on diagnosis.....	11
An urgent decision is needed on the general mechanisms, both managerial and financial, for merging currently HSE provided services into general practice.....	11
Different models of GP care will be needed in different places, and this will have to be supported.	11
Building on the existing commitment, and innovation of Irish GPs and other primary care providers will be vital.....	12
Systems to develop, update, and deliver, the basic package of care are the core of SHI	12
The health insurer(s) is/are key to the effective running of the SHI system	12
A national financial system is an absolute requirement for future service changes.....	12
The DOHC must prepare future reports using the OECD System of Health Accounts.....	12
Very clear regulation of the insurance sector will be needed.....	12
An effective, legally secure, agreed system of risk equalization will be needed.....	12
An early analysis needs to be done of the costs, progressiveness (or otherwise) sustainability, and acceptability of the various possible funding systems.....	13