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Ireland

Health system review

David McDaid • Miriam Wiley
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European

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on Health Systems and Policies

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Health Systems in Transition

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Preface

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each profile is produced by country experts in collaboration with the Observatory's research directors and staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a profile. HiT profiles seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries.

Compiling the profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Because of the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the World Health Organization (WHO) Regional Office for Europe Health for All database, national statistical offices, Eurostat, the

Organisation for Economic Co-operation and Development (OECD) Health Data, the International Monetary Fund (IMF), the World Bank, and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

A standardized profile has certain disadvantages because the financing and delivery of health care differ across countries. However, it also offers advantages, because it raises similar issues and questions. The HiT profiles can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals. Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to: info@obs.euro.who.int.

HiT profiles and HiT summaries are available on the Observatory's web site at www.euro.who.int/observatory. A glossary of terms used in the profiles can be found at the following web page: www.euro.who.int/observatory/glossary/toppage.

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The current series of HiT profiles has been prepared by the research directors and staff of the European Observatory on Health Systems and Policies. The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Norway, Slovenia, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

The Observatory team is led by Josep Figueras, Director, and Elias Mossialos, Co-director, and by Martin McKee, Richard Saltman and Reinhard Busse, heads of the research hubs. Jonathan North managed the production,

with help from Nicole Satterley (copy-editing) and with the support of Martyn Barr (layout). Administrative support for preparing the HiT profile on Ireland was undertaken by Caroline White.

Special thanks are extended to the WHO Regional Office for Europe European Health for All database, from which data on health services were extracted; to the Organisation for Economic Co-operation and Development (OECD) for the data on health services in western Europe; and to the World Bank for the data on health expenditure in central and eastern European countries. Thanks are also due to national statistical offices, which have provided national data. The HiT reflects data available in October 2008.

List of abbreviations

A&E	Accident and emergency (department of hospital)
ADHD/HKD	Attention Deficit Hyperactivity Disorder/Hyperkinetic Disorder
AIDS/HIV	Acquired immunodeficiency syndrome/Human immunodeficiency virus
APMI	Association of Pharmaceutical Manufacturers of Ireland
BIC	British–Irish Council
BUPA	British United Providential Association
C&AG	Comptroller and Auditor General
C/PAD	Corporate/Parliamentary Affairs Division
CAM	Complementary and alternative medicine
CAMH	Child and adolescent mental health
CAWT	Cooperation and Working Together (Initiative)
CEO	Chief Executive Officer
CIDR	Computerized Infectious Disease Reporting (system)
CPR	Cardio-Pulmonary Resuscitation
CT	Computerized tomography (scanning)
DMFT	Decayed, missing or filled teeth
DoF	Department of Finance
DoHC	Department of Health and Children
DRG	Diagnosis-related group
DSFA	Department of Social and Family Affairs
DUP	Democratic Unionist Party
EC	European Commission
EEA	European Economic Area
EHSS	Eastern Health Shared Services
EMA	European Medicines Agency
ERHA	Eastern Regional Health Authority
ESRI	Economic and Social Research Institute
EU	European Union
EU-SILC	EU Survey on Income and Living Conditions

EU10	Member States joining the EU in May 2004
EU15	Member States of the European Union prior to May 2004
EU25	All European Union Member States prior to January 2007
EU27	All European Union Member States including January 2007 accession states
EWTD	European Working Time Directive
FÁS	Irish National Training and Employment Authority
GATS	General Agreement on Trade in Services
GDP	Gross domestic product
GGB	General government balance
GMS	General Medical Services
GNP	Gross national product
GP	General practitioner
HAA	Health Services (Amendment) Act
HAZ	Health Action Zone
HeBE	Health Boards Executive
HIA	Health Insurance Authority
HiB	Haemophilus influenzae type b
HIPE	Hospital In-Patient Enquiry (system)
HIQA	Health Information and Quality Authority
HPV	Human papilloma virus
HRB	Health Research Board
HSE	Health Service Executive
HTA	Health technology assessment
HTD	High-Tech Drugs (Scheme)
ICD	International classification of diseases (WHO)
ICGP	Irish College of General Practitioners
ICSB	Irish Cancer Screening Board
ICSP	Irish Cervical Screening Programme
ICT	Information and communication technology
IHCA	Irish Hospital Consultants Association
IHQA	Interim Health Information and Quality Authority
IMB	Irish Medicines Board
IMF	International Monetary Fund
IMO	Irish Medical Organisation
INIsPHO	Ireland and Northern Ireland's Population Health Observatory
IP	Intellectual property
IPHA	Irish Pharmaceutical Healthcare Association
ISO	International Organization for Standardization
ISQSH	Irish Society for Quality and Safety in Healthcare
LHO	Local Health Office
LIG	Local (EWTD) Implementation Group
MAC	Management Advisory Committee
MBDS	Minimum basic data set
MHC	Mental Health Commission
MMR	Measles, mumps and rubella (vaccination)
MoHC	Minister of Health and Children

MRI	Magnetic resonance imaging
NCHD	Non-consultant hospital doctor
NCPE	National Centre for Pharmacoeconomics
NDP	National Development Plan
NHIS	National Health Information Strategy
NHO	National Hospitals Office
NHS	National Health Service (United Kingdom)
NIG	National (EWTD) Implementation Group
NSP	National Service Plan
NSUE	National Service User Executive
NTPF	National Treatment Purchase Fund
OECD	Organisation for Economic Co-operation and Development
PCCC	Primary, Community and Continuing Care (Directorate)
PCRS	Primary Care Reimbursement Scheme
PET	Positron emission tomography (scanning)
PIL	Patient information leaflet
PMR	Performance Monitoring Report
PPARS	Personnel administration, Payroll, Attendance monitoring/control, Rostering, Recruitment and Superannuation
PPP	Purchasing power parity
PRSI	Pay-related social insurance
PTR	Patient Treatment Register
R&D	Research and development
RCSI	Royal College of Surgeons in Ireland
RGN	Pre-Registration Programmes in General Nursing
RHO	Regional Health Office(s)
RMHN	Pre-Registration Programmes in Mental Handicap (Learning Disability) Nursing
RPN	Pre-Registration Programmes in Psychiatric Nursing
SCA	State Claims Agency
SI	Statutory Instrument
SPRI	Strategic Planning, Reform and Implementation
SWOT	Strengths, Weaknesses, Opportunities and Threats (analyses)
TB	Tuberculosis
TDs	Teachtaí Dála (Deputies)
VAT	Value-added tax
VHI	Voluntary Health Insurance
WHO	World Health Organization
WTE	Whole-time equivalent

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Abstract

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of policy initiatives in progress or under development. HiTs examine different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems; describe the institutional framework, process, content and implementation of health and health care policies; and highlight challenges and areas that require more in-depth analysis.

The Irish health system can be characterized as having been in a process of constant review and implementation of staged initiatives since the late 1990s. This process has culminated in major structural changes, made possible due to the economic growth that Ireland has enjoyed recently. The changes affect both the organization and orientation of the health care system. The reforms have revolved around the abolition of the former Health Boards and the creation of a single national body, the Health Service Executive (HSE). The aim is to make the system more primary and community care driven, backed up by improved access to specialist, acute and long-stay services.

Implementing such major change is challenging and it is too early to reach any definitive judgement on the success of these reforms, particularly as the pace of reform has varied across different sectors of the health system. Promoting equity within the health system is likely to remain a critical concern. Access to the primary care system tends to be pro-poor, in that services are free for this group, while the remaining 70% of the population who do not qualify for free primary care must pay the substantial cost of general practitioner (GP) fees out of pocket. In contrast, in the secondary care sector, those who can afford private health insurance can avoid waiting for treatment.

While much has been done to change the Irish health care system for the better since the late 1990s, major challenges remain, and none more so than primary care reform. The implementation of promised reforms is the key challenge, particularly now that the country, like most of the developed world, is likely to experience an economic downturn which will give the Government less room for manoeuvre in the near future.

Executive summary

The Republic of Ireland, an independent country, making up the majority of the island of Ireland, is situated in the north-west of Europe. Ireland's only land border is with Northern Ireland, part of the United Kingdom, located on the north-eastern part of the island. Ireland had a population of 4.2 million people in 2006, the highest population since 1861, reflecting both an increase in the birth rate and exceptionally high levels of net migration since 1991. Ireland has the highest proportion of people under 15 years old and the second lowest proportion over 65 years in the countries comprising the European Union (EU) prior to January 2007 (EU25). One quarter of the population live in the capital city, Dublin.

In recent years the country has been one of the “star performing” economies in the industrialized world. Between 1992 and 2005 Ireland enjoyed a real annual gross domestic product (GDP) growth rate of 7.09%. Prudent fiscal and monetary management, social consensus on pay policy, an expanding, well-qualified labour force and strong growth in domestic demand all contributed to this economic boom. The rate of unemployment has fallen from more than 16% in 1985 to 4.3% by 2006. The country's public sector infrastructure has, however, struggled to keep pace with the speed of economic change. The heavy reliance on foreign inward investment makes the country particularly vulnerable to any global economic downturn.

The health status of the population has markedly improved. Mortality rates have fallen substantially since the late 1970s in most disease areas. In 2006, average life expectancy for men was above the average for the countries comprising the EU prior to 1 May 2004 (EU15) at 77.46 years, while for women this was 82.22 years, still slightly lower than the EU15 average (82.7 years).

The main health challenges are circulatory system diseases and cancers. The country has some of the highest rates of deaths from breast and cervical cancer in the EU. Another challenge is respiratory disease: although deaths have fallen sharply since the late 1990s, they remain the highest in the EU25. Rates of smoking have steadily declined, but alcohol consumption is amongst the highest in the EU. Another public health concern is the persistent low uptake of the measles, mumps and rubella (MMR) vaccination.

Organization and regulation

At the time of writing, Ireland is implementing the most substantial reforms to the organization of its health system since 1970. Overall responsibility for the health care system lies with the Government, exercised through the Department of Health and Children (DoHC), under the direction of the Minister of Health and Children (MoHC). As part of the reforms the Health Boards that had been responsible for the provision of health care and personal social services were abolished on 1 January 2005 and replaced by a single body, the Health Service Executive (HSE). Many of the functions and staff from the former health care structure have been relocated within the new HSE. With a budget of more than €13 billion it is the largest employer in the country, with more than 65 000 staff in direct employment and a further 35 000 employed by voluntary hospitals and bodies funded by the HSE.

A range of statutory and non-statutory agencies also play a role in both the regulation and provision of services. These include the Irish Cancer Screening Board (ICSB) and the Irish Blood Transfusion Service. Many other executive agencies were merged or abolished and subsumed within the HSE as part of the reform measures. Other ministries with an interest in the health system include the Department of Social and Family Affairs (DSFA), which has responsibility for social welfare payments, including various forms of income support, disability allowances and payments made to support family carers. The Department of Justice, Equality and Law Reform, through the Director of Prison Medical Services, is responsible for the health of the prison population.

As part of the reform, a Health Information and Quality Authority (HIQA) was established in 2007. It is responsible for developing health information, setting and monitoring standards, promoting and implementing quality assurance programmes nationally, and overseeing health technology assessment (HTA), including the consideration of cost as well as clinical effectiveness. It has responsibility for most accreditation mechanisms for publicly funded health care services in Ireland. Mental health is the only area of the health care system that does not fall under the auspices of the HIQA. Instead, responsibility rests with the Mental Health Commission (MHC), a statutory body set up under

the Mental Health Act 2001 and launched in April 2002. In terms of regulating health care professionals, a number of professional associations and statutory bodies play a role. These include the Medical Council, Dental Council, Opticians Board and Health and Social Care Professionals Council.

More than 50% of the population have voluntary private health insurance. By far the largest insurance body is the Voluntary Health Insurance (VHI) Board set up in 1957. As of September 2006, the VHI Board's share of the private insurance market was approximately 75%. It has operated as a non-profit-making, semi-state private insurance body, with board members appointed by the MoHC. At the time of writing, it is undergoing a process of reform to put it on the same operating platform as the other two principal private health insurance providers, which cover most of the remainder of the private health insurance market. A Health Insurance Authority (HIA) was set up by the Government in 2001 to regulate private insurance. It helps promote competition while ensuring schemes use community rating, have open enrolment and provide lifetime cover. However, the triggering of risk-equalization payments between the insurers has led to upheaval in the insurance market in recent years and a series of legal challenges both in Ireland and at EU level. This may have a major impact on the future shape of VHI.

Financing

The Irish health care system remains predominantly tax funded. In 2006, 78.3% of total health expenditure (both public and private) was raised from taxation, including pay-related social insurance (PRSI) and other sources of government income, such as excise duties. The remaining components of total health expenditure are from private sources, in particular out-of-pocket household expenditure on general practitioner (GP) visits, pharmaceuticals and public/private hospital stays, as well as payments to VHI providers.

Gross health expenditure in 2007 by both the Health Service Executive (HSE) and DoHC was just under €14.4 billion or approximately 25.3% of all government expenditure. The exceptional growth of the Irish economy in recent years, somewhat misleadingly, makes public health expenditure appear to be relatively low compared to many other countries within the EU. If expenditure as a proportion of gross national product (GNP), rather than GDP is used¹ then Ireland would consistently exceed the EU average with approximately 8% of GNP allocated to public health expenditure.

In 2007 just over 30% of the population held Medical Cards entitling them to most services free of charge. The remainder of the population generally have to

¹ GNP is a more appropriate indicator in the Irish context because of the high penetration of foreign investment.

make some out-of-pocket payments for both hospital and primary care services, although exemptions and payment ceilings apply. In a move intended to boost the use of primary care services, a new means-tested GP Visit Card was created to provide access, free of charge, to GP services for eligible individuals and families. Income guidelines for eligibility were initially set at a rate 25% higher than the income ceiling for a Medical Card; in 2006, this ceiling was revised upwards and is 50% higher than the Medical Card qualifying level, at the time of writing. As of December 2007, 75 790 people had obtained GP Visit Cards. Additional support towards the costs of some services, such as dental and optical care, is provided via the Treatment Benefit Scheme operated by the DSFA. More than 50% of the population also have private health insurance which helps cover some of the out-of-pocket costs associated with public health services, (for example, the daily hospital bed charges). To a much lesser extent, private health insurance can cover some of the out-of-pocket costs of primary health care services.

One additional challenge concerns the way in which funds are allocated to hospitals and other health care facilities across the health system. This is still largely based on historical precedent, with some adjustments for the demographic characteristics of the population, rather than on an assessment of population needs. The move towards a greater use of diagnosis-related group (DRG) case-mix funding, coupled with further investment in information systems such as the Hospital In-Patient Enquiry (HIPE) system, may go some way towards improving system efficiency.

Physical and human resources

The 2001 Health Strategy included a commitment to increase the number of acute hospital beds across the country. Progress has been made, with the number of inpatient beds increasing by 13.1% between 1997 and 2006. Almost as many patients are now being treated on a day-case basis as admitted to hospital. Improved and less invasive medical practice is largely responsible for this changing pattern. New beds are planned. Moreover, one recent initiative intended to help ensure that no more than 20% of beds in publicly funded hospitals are earmarked for private patients is for the co-location of up to eight new private hospitals within the grounds of public hospitals.

Human resources are a key issue for the future of the health care service. The Government is committed to increasing both staff numbers and mix of skills: first, through increasing the number of hospital consultants; and second, by placing greater emphasis on primary care through the development of multidisciplinary Primary Care Teams. The primary care infrastructure has been relatively poor with the lowest rate of GPs per 1000 population in any of the

Organisation for Economic Co-operation and Development (OECD) countries. Another area in which capacity needs to be strengthened is mental health. The Mental Health Strategy report, *A Vision for Change*, suggests that a range of multidisciplinary personnel are required to provide comprehensive community-led mental health services. A joint committee on workforce planning was established in 2006, initially focusing on future human resource requirements in disability, care of older people and cancer services. An audit of available resources for mental health is also under way.

Medical training takes place at a number of universities across the country. Measures were announced in 2006 to reform medical education and training from undergraduate level through to postgraduate specialist training. These involve the doubling of the number of medical places for Irish and EU students over a 4-year period, as well as the introduction of a new graduate-entry programme for medicine from 2007. The curriculum and clinical training will also be modernized.

Information and communication technologies (ICT) have an increasingly important role to play in the health care system. There are plans to develop an electronic health record system and extend the use of ICT. The National Patient Treatment Register (PTR), for instance, can be accessed electronically by health service professionals seeking to match hospitals with spare capacity to the needs of waiting patients.

Provision of services

One key area of reform in service provision is in primary care. A Primary Care Strategy set out in 2001 aimed to integrate more fully primary, secondary and continuing care. The report identified a number of challenges including a poorly developed infrastructure. Central to reform was the development over a 10-year period of 400–600 multidisciplinary Primary Care Teams across the country. Each one would serve a population of between 3000 and 7000 people, depending on whether it is located in an urban or rural area. Work to implement the strategy is ongoing. The Primary Care Strategy had envisaged that 50–60 multidisciplinary Primary Care Teams would be in place by the end of 2005, but at that point only 10 pilot projects were up and running.

A common public perception is that there are inequities in access to care in both primary and secondary care. In the primary care sector, attention has focused on the level of utilization and access by those individuals who have neither a Medical Card nor private health insurance and who, therefore, may reduce inappropriately their use of primary health care services to avoid high out-of-pocket payments. In 2005 the Government significantly raised income

guidelines for Medical Card entitlement and introduced the new GP Visit Card for an estimated 230 000 individuals with incomes slightly above the maximum limit to qualify for a Medical Card. In another move to improve access to primary care services, by the end of 2005 out-of-hours GP cooperatives were available in at least part of 25 of the 26 counties within the country.

Inequities in access to hospital care between private and public patients have been addressed largely through commitment to increasing the number of acute beds within the health care system. Another key component of the Government's strategy to tackle inequities in access to treatment has been to establish the National Treatment Purchase Fund (NTPF), which allows those waiting for more than three months to be treated in the private sector in Ireland or the United Kingdom. This initiative has had considerable success in reducing waiting times, but at higher cost to the public purse. Attention has also focused on reducing some of the inefficiencies in the Consultants' Common Contract which allowed them to earn significant fee-based income from private patients, reducing substantially the time available for public sector patients. The recently concluded negotiations over a new Consultants' Contract do provide an opportunity for change, but the uptake of new and more financially generous public sector-only contracts is not mandatory.

Conclusion

The Irish health care system, in many ways, can be characterized as having been in a process of constant review and implementation of staged initiatives since the late 1990s. This process has culminated in major structural changes both to the organization of the health care system and its orientation, which are still being implemented.

These reforms aim to make the system more primary care driven and, in part, were possible due to the continued strong growth in the Irish economy over most of the period from the late 1990s to the time of writing, which allowed significant increases in funding to be injected into the health care system and contributed to increased public expectations about health care services. Life expectancy and many other health indicators have improved greatly.

At the time of writing, work is under way on approximately 91% of the 121 Actions set out in the Action Plan underpinning the 2001 National Health Strategy. The focus is on consolidating the new structures and implementing the provisions of the Health Act, 2004. However, it is still far too soon to determine how successful the HSE will be. Perhaps unsurprisingly, much of this early impetus for reform has focused on the secondary care sector and dealing with the management of waiting lists and access to public beds.

The challenges of promoting equity in the system are likely to remain critical to public confidence in the performance of the health service. Given the continuing commitment of successive Irish governments to support a “mixed” health care system whereby the same personnel may deliver public and private services within the same facilities, a clarification of the “boundaries” of each sector must be addressed if the rights and entitlements of public patients, in particular, are to be protected. More generally, this may yet prove to be a particularly challenging undertaking in an environment where half the population have private health insurance, and the capacity of the private – as well as public – systems to deliver in the face of rising consumer expectations may be open to question.

1 Introduction

1.1 Geography and social demography

The Republic of Ireland is an independent country making up the majority of the island of Ireland, situated to the north-west of Europe between 51.5° and 55.5° north (latitude) and between 5.5° and 10.5° west (longitude). The area of the Republic (referred to throughout this report as Ireland) is 70 282 km² (Fig. 1.1). The Atlantic Ocean is situated to the west and the Irish Sea to the east of the country. Ireland's only land border is with Northern Ireland, part of the United Kingdom, located on the north-eastern part of the island.

Ireland largely consists of a central plateau, almost entirely encircled by coastal highlands. The climate produces cool wet summers and mild winters, benefiting from close proximity to the Gulf Stream. The average annual temperature is 9° C, and ranges from a mean of 19° C in summer to 2.5° C in winter, while average annual rainfall across the country ranges from 800 mm to 2800 mm (Met Éireann, 2006).

Table 1.1 provides some basic sociodemographic indicators. The population, last estimated in the 2006 Census, is 4 239 848 (Central Statistics Office, 2007a), the highest reached since 1861 and an 8% increase since 2002. This continuing expansion is due not only to an increase in the birth rate but also to the exceptionally high level of net migration since 1991. Net migration accounted for 67% of population growth in the year up to April 2006, with the highest level of net immigration on record of 69 900. Of this, 43% were nationals of the 10 European Union (EU) Member States that joined the EU on 1 May 2004 (EU10), with 26% (22 900) of immigrants from Poland and 7% (6100) from Lithuania. Historically, emigration from Ireland had been high, accounting for a decline in the population between 1926 and 1961. With the exception of the period from 1971 to 1979, the country had a negative migration rate between

1926 and 1991 (see Table 1.2). By 2006 there were only 17 000 emigrants, the second lowest rate since 1987 (Central Statistics Office, 2006c).

In 2004 Ireland had both the highest proportion of people under 15 years old in the countries comprising the EU prior to 1 January 2007 (EU25) and the second lowest proportion of people over 65 (Central Statistics Office, 2006a). The average age of the population is 35.6 years of age and 49.97% of the population are female. Approximately 38% are under 25 years of age, and 21% under 15 years. A total of 11.04% of the population are over the age of 65, with just over 1% of the population over the age of 85. The birth rate is 15.1 per 1000 population, while the death rate is 6.6 per 1000 population. The fertility rate of 2.2 children per woman is the highest in the countries comprising the EU prior to 1 May 2004 (EU15) (Central Statistics Office, 2006d). The dependency ratio is low at 46.8, having fallen from 54.1 in 1996, reflecting the high proportion of the population that is of working age.

With the exception of the metropolis of Greater Dublin, which alone has a population of 1.045 million (25% of the total population) and Cork, the second city with a population of 119 418 (2.8% of the population), there are only two other towns with a population greater than 50 000 people – Galway, 72 414 (1.7%) and Limerick, 52 539 (1.2%). Overall, by 2006, 60.7% of

Fig. 1.1 Map of Ireland



Source: Author's own compilation

Table 1.1 Sociodemographic indicators

Population	4 239 848
Females	2 118 677 (49.97%)
Population aged 0–14	864 449 (20.39%)
Population aged 65 and above	467 926 (11.04%)
% Population annual growth	2.0
Population density per km ²	60.3
Fertility rate, total (births per woman)	2.2
Birth rate, crude (per 1000 people)	15.1
Death rate, crude (per 1000 people)	6.6
Dependency ratio (dependants to working age population)	46.76
Roman Catholic	3 681 446 (86.83%)
Church of Ireland and other Protestant	219 777 (5.18%)
Orthodox	20 798 (0.49%)
Islamic	32 539 (0.77%)
% Urban population	60.7
Proportion of single person households	22.4
% Population 3 years and above Irish speakers	40.8
% Traveller population (%)	0.5
Total number of immigrants 1991–2006	350 800
Annual net migration rate	69 900
% Population aged 15–64 with third-level* education (2005)	24.8
% Population aged 15–64 with at least secondary-level education (2005)	84.2

Source: Central Statistics Office, 2007a

Notes: * University-level education; All figures for 2006 unless otherwise stated

the population was classified as living in urban areas; that is, towns or cities with a population of more than 1500 people. The average population density is 60.3 inhabitants per km², and ranges from 11.3 per km² in county Leitrim to 4215 per km² in Dublin. While more than 88% of the population state that they are Roman Catholic, followed by 5% who are Protestant, immigration in recent years has led to an increase in membership of other faith groups. Although still very small, the Muslim population has more than quadrupled since 1991, while the Orthodox population has increased from 400 to more than 20 000.

The average size of a household in 2006 was 2.81; this has fallen continually from a size of 4.48 per household in 1926. There were 329 400 single-person households in 2006, representing 22.4% of all households. In the most recent Census, 40.8% of the population reported being able to speak Irish, and of this group 32.5% used the language on a daily basis, mainly in school. In the traditional Irish-speaking areas of the country, known as the *Gaeltacht* (the counties of Cork, Donegal, Galway, Kerry, Mayo, Meath and Waterford), 71.4% of the population reported speaking Irish, with 60% using the language

Table 1.2 Average annual births, deaths, natural increase and estimated net migration for each inter-censal period, 1971–2006 (thousands)

Period	Total births	Total deaths	Natural increase	Change in population	Estimated net migration
1971–1979	69	33	35	49	14
1979–1981	73	33	40	38	3
1981–1986	67	33	34	19	-14
1986–1991	56	32	24	-3	-27
1991–1996	50	32	18	20	2
1996–2002	54	31	23	49	26
2002–2006	61	28	33	81	48

Source: Central Statistics Office, 2007a

on a daily basis. Educational attainment in the country is good; in 2005 almost one quarter of the working-age population had attained a third-level (degree or non-degree, university-level) qualification (excluding those aged 15–24 who may still be in education; this figure rises to 28% if they are included). A total of 84% of the population aged 15–64 had attained qualifications at secondary-school level or above (Central Statistics Office, 2007e).

1.2 Economic context

In recent years Ireland has been nicknamed the “Celtic Tiger” and has been one of the “star performing” economies in the industrialized world since the late 1990s. Gross domestic product (GDP) increased 7-fold in real terms between 1960 and 2006. Real growth in gross national product (GNP) increased by 6.5% in the year to 2006 and by an average of 5.3% in the previous seven years (Table 1.3).² Yet as recently as 1987, Irish living standards, as indicated by private consumption per capita, were only at 73% of the EU average; by 2000 they were marginally above the EU average. Over the period from 1992 to 2005 within the Organisation for Economic Co-operation and Development (OECD), Ireland enjoyed the highest average real annual GDP growth rate of 7.09%. In 2005 the country was ranked fourth by the OECD, in terms of GDP per capita, behind Luxembourg, Norway and the United States (OECD, 2007b).

The unprecedented rapid rate of growth has been attributable to a range of factors, including prudent fiscal and monetary management, social consensus on

² GNP is considered to be a better indicator of economic performance than GDP because of the penetration in the country of foreign multinationals, much of the returns on which leave the country. GNP was 83% of GDP in 2005.

Table 1.3 Trends in selected economic indicators, 1980–2006 (selected years)

	1980	1985	1990	1995	2000	2001	2002	2003	2004	2005	2006
GDP per capita, current €s	n/a	n/a	n/a	n/a	27 608	30 397	33 243	35 037	36 723	39 097	41 205
GDP per capita, current US\$ PPP	6 228	8 755	13 043	17 959	28 662	30 624	33 114	34 574	36 554	38 226	40 893
Growth rate with GDP deflator	2.9	1.9	7.7	9.6	9.3	5.8	6.0	4.3	4.3	5.5	5.7
GNP per capita, Current £	3 684	6 260	9 141	13 046	23 521	25 418	27 125	29 459	30,982	32 857	35 173
Growth rate with GNP deflator	2.6	0.2	6.5	8.0	9.5	3.9	2.8	5.5	3.9	5.3	6.5
Consumer price index	18.2	5.4	3.4	2.5	5.6	4.9	4.6	3.5	2.2	2.5	4.0
GGB (€ million)	n/a	n/a	-1 019	-1 043	4 787	917	-534	556	2 063	1 627	5 031
GGB as a % of GDP	n/a	n/a	-2.8	-2.0	4.6	0.8	-0.4	0.4	1.4	1.0	2.9
Employment rate (% of working-age population)	n/a	50.1	52.2	53.6	64.5	65.2	65.1	65.1	65.5	67.8	68.7
Unemployment rate (% of labour force)	n/a	16.8	12.9	12.2	4.3	3.6	4.2	4.4	4.4	4.2	4.3

Sources: Central Statistics Office, 1998a; Central Statistics Office, 1998b; Central Statistics Office, 2006b; Central Statistics Office, 2007b; Central Statistics Office, 2007c; DoF, 2006; OECD, 2007a

Notes: GDP: Gross domestic product; GNP: Gross national product; GGB: General government balance; n/a: Not available

Table 1.4 Sector contributions to GNP 2006 (net value added at factor cost 2006 prices)

Sector	€ million	% of GNP
Value added in industry (including building)	52 763	36.5
Value added in agriculture, forestry and fishing	3 817	2.6
Value added in transport, distribution and communication	22 767	15.8
Value added in public administration and defence	5 281	3.7
Value added in other services (including rent)	65 875	45.6

Source: Central Statistics Office, 2007d

Note: GNP: Gross national product

pay policy, which in turn has permitted some wage moderation, foreign direct investment, EU Structural Funds, an expanding well-qualified labour force, a rapidly expanding high-technology sector and strong growth in domestic demand. Employment has responded in turn to this output growth, and the rate of unemployment has fallen from more than 16% in 1985 to 4.3% by 2006. Long-term (more than one year) unemployment rates were just 1.2% at the end of 2006 compared with 10.4% in 1988.

The service sector is the principal contributor to national income, accounting for 45% of GNP (Table 1.4). The industrial sector, especially high-technology industries and pharmaceuticals, is also a key contributor. Between 2000 and 2005 the output of industry as a whole (including construction) rose by 27%, while the output of the sectors dominated by multinational companies (reproduction of recorded media, chemicals, computers, and electrical machinery and equipment) increased by 37%. There was also an increase of 24% in the output of the distribution, transport and communications sector during the same period. Agricultural, forestry and fishing output also increased by 16% in real terms.

The economy is heavily dependent on the export market. Merchandise exports at current prices grew from €684 million in 1971 to €88 703 million in 2006 (DoF, 2007). The State's principal trading partner is the United States, accounting for 18.3% of all exports. Historically the United Kingdom had been the principal trading partner, but its share of total exports fell from 28.3% in 1993 to 17.5% by 2006. The other principal market is Belgium, with 16% of exports. Excluding the United Kingdom and Belgium, other EU Member States account for 29.1% of the export market. The main areas of growth in Irish exports have been in computing/electrical machinery and the chemicals/pharmaceuticals industries.

Because of the heavy reliance on foreign inward investment the country is very vulnerable to the effects of external events. A number of challenges have been identified by the OECD that will need to be addressed if the high level of economic growth is to be sustained (OECD, 2006a). These include increasing competition in many sectors – for instance, in the electricity and telecommunications markets – and the uptake of broadband has been noted to be slow. A lack of competition in the retail sector has meant that everyday groceries are expensive, while planning regulations have severely curtailed the development of larger retail stores. The country also experienced a housing price boom unparalleled in any other OECD country during the period from the end of the 1990s to the time of writing.

There is a need to increase the level of funding available to the higher education sector. Female participation in the labour force remains low (59.8% in 2006) and there are few child care facilities available (although the Government announced support for 50 000 places by 2010 in the 2006 Budget).

The country's public sector infrastructure also has struggled to keep pace with the speed of economic change and further upgrading is required. Recognizing this, the €184 billion National Development Plan (NDP) 2007–2013 includes investment of €54.6 billion in economic infrastructure (Government of Ireland, 2006a).

1.3 Political context

After many centuries of British influence, culminating in the 1801 Act of Union of the United Kingdom of Great Britain and Ireland, independence was gained in 1921 under the Irish Free State Agreement, or Treaty, when 26 of Ireland's 32 counties seceded from the United Kingdom and were granted Dominion status within the British Commonwealth. The other six counties in the north-east of the island chose to remain within the United Kingdom in what is known as the province of Northern Ireland. A brief period of civil war followed from June 1922 until April 1923 when pro-Treaty forces defeated those opposed to the Treaty, who felt that it had not gone far enough in securing independence for the whole of the island.

A new constitution, *Bunreacht na hÉireann*, was approved by referendum in 1937, further reducing constitutional ties with the United Kingdom and changing the official name of the State to *Eire* (Ireland in English). Irish is the national and first official language, and English is the second official language, as recognized by Article 8 of the Constitution. In 1949 Ireland became a Republic, with a President as Head of State, and simultaneously withdrew from the British Commonwealth.

The two major political parties in Ireland can be directly linked to the Civil War. Fianna Fáil was formed by anti-Treaty forces in 1926, while Fine Gael, the smaller of the two principal parties was formed in 1933 by pro-Treaty elements. Fianna Fáil has been the dominant political force in Ireland, being the only party to have formed coalition-free majority-led governments, and has been in power for 58 of its 83-year history. Since its formation Fine Gael has only been in power for 18 years, mainly in coalition in recent years with the Labour Party, the oldest political party in the country dating back to 1912.

The President of Ireland (since 1997, Mary McAleese) is elected for a 7-year term by direct public vote, and may only be re-elected once. The President is not a member of the executive and has limited constitutional powers. Most notably, the President can refuse to dissolve the *Oireachtas* (Legislature) in certain circumstances, or can refer a legislative bill to the Supreme Court for a

judgement on its constitutionality. The *Taoiseach* (Prime Minister) is head of the parliamentary democratic government. Usually, the Prime Minister is the leader of the majority political party, or principal partner in a coalition government.

The legislature, the *Oireachtas*, has two houses – the *Dáil* (House of Representatives) and the *Seanad* (Senate). The primary of these two bodies is the *Dáil*, to which the Government is directly accountable, while the *Seanad* acts primarily as a revising chamber. The *Dáil* has 166 seats; TDs (*Teachtaí Dála*) or Deputies are elected to multi-seat constituencies using a single transferable voting system of proportional representation. General elections to the *Oireachtas* must take place at least once every five years. The *Seanad* has 60 Senators: 11 are nominated by the *Taoiseach*; 3 each are elected by the National University of Ireland and the University of Dublin (Trinity College); and 43 elected from vocational panels – Culture and Education, Agriculture, Labour, Industry and Commerce, and Public Administration. The electorate consist of members of the *Dáil*, the outgoing *Seanad*, county councils and county borough councils.

The executive branch, the Government, can consist of not less than 7 and no more than 15 members. No more than two members of the Government can be members of the *Seanad*, and the *Taoiseach*, *Tánaiste* (Deputy Prime Minister) and Minister of Finance must sit in the *Dáil*. Ministers of State are appointed to help ministers in different governmental departments; however, they are not members of the Government. The judiciary is separated from both the executive and the legislature. Judges are appointed directly by the President, on the nomination of the Government.

The *Taoiseach* at the time of writing, since May 2008, is Mr Brian Cowen TD, leader of the Fianna Fáil party. From 1997 until 2007 Fianna Fáil led a coalition government with the Progressive Democrats, supported by a small number of independents. The 2007 general election saw Fianna Fáil maintain their position as the largest party in the *Dáil* with 78 seats. However, the Progressive Democrats were reduced from eight to just two seats and thus the new coalition also includes the Green Party's six TDs.

The largest opposition party in the *Oireachtas* is Fine Gael with 51 seats, followed by Labour with 20 and Sinn Féin with 4 seats. There are also five independent TDs. There have been three Ministers of Health and Children (MoHCs) since the current Government came to power in 1997. The MoHC at the time of writing is Mary Harney TD, of the Progressive Democrats (who was also the *Tánaiste* from 1997 to September 2006). In September 2004 she took over from Michéal Martin TD, who had held the health portfolio since January 2000.

In addition to central Government, local government consists of 30 county and city councils and 80 town councils. These bodies are responsible for a range of functions, including housing and planning, but have only a limited role in health care. The Social Partners of the Government (that is, the trade unions, employers, farming organizations and representatives of the community and voluntary sectors) formally also have some role in the broad direction of health policy in the country. The 10-year Social Partnership Framework Agreement for 2006–2015, *Towards 2016*, recognizes the importance of health across the life-cycle and within the NDP. Common health outcomes and system goals are agreed by the Government and the other social partners (Department of the Taoiseach, 2006). Ireland is a member of the United Nations, joined the EU in 1973, is a member of the World Trade Organization and a signatory to the General Agreement on Trade in Services (GATS). It has also ratified all principal international human rights treaties, including the Convention on the Rights of the Child, and the European Convention for the Protection of Human Rights and Fundamental Freedoms. The country has adopted a strict policy of neutrality since the creation of the Free State in 1921.

North–South cooperation

The complex situation in Northern Ireland has been an important factor in Irish politics and society, both before and ever since independence. Successive Irish governments have aspired towards the peaceful reunification of the whole island, and have worked with their counterparts in the United Kingdom to resolve the conflict, divisions and paramilitary violence that have been a feature of life in Northern Ireland, particularly since the early 1970s. By the late 1990s the situation had improved markedly, with the major paramilitary organizations on ceasefire, and significant political progress made between the local parties, culminating in the British–Irish Agreement (also known as the Belfast or Good Friday Agreement), approved by referendum across all of the island in 1998. As part of the Agreement, Articles 2 and 3 of the Irish Constitution were amended, removing the territorial claim to Northern Ireland.

A locally elected, devolved executive administration for Northern Ireland was then established in 1999 involving all the principal political parties, alongside the establishment of a North/South Ministerial Council and a number of cross-border bodies, as well as the British–Irish Council (BIC). The executive was suspended on several occasions, the last time being in October 2002, with power returning to United Kingdom direct-rule ministers. Despite this, aspects of the agreement relating to North–South cooperation and

the BIC continued to be implemented (see later). The political climate continued to improve and the principal republican paramilitary group, the provisional Irish Republican Army, formally ended its armed campaign and completed a process of disarmament in September 2005. Intensive discussions held in St Andrews, Scotland in November 2006, led to the publication by the United Kingdom and Irish governments of the St Andrews Agreement. This set out a framework paving the way for a return to devolved government following local elections in March 2007. These elections saw the Democratic Unionist Party (DUP) and Sinn Fein retain their positions as the largest unionist and nationalist parties, respectively, and subsequently all political parties agreed to participate in a devolved administration. This was restored on 8 May 2007, under the leadership of the then DUP First Minister, the Reverend Ian Paisley and Deputy First Minister, Martin McGuinness from Sinn Fein.

The North/South Ministerial Council, established in 1999, brings together those with executive responsibilities “... to develop consultation, cooperation and action within the island of Ireland – including through implementation on an all-island and cross-border basis – on matters of mutual interest and within the competence of each administration, North and South” (North/South Ministerial Council, 2005). One of the areas identified for cooperation is the health sector, with joint working groups set up between the two Departments of Health to bring forward proposals in the area of cancer research, health promotion, health technology equipment, accident and emergency (A&E) services, and major emergencies. A number of joint North–South bodies have been set up including the Food Safety Promotion Board and the all-island Institute of Public Health.

Another element of the British–Irish Agreement has been the establishment of the BIC, comprising representatives from the United Kingdom and Irish governments, the devolved institutions in Northern Ireland, the Scottish Government, Welsh Assembly Government, and representatives from the Isle of Man, Jersey and Guernsey. The BIC works to exchange information and promote cooperation on a range of issues of mutual interest within the competence of the different administrations. One of these areas focuses on health, particularly on the use of telemedicine, on which the Isle of Man is taking the lead. The Irish Government has taken the lead on work relating to substance abuse within the islands (BIC, 2005).

Table 1.5 Basic health indicators, 1970–2006 (selected years)

	1970	1980	1985	1990	1995	2000	2001	2002	2003	2004	2005	2006
Female life expectancy at birth (years)	73.19	75.26	76.58	77.73	78.33	79.29	79.94	80.47	80.77	81.43	81.79	82.22
Male life expectancy at birth (years)	68.54	69.90	70.75	72.05	72.76	73.98	74.58	75.07	75.78	76.46	77.32	77.46
Total life expectancy at birth (years)	70.75	72.46	73.53	74.81	75.48	76.61	77.24	77.75	78.28	78.95	79.59	79.85
Female mortality rate (per 1000)	10.09	8.94	8.16	7.29	6.99	6.4	5.99	5.75	5.61	5.27	5.08	4.92
Male mortality rate (per 1000)	14.33	13.58	13.18	11.89	11.22	9.93	9.46	9.07	8.55	8.08	7.49	7.48
Infant mortality rate (per 1000 live births)	19.49	11.09	8.85	8.18	6.37	6.17	5.72	5.04	5.30	4.86	4.0	3.71
Under-5 mortality rate (per 1000 live births)	22.78	13.74	10.64	9.71	7.56	7.01	7.14	6.09	6.17	5.70	4.81	4.25

Source: WHO Regional Office for Europe, 2008

1.4 Health status

The health status of the Irish population has steadily improved since 1970 (Table 1.5), although only as recently as 2002 it still had one of the poorer sets of health outcome indicators in the EU15 (Chief Medical Officer, 2002). Disability-adjusted life expectancy in 2002 was estimated at just 69.8 years, the joint second lowest in the EU15. However, the last few years have seen a marked improvement in the health status of the population. In 2006, average life expectancy for men was 77.46 years; at the time of writing, this rate is higher than the EU25 average (75.62 years), and is only surpassed by Greece (77.48) and Sweden (78.57) within the EU15. The improvement has been rapid; as recently as 2003, Ireland ranked only 11th in terms of male life expectancy, above Denmark, Finland, Germany and Portugal. In 2006, average life expectancy for women was 82.22 years, still slightly lower than the EU15 average (82.7 years). Infant mortality rates fell from 19.49 per 1000 live births

in 1970 to 3.71 in 2006, the 7th lowest rate in the EU15. Maternal deaths are low; in 2005, 3.28 deaths per 100 000 live births were recorded. This is below the EU15 average of 5.64, and only 5.7% of live births in 2004 weighed below 2500 grams, well below the EU average that year of 7.19%. The number of decayed, missing or filled teeth (DMFT) in 12-year-old children is one of the lowest in the EU at just 1.2 per child in 2002.

The principal causes of mortality and age-standardized mortality rates are presented in Table 1.6. Mortality rates have fallen substantially since the late 1970s in most disease areas. The age-standardized death rate from female breast cancer in 2006 was 29.8 per 100 000 females. This was one of the highest rates in Europe, compared to the latest available data from other EU15 countries, with only Belgium (1997 data) and Denmark (2001 data) having higher reported rates of 35.02 and 36.06 respectively, and compared to Portugal in 2004, where the rate was just 11.24 (WHO Regional Office for Europe, 2008). Ireland also has the highest rate of deaths from cervical cancer in the EU15 for women under 65 years, at 3.81 per 100 000 females in 2006, more than double the EU15 average. Although deaths from all respiratory diseases have fallen from 129.15 per 100 000 population in 1995 to 83.19 per 100 000 in 2006, this rate remains the highest among the EU Member States including the January 2007 accession (EU27). The next highest rate in 2006 was seen in the United Kingdom at 74.27 per 100 000, while the EU as a whole had a mortality rate of 47.31 per 100 000 and Finland just 24.97 per 100 000 (WHO Regional Office for Europe, 2008).

The suicide rate has become a major concern, being more than four times greater than that seen in 1970 and most prevalent among young adults. However, the overall suicide rate per 100 000 population has fallen from 13.5 in 2001 to 9.1 by 2006, when 409 deaths were reported (Central Statistics Office, 2007f). Data from the Health Service Executive (HSE) indicate that circulatory diseases remain the leading cause of death, followed by cancer. These two categories alone accounted for 62% of all deaths in 2005 (Fig. 1.2). Of all cancers, lung cancer is most common (21%), followed by colorectal cancer (12%) and breast cancer (8%).

By 2006 only 24.7% of men and women over the age of 15 reported being regular or occasional smokers, compared with rates of 32% and 31%, respectively, in 1998. Alcohol consumption per head of population in 2005 was 10.61 litres; only Austria, the Czech Republic, Germany and Luxembourg had higher rates within the EU. More young females than young males are likely to engage in binge drinking (Kiely, 2004). Ireland had one of the lowest measles vaccination rates for children in Europe at 73% in 2001; only the United Kingdom and Austria had lower rates in the same year. This low rate, in part, was attributed to adverse media reporting over the safety of the vaccination (Kiely, 2004). Subsequently, the rate of immunization increased to reach 86.2%

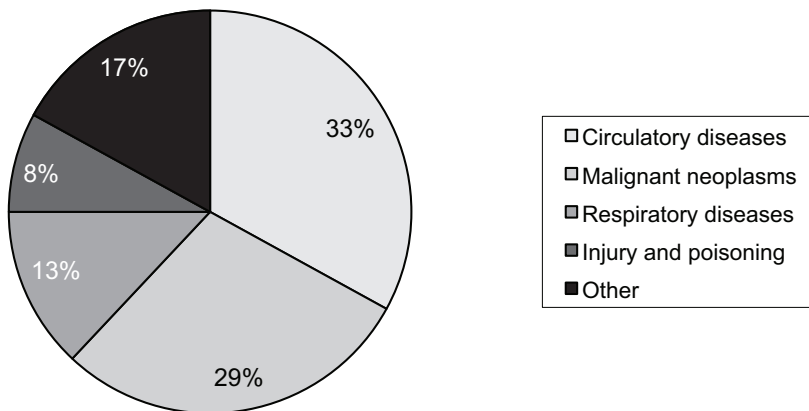
Table 1.6 Principal causes of death, age-standardized mortality rates per 100 000 population

Cause	1973	1983	1993	2003	2004	2005	2006*
All circulatory system diseases	615.5	531.3	406.0	255.2	241.5	218.2	207.5
Ischaemic heart disease	301.8	276.3	227.0	132.9	123.7	113.0	105.7
Stroke	165.6	117.5	83.8	51.1	46.4	42.8	40.1
All malignant neoplasms	205.9	211.2	220.8	189.2	190.5	180.9	182.4
Cancer of trachea, bronchus and lung	37.7	48.3	46.9	40.3	40.1	37.9	38.1
Cancer of female breast	36.5	35.8	37.5	31.3	31.5	31.0	29.8
All external causes	55.4	49.1	39.8	38.2	38.1	34.1	
Traffic accidents	20.7	15.6	11.4	7.0	7.3	6.2	6.2
Suicide	4.0	9.2	9.8	10.9	12.1	10.3	9.1
All causes	1194.0	1050.0	903.8	684.7	664.1	615.7	604.6

Sources: DoHC, 2006f; DoHC, 2007c; WHO Regional Office for Europe, 2008

Notes: Age-standardized rates based on WHO Standard European Population; * Taken from WHO Regional Office for Europe European Health For All database

Fig. 1.2 Principal causes of mortality, 2005



Source: Central Statistics Office, 2007e

of all children by 2006. Nonetheless, within the EU, only Austria and the United Kingdom had a lower rate of immunization in 2006. Diphtheria vaccination rates for infants were 91.0% in 2006 – only Austria, Germany, Greece and Malta had lower rates within the EU (WHO Regional Office for Europe, 2008).

Inequalities in health outcomes

One study produced by the Institute of Public Health in Ireland reported that health outcomes between 1988 and 1998 in Ireland were significantly different across socioeconomic groups (Harkin, 2001). All-cause mortality was two to three times as high in the lowest socioeconomic group compared with the highest. Specifically, for circulatory diseases it was 120% higher, for cancers 100% higher, for respiratory diseases more than 200% higher and for injuries and poisonings more than 150% higher. Excess mortality among males was also reported; the all-cause mortality rate for males being 54% higher than that for females.

The Chief Medical Officer also reported that there were increasing differences in the incidence of all psychiatric conditions between all professional and unskilled manual groups, based on data from the 1991–1996 National Psychiatric Inpatient Reporting System (Chief Medical Officer, 2002). Another, more recent study, looking at the links between the social environment and health across all of the island, reported that those with no formal education were half as likely as those with third-level education to have excellent or good health; and that those who rent their accommodation were nearly half as likely as those who owned their own homes to report having a good quality of life (Balanda & Wilde, 2003). More recent research confirms the adverse impacts of socioeconomic deprivation: 38% of those classed as being at risk of poverty (that is, living on an income of less than €202.50 per week) in Ireland reported that they were suffering from a chronic illness, compared to just 23% of the general population (Farrell et al., 2008).

One group with particularly poor health outcomes is the 31 000-strong Irish Traveller community. The proportion of the Traveller population under 15 years is markedly different, being double that of the general population, at 42.2%, while the population over 65 years in 1996 was only 1%, much lower than the 11% national average at the time. The fertility rate per 1000 women between the ages of 15 and 49 years was more than double that of the general population in 1987: 164.2 compared to 70.1. Data on the health status of the Irish Traveller community indicate that their level of health is much poorer than that of the general population, and mortality rates among adults are much higher. In the most recent data available, from 1987, the life expectancy of Traveller women was 12 years less than women in the general population and the difference for

men was 10 years. The infant mortality rate in 1987 was 18.1 per 1000 live births compared with 7.4 per 1000 nationally (DoHC, 2002b). In their annual report in 1999 the Irish Sudden Death Association stated that sudden infant deaths among Travellers were 12 times greater than in the general population. While no specific survey of Traveller health has been conducted since 1987, available evidence suggests that the inequalities in health status between Travellers and the rest of the population have not reduced (McCabe & Keys, 2005).

Travellers continue to experience general disadvantages, being subject to social exclusion, discrimination and racism. In addition, it is estimated that as many as 80% of all adult Travellers are illiterate, acting as a barrier to the use of health services. In response to this issue a national strategy to improve Traveller health, *Traveller Health, a National Strategy 2002–2005*, was drawn up by the Government to collect appropriate data, improve access to health care services and to tackle poor health outcomes (DoHC, 2002b). The first all-island census of Traveller health was also due to commence in late 2008 and be completed by 2010 (HSE, 2008b).

2 Organizational structure

2.1 Brief overview of the health care system

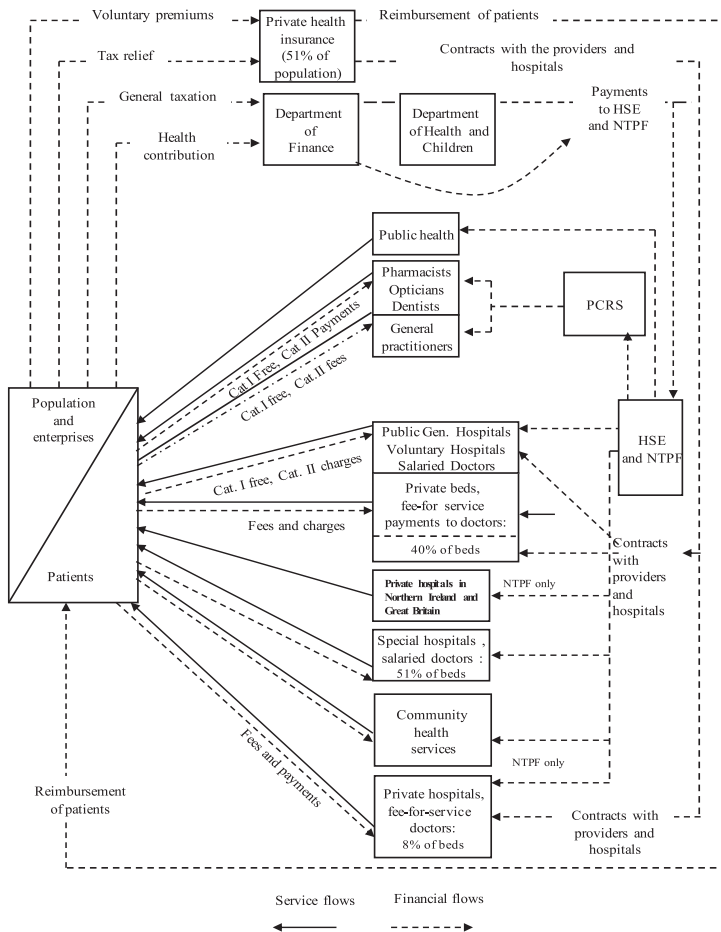
The Irish health care system is predominantly tax funded, although about half the population also has voluntary health insurance (VHI). Around one third of the population can access public services free of charge; the remainder has to make some contribution towards the cost of services utilized. There are three principal groups providing VHI; by far the largest share of this market still rests with the Voluntary Health Insurance Board (VHI Board), which operated as a virtual monopoly from the 1950s to the 1990s.

The State has long played a major role in the provision of services and in the regulation and setting of standards for the health care system. The Department of Health and Children (DoHC) (*An Roinn Slainte Agus Leanaí*), under the direction of the MoHC, together with Ministers of State, has strategic responsibility for health and personal social services. The most substantial reforms to health system structures since 1970 are in the process of being implemented at the time of writing. In 2005 a new Health Service Executive (HSE) took responsibility for both the budget and management of health services as a single national entity, accountable directly to the Minister of Health. This replaced a system where the provision of services had been the responsibility of seven regional health boards and the Eastern Regional Health Authority (ERHA) (serving the Dublin area).

The HSE has three key divisions responsible for population health, hospitals, and primary, community and continuing care. The hospital sector incorporates voluntary and HSE-owned hospitals. Voluntary hospitals are primarily financed by the State but may be owned and operated by religious or lay boards of governors. Beds within these hospitals may be designated for either public or private use. There is also a small number of purely private hospitals.

Hospital consultants have contracts with the public sector but also supplement their income through private activity. A National Treatment Purchase Fund (NTPF) is used to tackle excessive waiting periods for elective procedures within the publicly funded system. This can, in specific circumstances, be used to purchase care anywhere in the country, the private sector or even in the United Kingdom. General practitioners (GPs) are self-employed and often work in a single-handed practice. Dentists, opticians and pharmacists also operate in independent practice. Multidisciplinary Primary Care Teams are being developed at the time of writing. Figure 2.1 provides an overview of the health system in Ireland following recent reforms.

Fig. 2.1 Overview chart of the health system



Source: Adapted from OECD, 1992

Notes: HSE: Health Service Executive; NTPF: National Treatment Purchase Fund; PCRS: Primary Care Reimbursement Scheme

2.2 Historical background

The role of the State in health care has evolved considerably since the end of the 19th century when its principal function was the provision of essential services, locally funded, to the poor and indigent. Today, the State plays a major role in the provision of services, as well as in the regulation and setting of standards for inputs to the health system.

The first steps towards greater involvement in funding and delivering health care services came about at the end of the 19th and early part of the 20th century. The 1878 Public Health Act made provisions for the regulation of water supplies and sewage systems, while access to free medical treatment for those suffering from tuberculosis (TB) was introduced in 1912. Subsequent pieces of legislation, such as the introduction of the school medical service, continued to increase the role of the State.

During the period known as “the Emergency” (the Second World War) in the early 1940s, there were discussions within the Fianna Fáil Government about the possibility of setting up a national health service, not dissimilar to that being proposed at the time in the United Kingdom. The introduction of such a system was resisted by elements within the medical profession, and there was also strong opposition to the notion of “socialized medicine” within elements of the Roman Catholic Church in Ireland, which believed such a system would reduce individual responsibilities and may be incompatible with church teaching.³

1947–1970

The Department of Health was established in 1947 under the Ministers and Secretaries (Amendment) Act of 1946. Prior to this, public health services were the responsibility of the Department of Local Government and Public Health. Such services continued to be administered by local authorities until 1970. Between 1947 and 1970 the system was shaped into the basic structure that still exists at the time of writing: a mixed public/private system of health service funding and provision.

The Health Act (1953) extended free hospital and specialist care in public wards to approximately 85% of the population, and in 1957, the VHI Board was established as a non-profit-making, semi-state private insurance body by the Government. The primary concern at the time was to ensure that the 15% of the population not covered by the State (under the 1953 Act) would have an

³ To this day, the Church continues to have a significant influence on health and social issues, such as a strong influence on public opinion during various referendums on the circumstances where terminations during pregnancy are permitted; contributing to the long prohibition, until recently, of divorce; and maintaining an involvement in the management of voluntary hospitals.

opportunity to purchase private health insurance. The VHI Board continued to operate with a virtual monopoly over health insurance until the mid-1990s when the Health Insurance Act of 1994 was passed to comply with EU requirements to open up the insurance market to competition (the first competitor, BUPA Ireland (British United Providential Association), entered the market in 1997).

1970–2000

Following the publication of the 1966 White Paper *The Health Services and Their Further Development*, the blueprint for the modern Irish health care system – the Health Act (1970) – was passed. This established eight regional Health Boards, primarily on a population basis and shifted the responsibility for the development and execution of health policy from local authorities to the Department of Health (see 10.2 *Health Boards and associated structures, 1970–2005* for more on the organizational structure of the health care system during this period). The emphasis on the curative and regulatory aspects of health services and on the need to develop the acute hospital sector in particular remained one of the defining characteristics of health policy in the decades following the passing of the Act.

Under the Health Act (1970) all residents of Ireland qualify to receive services either under eligibility Category I or Category II (see Section 3.2 *Population coverage and basis for entitlement*). Those falling within Category I are entitled to services without charge, other than for long-stay care in publicly funded facilities. Just under one third of the population today has this type of full eligibility. Those within Category II (or limited eligibility) incur some charges for services utilized.⁴ Eligibility is determined on the grounds of income or age. All people over 70 years of age since July 2001 qualify for the Medical Card issued to Category I individuals. Those with Category II status have coverage for publicly funded hospital services (subject to some charges) but have to pay towards the cost of most other services, including prescription pharmaceuticals. Until 2005, such individuals had no entitlement to GP services and had to meet all costs privately. However, in 2005 a GP Visit Card was introduced, providing free access to GPs for an estimated 230 000 Category II individuals whose incomes were slightly above the maximum limit to qualify for a Medical Card.

The General Medical Services (GMS) Scheme was established in 1972, with the intention of providing a choice of private GPs and pharmacists to all Category I patients. Prior to this, patients had to rely on a network of public dispensaries whose origins date back to the 19th century. Private GPs could choose to enter into GMS contracts with Health Boards (now the HSE) to

⁴ Originally, there were two limited eligibility categories – Category II and Category III for those with the highest incomes, but these groups were merged in 1991.

provide services. Similarly, at the time of writing, pharmacists are reimbursed by the public purse for both pharmaceuticals supplied to eligible patients under the GMS scheme and those dispensed to the remainder of the population as part of the Drugs Payment Scheme (see Subsection *Health care benefits*, within Section 3.2 *Population coverage and basis for entitlement*).

The overall structure of the health care system remained essentially unaltered between 1970 and 2000. Strategy documents such as *Health: the Wider Dimensions*, published in 1986, and *Shaping a healthier future: A strategy for effective health care in the 1990s*, published in 1994 tended to concentrate on tackling specific diseases and population group health problems, such as those of older people, people with mental health problems or those with cardiovascular disease. The Department of Health was renamed the Department of Health and Children (DoHC) in 1997. Some restructuring of the health care system took place in the year 2000 following the implementation of recommendations from several earlier reviews. In particular, one of the Health Boards – the Eastern Health Board – was replaced with the ERHA. The establishment of the ERHA was motivated primarily by the need to address the problems of fragmentation and inefficiencies that arose because the main teaching hospitals in the Dublin region had remained outside of the Health Board structure when the Eastern Health Board was established in 1970. At the time of this restructuring, the number of agencies reporting directly to the DoHC was also reduced, with the devolution of executive work to other agencies and the transfer of the funding of voluntary agencies to the Health Boards. The ERHA itself consisted of three Area Health Boards. It did not have a management role in the direct delivery of service; instead, it was responsible for commissioning service provision with service providers based on service agreements. These structural changes enabled decisions regarding the provision of local services to be made closer to the point of delivery and also allowed for the involvement of the local community, through representatives on the Area Health Boards.

Across the country, the Regional and Area Health Boards continued to be the main providers of health and personal social services through three core programmes: general hospitals, special hospitals and community care programmes. The voluntary sector continued to play a vital role in the delivery of health and personal social services. Voluntary agencies range from major hospitals and national organizations to small community-based support groups set up in response to local needs. In addition, a number of specialist agencies, including the National Breast Cancer Screening Board, were established to address issues of quality control and/or to provide particular services.

Other major changes during this period included the introduction of the Freedom of Information Act of 1997. This Act gave the right of access, subject

to some exceptions, to information such as medical records or the decision-making process used to determine eligibility for Medical Cards.

In addition to the cross-border bodies with an interest in the health field (outlined in Chapter 1 *Introduction*) that were set up following the British–Irish Agreement in 1998, another earlier initiative – Cooperation and Working Together (CAWT) – was launched in 1992, involving the Southern and Western Health and Social Services Boards in Northern Ireland, and the North Western and North Eastern Health Boards in Ireland. The main aim of CAWT has been to work together for health gain and social well-being in the border area.

2001–2007

At the start of the new millennium the Irish health care system was characterized by a number of independent reviews of its functions. These were in direct response to the publication in 2001 of a strategy on national health policy, *Quality and fairness: A health system for you* (DoHC, 2001b). This National Health Strategy set out a challenging and ambitious agenda intended to guide development and reform within Irish health services over the subsequent 7–10 years. This continued to develop the commitment to pursuing the principles of equity, quality and accountability which had underpinned previous Health Strategy statements, but with an additional focus on placing the patient at the centre of future reform.

Specifically, the National Health Strategy required:

- a review of the functions and operations of the DoHC and Health Boards, aimed at strengthening strategic planning and effective service delivery, respectively;
- the development of new mechanisms and structures to support the development and application of national standards for the whole health system; and
- a review of the roles of existing health agencies in light of new strategic goals and objectives.

The reforms set out were centred on six main areas: strengthening primary care provision, development of the acute care hospital system, improved funding, better planning and training for the health care workforce, review of current health care structures and improvement of health information systems.

To reinforce and elaborate the plans proposed for primary care and the acute care hospital system, individual strategy statements were subsequently published. *Primary care: A new direction* essentially proposed the development of a “one-stop shop” for primary care services (DoHC, 2001a), while the report on *Acute hospital bed capacity* proposed an expansion in hospital bed capacity of close to 3000 beds over a 10-year period (DoHC, 2002a).

The year 2001 also saw the establishment of the Health Insurance Authority (HIA), set up to facilitate the further development of the private health insurance market in Ireland, and to promote competition, while ensuring schemes still use community rating, have open enrolment and provide lifetime cover. Following further reviews investigating the functioning of the private insurance market in April 2007, the Government approved reform measures to change the status of VHI, so that this would be the same as that of other insurers by the end of 2008. Until the time of writing, VHI has not been subject to the same rules governing solvency requirements as other insurers. In addition, the 3-year exemption from risk-equalization payments for new entrants to the insurance market has been abolished. To encourage competition and new entrants, and with regard to proportionality, risk-equalization payments now will be discounted by 20% (see Chapter 3 *Financing*).

In 2003 the *Prospectus audit of the health system* (Prospectus, 2003) and the *Commission on financial management and control systems in the health service* report, chaired by Niamh Brennan (Brennan, 2003),⁵ set out a series of recommendations for structural change which formed the basis of a new Health Service Reform Programme.

Both these reviews recommended establishing an Executive which would be responsible for managing the health system on a national basis. The Brennan Report noted that despite public perceptions, technically the DoHC was not accountable for service delivery issues, but nevertheless had been drawn into these issues, reducing resources available for strategic planning and policy development. Both reports also noted the high degree of fragmentation in the health care system and the frequent overlap in functions between different agencies.

The Health Service Reform Programme was published in June 2003. Under the Reform Programme Model announced by the Government, the structure of the DoHC was to be revised so as to

... focus on strategic and policy issues (by reducing its involvement in day-to-day matters) and having ultimate responsibility for holding the service delivery system to account for its performance. This will remove any confusion within the broader system about the role of the Department and create room to analyse and evaluate the performance of the service delivery system. (DoHC, 2003a)

This reform programme has been without doubt the most radical change in the structure of the Irish health care system since 1970. Among the changes announced and subsequently implemented were a reorganization of the DoHC and the abolition of all the Health Boards and the ERHA. A new HSE, to be

⁵ Known as the Brennan Report, the assessment was commissioned as a result of the 2001 Strategy.

responsible for managing services as a single national entity, came into operation on 1 January 2005, with a full transition from the former Health Board system to a single unified structure achieved by June 2005. Responsibility for day-to-day management and the allocation of financial resources across the health sector rests solely with the new HSE at the time of writing. A Health Information and Quality Authority (HIQA) is also in place.⁶ Many other executive agencies were merged as part of the reform measures.

2.3 Organizational overview

The Irish health care system maintained a relatively stable structure for more than 30 years until the major reorganization of the Health Service Reform Programme, announced in June 2003 and implemented from the beginning of 2005 (DoHC, 2003a). This reform programme is intended to help implement the 2001 National Health Strategy, which recognized the need for restructuring within the health care system. It was anticipated that full implementation would take up to three years and, at the time of writing, therefore, the reforms are still in progress, with not all of the elements of the new structure yet in place.

Figure 2.3 illustrates the new organizational structure for the Irish health care system from 2005. Overall responsibility for the health care system lies with the Government, exercised through the DoHC under the direction of the MoHC. The Health Boards that had been responsible for the provision of health care and personal social services were abolished on 1 January 2005 and replaced by a single body, the HSE. Many of the functions and staff from the former health care structure have been relocated within the new HSE.

The HSE provides many health care services directly, but the voluntary sector, including organizations linked with the Church, have and will continue to play an important role in the delivery of health and personal social care services, ranging from running hospitals to small community-based projects. In addition, there were nearly 60 statutory specialist groups with advisory and service functions established under the terms of the 1961 Health (Corporate Bodies) Act; half of these have been set up since the late 1990s, but many have or will be merged as part of the reform programme. There has also been limited recent development of formal governmental cross-border cooperation between the Republic of Ireland and Northern Ireland on common objectives in the health field following the 1998 British–Irish (Good Friday or Belfast) Agreement. A joint Food Safety Promotion

⁶ This was established as an interim body in 2005 and has operated with full statutory powers since 15 May 2007.

Following the 2007 general election, there are four Ministers of State at the DoHC, all from the party Fianna Fáil. They each have responsibility for one health-related portfolio: Children; Health Promotion and Food Safety; Disability Issues and Mental Health; and Older People. The visibility of the health portfolio has been expanded since the early 2000s; the number of ministerial posts had already been increased from two to three after the 2002 general election. In particular, the profiles of both mental health and disabilities within the DoHC were raised and continued to be a major priority for the Department in the 2005 and 2006 Budgets (Cowan, 2004; Government of Ireland, 2006b).

The DoHC's primary function is to advise and support the MoHC in developing and evaluating policies for the health service. Prior to the implementation of the Health Service Reform Programme it also had a role in strategic planning alongside other stakeholders, most notably the Health Boards, the voluntary sector and other governmental departments. Its new mission is "to support, protect and empower individuals, families and their communities to achieve their full health potential by putting health at the centre of public policy and by leading the development of high-quality, equitable and efficient health and personal social services" (DoHC, 2005h).

The Department has been undergoing restructuring as part of the Health Service Reform Programme and a number of its functions were devolved to the HSE in 2005. The reshaped role of the Department is built around supporting the MoHC and Ministers of State, and accounting to the Government and the *Oireachtas*. This includes legislation and regulation, monitoring of both the financial position of the health system and service provision, evaluating efficiency and effectiveness of service delivery, as well as policy analysis and formulation. The new key objectives of the DoHC in supporting the MoHC are summarized in the list that follows.

- Formulating policy underpinned by an evidence-based approach and providing direction on national health priorities, ensuring that quality and value for money are enhanced through the implementation of an evidence-based approach underpinned by monitoring and evaluation.
- Protecting the interests of patients and consumers and supporting practitioners and professionals to practise to the highest standards by providing a prudent and appropriate regulatory framework.
- Providing effective stewardship over health resources by demanding accountability for achieving outcomes, including financial, managerial and clinical accountability, and by providing the necessary frameworks, including enhanced service planning at national level, to improve the overall governance of the health system. Fulfilling obligations in relation to the requirements of the EU, WHO, the Council of Europe and other international

bodies and the continued implementation of the cooperation agenda decided by the North/South Ministerial Council (DoHC, 2005h).

The Secretary-General is the permanent head of the Department. A Management Advisory Committee (MAC) consisting of senior DoHC officials including the Chief Medical Officer, Assistant Secretaries and Division Directors advise the Secretary-General with regard to the formulation of policy proposals for the Minister of Health. A number of specialist agencies have been established to address particular needs or to provide specific services on a national basis. In addition to the Office of the Chief Medical Officer there are (at the time of writing) nine divisions within the Department, all of which are accountable to the Secretary-General. These are:

1. Finance, Performance, Evaluation, Information and Research
2. National Human Resources and Workforce Planning
3. Eligibility and Patient Safety
4. Parliamentary and Corporate Affairs
5. Office of the Minister of Children and Youth
6. Primary Care and Social Inclusion/Public Health
7. Acute Hospitals, Cancer and Associated Services
8. Office for Disability and Mental Health
9. Office for Older People.

Other ministries

The Department of Finance (DoF) allocates funds raised through general taxation between health and social care and other government departments on the basis of interdepartmental discussion. Health care is the single largest component of national public expenditure, and was projected to account for more than 29% (€12.39 billion) of total public expenditure in 2006 (Government of Ireland, 2006b). The DoF also agrees with the DoHC the upper ceiling on the number of employees within the health service and has to approve capital project costs that are in excess of €6.3 million. The DoHC commissioned the Brennan Commission Report (Brennan, 2003) whose terms of reference were to examine various financial management systems within the DoHC, the Health Boards and other significant budget holders within the health care system.

Other ministries with an interest in the health system include the Department of Social and Family Affairs (DSFA), which has responsibility for social welfare payments, including various forms of income support, disability allowances and payments made to support family carers. The Department of Justice,

Equality and Law Reform, through the Director of Prison Medical Services, is responsible for the health of the prison population. The Department of Agriculture and Food is responsible for monitoring and controlling aspects of food safety, while the Department of Education and Science is responsible for the provision of funding for higher education courses in medicine.

The Health Service Executive

One of cornerstones of the Health Service Reform Programme is the HSE (*Feidhmeannacht Na Seirbhíse Sláinte*). With a budget of more than €13 billion it is the largest employer in the State with more than 65 000 staff in direct employment and a further 35 000 employed by voluntary hospitals and bodies that are funded by the HSE. It has its headquarters in Naas, County Kildare, and will ultimately have a staff of approximately 300 at head office alone. It took over full operational responsibility for running the country's health and personal social services on 1 January 2005. The HSE reports to an 11-member board appointed by the MoHC.

The HSE is divided into four administrative areas: Western; Southern; Dublin/North-East; Dublin/Mid-Leinster (Fig. 2.2). These administrative areas largely use the geographical boundaries of the Health Boards they have replaced.

As Table 2.1 indicates, Dublin Mid-Leinster has the greatest catchment population, accounting for 28.7% of the population in 2006, with population growth most rapid in the Dublin/North-East region.

Table 2.1 Health Service Executive Area Population, 2006

HSE Area	Population	% of total population	% population growth since 2002
Dublin/North-East	927 525	21.9	11.5
Dublin/Mid-Leinster	1 215 711	28.7	6.7
Southern	1 080 999	25.5	7.7
Western	1 010 690	23.9	7.4

Source: HSE, 2007f

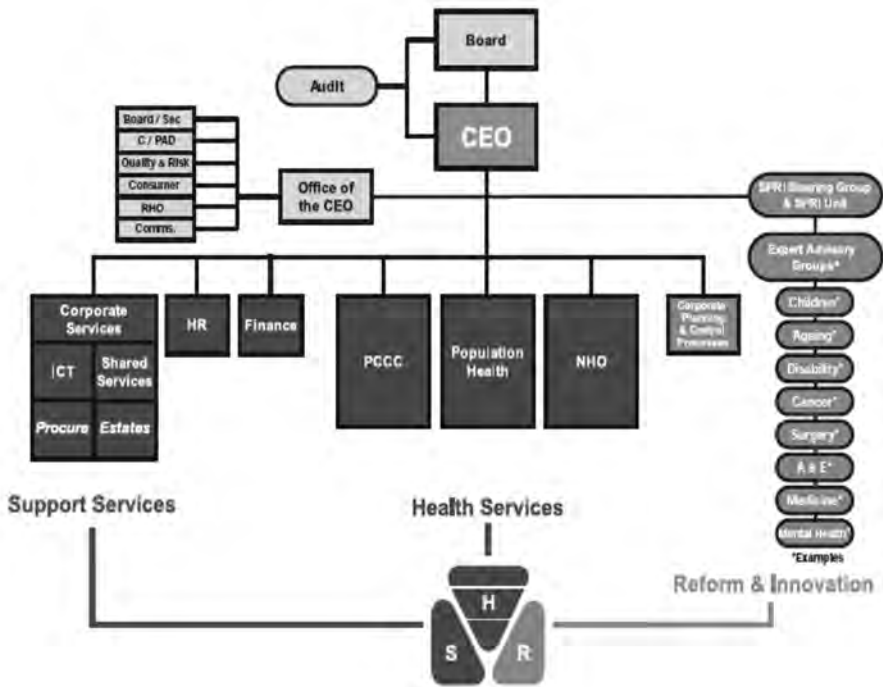
Note: HSE: Health Service Executive

The four administrative offices are located in Galway City, Cork City, Kells County Meath and Tullamore County Offaly, respectively, and assist in the coordination of services delivered through local health offices. They do not have a board structure; instead, a local manager is directly accountable to the HSE chief executive officer (CEO). This is intended, in part, to reduce the potential conflict of interest between local political considerations

and the national strategy, an issue that had been identified as problematic in the past (Brennan, 2003; Prospectus, 2003).

The HSE is organized into a number of directorates which focus on three main areas: health and personal social service delivery, support services, and reform and innovation (Fig. 2.3). The first of these directorates, health and personal social services is itself divided into three units.

Fig. 2.3 Organizational structure of the Health Service Executive, December 2005



Source: www.hse.ie, 2006 (no longer available)

Notes: CEO: Chief Executive Officer; C/PAD: Corporate/Parliamentary Affairs Division; RHO: Regional Health Office; SPRI: Strategic Planning, Reform and Implementation; ICT: Information and communication technology; HR: Human resources; PCCC: Primary, Community and Continuing Care Directorate; NHO: National Hospitals Office; A&E: Accident and emergency

At the time of writing, a National Hospitals Office (NHO) is responsible for the management of acute services in 51 hospitals nationally, through eight larger local hospital networks – two in each regional area. This includes advising on the organization, planning and coordination of acute services, including the location and configuration of particular services and specialties. The NHO also advises on the provision of specialist services for Irish patients that are not available in the country and have to be provided elsewhere.

A recent key focus has been to improve integration with primary care services. The NHO is also responsible for nationwide ambulance pre-hospital care.

The Primary, Community and Continuing Care (PCCC) Directorate is responsible for a range of services including general practice, community-based health and personal social services, services for older people, children, disability services, mental health services and social inclusion. Since September 2005 the PCCC Directorate has consisted of 32 Local Health Offices (LHOs) which represent the first point of call for access to a range of community services. Each has a local health manager who works closely with the hospital managers in their geographic area to ensure that patient needs are met. These LHOs are also responsible for implementation of public health strategies developed by the HSE.

The Population Health Directorate is responsible for the strategic planning of all aspects of the HSE in order to positively influence health, health service delivery and outcomes by promoting and protecting the health of the entire population and target groups. It has a special focus on tackling inequalities in health and is also responsible for immunizations, infection control and environmental health. Strategy and policy recommendations can cover many areas ranging from the need for greater capacity or development of specialist treatment centres to the use of taxation instruments to promote healthy living. Its functions are organized at local level through the 32 LHOs and the 8 hospital networks.

Within the Support Services area, the Finance Directorate has overall responsibility for the management of the health system budget and ensuring value for money, while the Human Resources Directorate plans future personnel needs and policies including recruitment and training. Other divisions include Information and Communication Technology (ICT); the Office for Procurement, which is charged with securing savings through integrated procurement and the use of the HSE's purchasing power; and the Estates Office which aims to maximize the value of the HSE's estates portfolio and to release resources as appropriate to be redirected towards service improvements.

Within the Reform and Innovation area of the HSE's functions is a directorate for Corporate Planning and Control Processes and another for Strategic Planning, Reform and Implementation (SPRI). SPRI "will deal with the strategic planning, reform and implementation aspects of national initiatives and events that will have a significant impact on patient care" (HSE, 2005e).

A new Corporate Pharmaceutical Unit promotes best practice across the HSE in relation to the use of pharmaceuticals and medical devices. It is to be responsible for evaluating the many schemes that exist in relation to the provision of pharmaceuticals and devices to patients, and has already

played an important role in the negotiation of new rules governing the reimbursement and pricing of pharmaceuticals (see Chapter 6 *Provision of services*). There is also a Winter Initiative Project Team to ensure that the extra demands placed on the health care system during winter do not lead to deterioration in the quality of services provided. It coordinates its activities across the NHO, the PCCC Directorate and Population Health Directorates and has eight local implementation teams.

The HSE is still in its infancy and changes to the existing system have taken place in an incremental fashion; the CEO of the HSE, Brendan Drumm, was not in post until August 2005 and some heads of divisions within the HSE (such as the Head of Corporate Services) were appointed even later. Initially, an Interim HSE had been responsible for managing the transition process. This body had acknowledged that while the legal structures were changing, change on the ground would take more time (DoHC, 2004b). Further changes to the HSE structure were announced in December 2005 and the HSE, with the establishment of a series of national Expert Advisory Groups, is to advise on policy, organization and development of health and social care services. The first four groups – covering older people, mental health, children and diabetes – were officially launched in October 2006. These independent groups include health professionals, patients, clients and other service user groups. Reports and recommendations developed by the groups will be first presented to the HSE's SPRI Steering Group for initial consideration and review and, in turn, presented to the CEO and Management Team. Following adoption of reports and recommendations, an Implementation Group will ensure they are put into practice.

Four Regional Health Forums to provide a link to local political structures also have been put in place, with the first meetings occurring in March 2006. The Forums are made up of representatives of the city and county councils and will be able to make representations to the HSE on the range and operation of health and personal social services in their area (DoHC, 2005g).

Central elements of the statutory accountability within which the HSE operates are: the Annual National Service Plan (NSP), the Annual Financial Statements, the 3-year Corporate Plan and the Code of Governance. The Service and Corporate Plans and the Code of Governance are subject to the approval of the MoHC. In addition, the HSE is required to obtain the MoHC's prior written permission for major capital spending. The HSE Annual Report is submitted to the MoHC and laid before the Houses of the *Oireachtas*. Moreover, the DoHC has an agreed monitoring framework with the HSE and receives detailed comprehensive monthly and biannual performance monitoring reports from the HSE on all aspects of progression of the NSP.

The Health Information and Quality Authority

The HIQA, established in interim form in 2005 and with full statutory powers in May 2007, is responsible for developing health information; promoting and implementing quality assurance programmes nationally; and overseeing health technology assessment (HTA), including consideration of cost as well as clinical effectiveness (see Chapter 4 *Regulation and planning* for a fuller discussion of HIQA). The Health Act (2007) also placed the Social Services Inspectorate within the HIQA on a statutory basis in the form of the Office of the Chief Inspector of Social Services with specific statutory functions. The work of the Inspectorate had been focused on children in care, primarily on inspection of residential care, but its role has expanded to include the inspection and registration of residential services in the public, private and voluntary sectors for older people and people with disabilities.

Health Boards

Although the Health Boards officially ceased to exist on 1 January 2005, with all their staff and assets transferred to the HSE, the CEOs of the Health Boards continued to handle regional and local management, and maintain existing reporting relationships as they continued to devolve their functions to the HSE over the first six months of 2005. The CEOs were accountable to, and had delegated authority from, the Interim CEO of the HSE. Only in mid-June 2005 were all structures unified within the HSE. Section 10.2 *Health Boards and associated structures, 1970–2005* highlights the previous role of the Health Boards and the ERHA. It is important to understand how these structures functioned in order to fully understand the reform process. Moreover, although no longer officially functioning, many of the staff and structures of the Health Boards continued to deliver and manage services on a day-to-day basis as the transition to a single unified structure under the HSE progressed.

Other agencies

The Irish health care system has been characterized by a fragmented structure, and prior to the implementation of the current reforms there were almost 60 statutory and non-statutory agencies involved in strategic issues, regulation, quality assurance and the delivery of services. Some bodies are described in the paragraphs that follow, and key professional regulatory bodies are discussed in Chapter 4 *Regulation and planning*.

National Shared Services Primary Care Reimbursement Service. Originally set up as the GMS (Payments) Board in 1972, this agency was responsible on behalf of all the Health Boards for the calculation, implementation and verification of payments for GP services and prescriptions for GMS scheme card holders, and payments under the Long-Term Illness and Drugs Payment Scheme, as well as those for dental care, optical services, high-tech pharmaceuticals, primary childhood immunization and methadone treatment. Payments by the Board amounted to €1.88 billion in 2005 (General Medical Services (Payments) Board, 2005). In 2005 the Board became an agency within the new HSE, and is known at the time of writing as the National Shared Services Primary Care Reimbursement Service.

Office for Health Management. In existence since 1997, this body was funded directly by the DoHC to facilitate personnel, management and organizational development within the health services, through a joint commissioning process on behalf of employers in health and personal social services. Activities to develop management have included leadership programmes, a newsletter, and master classes and training programmes for specific professional groups, such as nurses and clinicians. The Office also worked with the DoHC in facilitating discussions on the implementation of the National Health Strategy. It played an important role, at the request of the DoHC, in leading the communication and consultation process on the reform programme. It also provided a neutral forum for debate on proposed reforms where stakeholders could discuss issues in the strictest confidence. Under the Health Service Reform Programme, the Office was subsumed within the HSE on 1 January 2005, where its work continues.

Irish Blood Transfusion Service. Set up in 1965, and operating with a total income of €101.41 million in 2005, this is the national service for recruiting and obtaining blood donations (Irish Blood Transfusion Service, 2006). It also maintains eye, heart valve and bone banks. Testing and quality assurance are key concerns, with donations rising in 2002 for the first time since 1996. In its history, two events have rocked confidence in the service and were the subject of major independent reports. A report chaired by Justice Tom Finlay looked at the infection with hepatitis C of over 1000 women given Ante D in the 1970s (Finlay, 1997), while Justice Alison Lindsay investigated the infection of people with haemophilia in Ireland in the 1970s and 1980s through the contamination of blood products (Lindsay, 2002). A total of 11 recommendations of an international panel on the testing of blood products in Ireland were subsequently accepted by the Service (Irish Blood Transfusion Service, 2003).

Irish Cancer Screening Board (ICSB). The Board was established in early 2007 as part of the DoHC's Cancer Control Strategy. This brings together two previous screening programmes within one bracket – the National Breast Cancer Screening Board and the Irish Cervical Screening Programme (ICSP). The former, also known as BreastCheck (*An Bord Cioch Scrudaithe Naisiunta*) was set up in 1998, with a National Breast Cancer Screening programme launched in 2000. Initially, the programme screened women between the ages of 50 and 64, every two years and free of charge. In its initial phase the programme covered the ERHA, North Eastern and Midland Health Boards, with the intention of expanding the scheme nationally using mobile screening units. In 2004 over 68 000 women were invited for screening, with more than 50 000 attending – an uptake rate of more than 70%. Services were also extended to areas of the south-east of the country, including Wexford and Carlow, with Kilkenny following in May 2006. In 2005, plans were also announced to extend screening elsewhere in the south and west of the country from 2007 (BreastCheck, 2005). The building of two screening units in Victoria Hospital, Cork and University College Hospital, Galway began in autumn 2006. The ICSP began with a regional development in the Mid-West Health Board region in 2000. The aim of this regional programme was to develop and pilot a population-based test/recall system to screen women between the ages of 25 and 60. The aim was to roll out the programme on a national basis by 2008 (ICSP, 2006).

Health Research Board (HRB). The HRB promotes, funds, commissions and conducts medical, epidemiological and health services research in Ireland. It is a lead body in implementing the government strategy “Making Knowledge Work for Health”. It has a “particular mission to encourage research that translates into improved diagnosis, understanding, treatment and prevention of disease and improves efficiency and effectiveness of the health services” (HRB, 2007b). The HRB works with international partners within and outside the EU. For instance, joint work on cancer research has been undertaken with partners in Northern Ireland, the rest of the United Kingdom and the United States. A number of research databases are also maintained. The HRB had an operating budget of €45 million in 2006 (HRB, 2007a), with 74 research grants and 23 career development awards granted. In previous years, further awards were made through the summer students scheme and science writing workshops (HRB, 2007b).

Institute of Public Health. The Institute is funded by both the DoHC in the Republic of Ireland and the Department of Health, Social Services and Personal

Safety in Northern Ireland. It was established under the British–Irish (Good Friday) Agreement of 1998, with the purpose of promoting cooperation in public health across all of the island of Ireland. A key element of work is to research and collect data to improve understanding of health inequalities. Another element is to improve collaboration, both across the island and internationally on the surveillance of public health (Institute of Public Health, 2005).

Other statutory and private sector bodies

Voluntary health insurance

VHI has played an important role in the Irish health care system for almost 50 years and approximately 51% of the population are covered by some form of private insurance scheme (HIA, 2007b). Companies or individuals can directly contribute to one of 20 different schemes: 3 commercial schemes (covering 48% of population) and 17 long-standing restricted, vocation-based funds. By far the largest insurance body is the **VHI Board**, set up in 1957, which operates as a non-profit-making, semi-state private insurance body, with board members appointed by the MoHC. As of September 2006, the VHI Board's share of the market was approximately 75% (HIA, 2007b). Prior to the 1994 Health Insurance Act, the VHI Board had a virtual monopoly in Ireland, but the Act opened the market to other providers, with the principal competitor being **QUINN-healthcare** (until 2006 BUPA Ireland), which covers approximately 440 000 people, about 22% of the private insurance market. A third insurer, **Vivas**, entered the market in October 2004 and has approximately 3% of the market at the time of writing (HIA, 2007b). The remaining insurance schemes are closed schemes covering approximately 3% of the population. They are provided to specific employee groups, mainly the *Gardai* (Police), covering approximately 46 000 individuals, Prison Officers (10 000) and the Electricity Supply Board (30 000). Care funded through VHI may be provided within state and voluntary sector hospitals, as well as in private hospitals (see Chapter 3 *Financing* for further information on the role of VHI).

Voluntary hospitals and agencies

Voluntary organizations provide a wide range of services that complement the state health system. These organizations range from large teaching hospitals and national organizations to small community-based support groups. There are 29 voluntary hospitals in Ireland, of which 25 are in Dublin, 3 in Cork and 1 in Limerick, all predominantly established by religious orders and philanthropic groups. In particular, there is a long and established tradition of

care and service provision for people with intellectual and physical disabilities. While these agencies may undertake voluntary fund raising, where services are considered central to state provision, funding is provided by the DoHC through the HSE.

General practitioners

The private sector also plays a role in providing health care services to meet the overall health needs of the population. In total there were estimated to be 2128 GPs employed in Ireland in 2005 (OECD, 2006b).⁷ While there are some GPs who work exclusively in either the public or private sector, the majority of GPs treat both private and public patients. Even GPs working solely in the private sector may enter into contracts with the HSE to provide publicly funded care for their private patients when they reach the age of 70, or if patients are infected with hepatitis C, as well as more generally providing public maternity, infant and vaccination services on behalf of the HSE.

Private hospitals and private hospital beds

While private hospitals operate on an independent basis, approximately 20% of all beds in public hospitals and voluntary hospitals have been designated for use by private patients. There are approximately 20 purely private hospitals, most of which are members of the Independent Hospital Association of Ireland. As part of a government initiative intended to free up public beds by building private hospitals within the grounds of existing public hospitals, a process known as “co-location”, expressions of interest were invited in May 2006 for the provision of such facilities on 11 public hospital sites. Six winning bids to build units providing 914 private beds in total were announced in July 2007. Two more winning bids are also to be announced, although under the programme for government agreement between Fianna Fáil and the Green Party, there will be an assessment of the value for money of the proposals before any additional co-location hospitals are allowed (Bowers, 2007).

The private sector also has a strengthened role in providing public health services following the creation of the NTPF in 2002. This is intended to shorten waiting times for people currently on waiting lists for hospital services. It was proposed in the 2001 National Health Strategy “Quality and Fairness”, “for the sole purpose of purchasing treatment for public patients who have waited more than three months” until the target of treatment within three months is achieved (DoHC, 2001b). In the event that it is not possible to secure the required treatment in Ireland within a reasonable time period, public patients

⁷ This number is the actual number and not the full-time equivalent.

may also be treated privately within public hospitals, referred to a private hospital or sent abroad for treatment “having regard to quality, availability and cost”. Established with €30m initially, at the time of writing the NTPF has the authority to contract for services with public or private hospitals in Ireland or with private hospitals in Northern Ireland, England and Scotland to provide services for patients who exceed the target time on acute hospital waiting lists. In addition, the DoHC has funded, over a longer period, some specialist services not provided in Ireland – for instance, the Department has had a contract with the Freeman Hospital in Newcastle (United Kingdom) to provide national heart and lung transplantation services, although this is to be phased out, with the first lung transplant in Ireland performed in 2005.

2.4 Decentralization and recentralization

The Irish health care system had been characterized by a high degree of decentralization, with the delegation of service delivery to the Health Boards (and prior to this to the counties), in addition to delegation of planning, management and delivery functions for some specific services. This was an important factor influencing the shape of health care reforms. During the process of developing reform proposals, one particular issue of note was that, in the politically sensitive area of acute hospital provision, local considerations rather than national strategies might have greater influence, particularly as the majority of Health Board members were political appointees. Loyalty to county priorities might have had greater weight than the regional identities of the Boards. In consultations for the development of the National Health Strategy (2001) it was further noted that there was some perception that the Boards had developed services in very different ways, and thus there was a lack of consistency across the country.

Thus, decentralization has been subject to much criticism, and the new reforms in many respects reverse the process, with the Health Boards replaced by one national HSE that is responsible for delivering an NSP, combined with the amalgamation and/or abolition of many statutory agencies. At the same time, the new structures also theoretically allow for greater local involvement, such as through the 32 local primary and community care offices, where dialogue and involvement of a range of local stakeholders are explicitly encouraged. It is still too early at the time of writing to judge how these arrangements are working in practice.

2.5 Patient empowerment

Patients' rights

Broadly speaking, the provisions outlined in the 1994 WHO Declaration of Patient's Rights in Europe are in place in Ireland. The 1937 Constitution of Ireland enshrined into law a range of basic fundamental human rights relevant to patients, including the right to life. Over the years, the Irish courts have also invoked international human rights treaties to which Ireland is a party in their judgements, including the right to bodily integrity. Measures are in place with regard to patient confidentiality and access to information, as well as for claims and compensation. The Health Acts of both 1970 and 2004 place a duty on the State to provide access to appropriate medical care for those individuals who would otherwise not be able to do so because of low income. However, the Constitution does place tight restrictions on access to certain medical procedures, most notably the termination of pregnancy.

One important advocate for patient rights in Ireland is the Human Rights Commission, established under the Human Rights Commission Act of 2000. The Commission is charged with promoting and protecting human rights as defined both in the Constitution and in international agreements to which Ireland is a party. The European Convention on Human Rights Act was passed in 2003; this allows any health service user to bring a Convention right before the courts. The High Court can declare that national legislation breaches the Convention, in which case the matter is referred to the *Oireachtas*, which must remove the inconsistency between the Convention and Irish law.

The 2001 Health Strategy, *Quality and fairness*, also put a great emphasis on the importance of patient rights, setting out a vision of a health system that “encourages you to have your say, listens to you, and ensures that your views are taken into account” (DoHC, 2001b). A number of mechanisms to incorporate public views into consultative mechanisms and forums are being implemented (see following subsections).

Patient choice

The majority of Irish patients state that they are involved in choices over different treatment options. In the Irish Society for Quality and Safety in Healthcare (ISQSH) national survey of patient perceptions in 2004, more than 85% of patients felt that they had been involved in decisions about their treatment and care as much as they would have liked (ISQSH, 2005).

Individuals are also free to select the GP of their choice, although those with Medical Cards can only choose from those GPs operating within the Primary Care Reimbursement Scheme (PCRS). Within the hospital sector, those with health insurance are free to elect to be treated in private beds rather than public beds, which may lead to inequities in access to services. They might also choose to be treated in purely private hospitals (where costs are higher) and in future, at one of the recently announced private hospitals to be co-located on the grounds of a public hospital. The NTPF is designed to ensure that public patients who have been waiting excessively long for treatment have the choice to obtain, at public expense, treatment in the private sector either in Ireland or abroad.

Empowerment of patients to have a greater say over treatment decisions is evident within the agreement on pharmaceutical pricing made between the Irish Pharmaceutical Healthcare Association (IPHA) and the HSE in September 2006. As part of this agreement, the HSE will seek to increase patient awareness of the whole range of prescription options available. Prescribers, in consultation with their patients, may prescribe medicines of their choice from the list of medicines available under the PCRS and other specialist entitlement schemes as appropriate (see Section 3.2 *Population coverage and basis for entitlement*), although the HSE reserves the right to influence the prescribing habits of prescribers. At the time of writing, pharmacists are required to dispense these medicines as prescribed (HSE, 2006d).

Individuals who wish to obtain private insurance also have a choice of three different private insurers offering a range of different coverage plans. As noted earlier, VHI remains the dominant player and there has been little switching between health insurance providers by consumers. Only 10% of consumers switched providers in the first 10 years in which BUPA Ireland operated (Insight Statistical Consulting, 2005).

A business appraisal of the private health insurance market in Ireland, chaired by Colm Barrington, was commissioned by the DoHC in January 2007. One area that the review looked at was consumer rights. Key issues included a lack of awareness among consumers that no one can be refused cover under the principles of community rating, as well as a general misunderstanding regarding the rules governing the time period for which individuals must wait before they can make claims for pre-existing conditions, and particularly the fact that if consumers switch between insurers they are not required to serve a new waiting period. The report also noted that consumers needed more information on the cost of various medical procedures in order to make informed choices about their health care (Private Health Insurance Advisory Group, 2007).

In response to the Barrington Group's report, the MoHC announced measures to address certain issues in April 2007, such as enhanced rights for private

health insurance customers including clear statements of consumers' rights and standardized renewal notices.⁸ Companies with payroll deduction schemes also will be required to offer at least two companies' products to employees; and group schemes will have to be put out to tender on a regular basis.

Patient information

To date, making any comparison between services offered in different hospitals across the country is difficult, as there have been few national publications looking at rating quality and/or performance. However, all public and voluntary hospitals do produce annual reports that can be freely downloaded online.

This gap in information was recognized in the 2001 National Health Strategy. Improving access to information on the quality of services is a key task for the new HIQA. It is responsible for developing standards for the collection and sharing of information across health and social services. It is also charged with evaluating, interpreting and publishing available information on health and social care services and on population health, with an explicit objective to help all health care users and professionals make choices based on the best information available (HIQA, 2007b).

One of the few existing sources of national data in the public domain is the results of the national acute hospital hygiene audit, published annually since 2005. The focus is on the environment, ward/departmental kitchens, linen, waste handling, hand hygiene and the management of general patient equipment. A "yes", "no" or "not applicable" score is recorded and overall scores result in a department being "compliant" if it scores in excess of 85%, "partially compliant" if it scores between 76% and 84%, and "minimally compliant" if it scores less than 76% (HSE, 2006a).

Other than this audit, the lack of information on quality has led to one independent health web site, Irishhealth.com (with more than 100 000 registered members, and claimed to be the country's most visited health web site) launching a "snapshot" opinion poll which gives a picture of a selection of patient opinions at a given time on the level of hospital service they were offered. The web site makes clear that it is not intended as a scientific study on clinical outcomes, but as a general information service for patients and hospitals. Hospitals are ranked in terms of overall patient satisfaction. Patients or their close relatives can take part in the poll for a certain hospital no more than once a month (Irishhealth.com, 2007). Hospitals can also be ranked by specialty and over different time periods.

⁸ It is hypothesized that the latter might make it easier for individuals to consider switching between providers, where appropriate.

Access to information on medicines

The advertising of medicinal products for human use in EU Member States, including Ireland, is governed by Council Directive 2001/83/EC of 6 November 2001 as amended by Council Directive 2004/27/EC of 24 March 2004. Subject to the provisions of the Medical Preparations (Advertising) Regulations, 1993–1996, medicines may not be advertised or promoted to the general public if they are prescription-only medicines.

The IPHA operates a Code of Marketing Practice for the Pharmaceutical Industry within the scope of these European Directives and compliance is a condition of membership of the IPHA (IPHA, 2006a). The Code includes specific measures in respect of the lay public and general communication media. These stipulate that “requests from individual members of the public for information or advice on personal medical matters must always be refused and the enquirer recommended to consult her/his own health care professional”. Guidance on interacting with patient associations is also produced. Complaints procedures are in place to deal with any alleged breaches of the Code.

A separate voluntary code on the advertising of over-the-counter medication has also been developed (IPHA, 1999). Products which should not be promoted include analgesics for the relief of pain containing codeine, dextromethorphan or related pharmaceuticals, cough mixtures containing these medications (in some circumstances) and anti diarrhoeals.

The IPHA maintains an online IPHA Medicines Compendium which provides non-promotional, factual information on all medicinal products available in Ireland. This consists of a summary of product characteristics and a patient information leaflet (PIL) where relevant, both of which are approved by the Irish Medicines Board (IMB) as part of the process of authorizing the product for sale or supply in Ireland.

Freedom of information

In most circumstances individuals can also access their own personal information from the health service organizations concerned by requesting this in writing. The Freedom of Information Acts of 1997 and 2003 provide the legal right for individuals to seek access to both personal and non-personal (corporate) records held by any public body (as distinct from private bodies); to have personal records amended or deleted where the information is incorrect, incomplete or misleading; and to seek reasons for decisions made. These rights are also extended, in specific circumstances, to the children of an individual and any deceased relatives. The Data Protection Acts 1988 and 2003 provide somewhat similar rights of access as the Freedom of Information Acts, the main difference being that the Data Protection Acts do not apply to the records of the deceased.

Complaint procedures

In the most recent national patient satisfaction survey (2004), 20% of patients stated that they wished to complain about an area of dissatisfaction during their hospital stay. However, some individuals may be reluctant to pursue these matters and nearly half of all individuals in the survey did not discuss their complaints with health care staff. Of those individuals who did make a formal complaint, only 27% were satisfied with the outcome (ISQSH, 2005).

Patients have always had a number of options open to them if they have been dissatisfied with the care that they have received from the health care system. These procedures were most recently updated and harmonized across all health and social care providers as part of the Health Act of 2004, and implemented from 1 January 2007, following consultation.

The first step is to formally make a complaint to the HSE or other service provider, using the standardized complaints procedure. The complaint is then investigated by a Complaints Officer appointed by the HSE or other service provider. The complainant has the right to request a review of any recommendation made by the Complaints Officer. This review is carried out by a Review Officer appointed by the HSE or other individual to whom the HSE has assigned review functions. The HIQA will also undertake investigations where there are concerns about patient safety. If still dissatisfied, a complainant can also take their complaint to the organization that regulates the particular health care professional, such as An Bord Altranais (for nurses) or the Medical Council of Ireland (for physicians).

If this fails, they can approach the Office of the Ombudsman. The powers of the Ombudsman within the health and personal social services arena were extended from January 2007, as a result of a new statutory complaints procedure enshrined in the Health Act of 2004 (Office of the Ombudsman, 2007). This is something that the Ombudsman at the time of writing, Emily O'Reilly, and her predecessors have long called for. At the time of writing, the Ombudsman has the power to carry out independent and impartial investigations. S/he can summon witnesses and has full right of access to hospital and other records. If s/he upholds the complaint, s/he can recommend an appropriate remedy for the complainant along with changes to hospital or other procedures.

All health service providers – not just those owned by the HSE – now come within the Ombudsman's remit. At the time of writing, this includes all voluntary hospitals, as well as all institutions providing services on behalf of the HSE or who receive assistance from the Executive towards the provision of a service similar or ancillary to a service that the Executive may provide. Such agencies may include senior citizen centres, therapeutic centres and various supporting associations and federations. There are no fees for bringing

grievances to the Ombudsman. In 2006, 398 valid complaints related to the HSE were dealt with by the Ombudsman, 17.7% of her total caseload. In 2005 and 2004, respectively, 447 and 361 valid complaints against the HSE and the former Health Boards were processed (Office of the Ombudsman, 2007).

In order to improve the complaints process a “Statement of Good Practice for the Public Health Service in dealing with Patients” has been developed by the Ombudsman from her experience of dealing with complaints relating to former Health Board hospitals. The Statement also takes account of the ethical guidelines published by the Medical Council and the Code of Professional Conduct published by An Bord Altranais. The Ombudsman uses this code, together with the Ombudsman Act (1980), as a framework for the examination of health complaints.

Patient safety and compensation

The issue of patient safety and quality of care has been highly visible in recent years. In particular, the contamination of blood products (see also Chapter 4 *Regulation and planning*) pushed the issue to a more prominent position on the political agenda and public consciousness. A questioning of the role of consultants and other health care professionals emerged as a result of tragic blood transfusion scandals, when it transpired that more than a thousand haemophiliacs, pregnant women and others had been infected with HIV and hepatitis C (Wren, 2003). This led to the establishment of the high-profile Finlay and Lindsay tribunals, which were reported in 1997 and 2002, respectively. Measures to reduce the risk of contamination were put in place following these tribunals.

More recently, gaps in the monitoring and surveillance of procedures at the Lourdes Hospital in Drogheda, identified in the Lourdes Inquiry (see Chapter 4 *Regulation and planning*) chaired by Judge Maureen Harding Clarke, led to the establishment of a Commission on Patient Safety and Quality Assurance in early 2007 (Clarke, 2006). The Commission is chaired by Deirdre Madden, a leading expert on medical law and ethics. It includes nursing and medical representatives, management representatives and, importantly, two representatives of patients and carers. The Commission’s remit is to develop an accountable governance framework for the quality and safety of health services and is expected to report to the MoHC within 18 months. One issue it is considering is how to improve the level of participation of patients, carers and support staff engaging with health care providers regarding health services planning and the quality of care received.

Clinical Indemnity Scheme

The Clinical Indemnity Scheme (established in 2002) transferred to the State responsibility for managing clinical negligence claims and associated risks of hospitals and other health agencies. Under the Scheme, managed by the State Claims Agency (SCA) (part of the National Treasury Management Agency), the State assumes full responsibility for the indemnification and management of all clinical negligence claims, including those which are birth related.

The Clinical Indemnity Scheme covers HSE, statutory bodies, public voluntary hospitals and other agencies commissioned to provide clinical services to eligible patients. This includes all hospital-based doctors, nurses and other clinical staff, whether permanent or temporary. It also covers clinical support services staff in pathology and radiology, dentists providing public practice, along with the clinical activities of public health doctors, nurses and other community-based clinical staff. Claims arising from treatment provided as part of clinical trials or other approved research projects are also covered. In trials sponsored by external organizations, such as pharmaceutical companies, cover extends to treatment only and does not cover product liability or claims arising from trial design or protocol, except when the trial is designed by an agency covered by the Clinical Indemnity Scheme or any of its employees (including investigator-led trials where the investigator is an employee). Otherwise, coverage against such claims remains the responsibility of the body conducting the trial or research project.

The scheme does not cover GPs, who have to purchase their own medical indemnity cover from the private insurance market. Subscriptions to one company in 2006 offering a medical indemnity policy were €3800 per GP per annum (Medisec Ireland, 2007). The Clinical Indemnity Scheme also does not cover private hospitals, acts outside the island of Ireland, needle-related injuries to staff, disciplinary hearings or criminal cases.

Clinical Risk Advisers at the SCA notify claims colleagues of serious adverse events that may give rise to litigation, while also ensuring that an appropriate risk-management exercise is carried out at health enterprise level. The Clinical Claims Managers at the SCA are responsible for the formulation of claims management strategies. Following rigorous examination of medical records and detailed consultation with practitioners, decisions are made on the basis of relevant case law, expert peer review and the opinion of legal counsel. The Clinical Claims Managers also manage hospital inquests on behalf of participating hospitals and practitioners, as well as operating an emergency medico-legal helpline. Payments made by the SCA under the scheme are reimbursed by the DoHC. Obstetrics represents approximately 17% of current cases, and approximately 60% of the costs of settling claims (Commission on Patient Safety and Quality Assurance, 2007).

There are also specific schemes set out to deal with compensation arising from major failings in the health system, such as the contamination of blood products and, more recently, for those women who underwent unnecessary obstetric hysterectomy and bilateral oophorectomy under the care of one doctor at Our Lady of Lourdes Hospital in Drogheda, where *ex gratia* compensation payments can amount to several hundred thousand euros per individual (DoHC, 2007d).

Reporting adverse events

All enterprises covered by the Clinical Indemnity Scheme have a statutory duty to report all adverse events to the SCA, to preserve relevant documentation and to permit and facilitate SCA investigations when requested. Adverse events are reported to the SCA through a web-based IT system called STARSWeb. Each enterprise has access only to its own data but the SCA has access to all data in order to identify emerging trends. National rollout of the STARS Web system commenced in November 2003, and the majority of all acute sector health enterprises and former Health Boards are active within the system, at the time of writing. The clinical incident reporting feature is also designed to support sharing of lessons learned from “near misses” and the aftermath of serious adverse clinical events, at local and national levels.

Based on these data, the Clinical Indemnity Scheme, in conjunction with the enterprises, is equipped to identify and analyse adverse trends and clusters. Data can be manipulated to provide a wide range of report options. Any enterprise may use the system to benchmark itself against overall national data or as an aid for quality improvement initiatives within the enterprise. In order to assure the quality and integrity of data inputted into the system, the Clinical Indemnity Scheme, in partnership with HIQA and the HSE, is developing a quality assurance tool.

Patient participation and involvement

The second National Health Consultative Forum was held in Kilkenny in October 2006. The Forum helps to advise the MoHC on matters related to the provision of health and social care services. Approximately 350 Forum members were appointed under Ministerial Order, including a small number of representatives of patients and client groups. The theme of the Forum was collaborative partnership between policy-makers, providers, users and local communities (DoHC, 2006e).

Patients and service users also have an opportunity to be involved at a high level in the organization and planning process of the HSE, through the recently launched HSE Expert Advisory Groups (initially covering older people, children,

mental health and diabetes). One of the objectives of these groups is to provide patients and consumers with a voice to influence decision-making processes; however, the composition of these first four groups is heavily dominated by professionals. It is also too early to tell how effective these groups will be in giving patients and service users a voice in policy-making.

On 31 January 2007 the HSE launched a new National Service User Executive (NSUE) for mental health services. The establishment of this group was recommended by the HSE's Expert Advisory Group on Mental Health and it will have a budget of €200 000. It is intended to ensure that service users have the opportunity for a meaningful and significant input into shaping the future development and direction of mental health services. It will also offer advice and make recommendations to the HSE and the DoHC regarding policy change, as well as playing an active role in service design and delivery, and promoting the role of service users throughout the mental health services sector (HSE, 2007d).

Public and patient perceptions of the quality of health care

The *Quality and fairness* National Health Strategy also promised a national standardized approach to the measurement of patient satisfaction. Using data routinely collected through satisfaction surveys this information would be publicly available and would feed back into system planning. User satisfaction is now a critical variable in any calculation of quality or value and, therefore, in the assessment of corporate/individual accountability. Thus, it is a legitimate and important measure of the quality of health care. At the time of writing, the HIQA has responsibility for the development of such surveys. The importance of service user participation is also a key priority in the HSE Corporate Plan 2006–2008. There is a new Corporate Plan in place for 2008–2011.

A number of surveys of both public and patient satisfaction with the health care system have been conducted in recent years. The Economic and Social Research Institute (ESRI) conducted a telephone survey in 2001, sponsored by BUPA Ireland, on "Perceptions of the Quality of Health Service in Ireland" (Watson & Williams, 2001). The survey included data from 3000 questionnaires (61% response rate) from individuals randomly selected across the country. Overall, 43% of respondents rated the quality of care in the public health system as "good" or "very good"; 34% rated it as "adequate"; and the remaining 23% as "poor" or "very bad". A total of 47% of those outside Dublin rated the system as "good" or "very good" compared with only 34% of those in Dublin. The survey also found that positive views of the health care system decline with higher educational status and income. A total of 60% of those who had been recently hospitalized in the public system rated it as "good" or "very good"

compared with 42% of those not hospitalized and 36% of those hospitalized as private patients. When looking at waiting times for treatment, 59% believed that waiting times in the public system had increased over the previous three years (again in Dublin this figure was higher at 70%). Those with lower educational status and income were slightly more likely to believe that waiting times had increased, while 71% of individuals treated privately believed waiting times had risen compared with 67% of those who had been treated publicly. Views of the quality of care in the private system were much more positive, with 83% of respondents rating care as “good” or “very good”, although those that were actually treated privately had slightly less favourable perceptions than those not treated privately. A total of 62% of respondents believed the quality of care in the private sector to be better. When asked whether hospital treatment would be received more quickly in the private or public sectors, 88% believed the private sector would lead to more rapid treatment, with only 12% believing that there would be no difference. The survey also reported that the primary reasons for taking out private health insurance were to avoid large bills (88%), to receive treatment quickly (85%) and to ensure good hospital treatment (73%).

The ISQSH is also involved in conducting surveys, some commissioned by the HSE and its predecessors. National patient perception surveys were conducted by the ISQSH in 2000, 2002 and 2004. The 2002 ISQSH survey looked exclusively at discharged acute patients (both public and private) between April and August 2002 to examine key aspects of the quality of inpatient care (Fallon, 2002). This survey of 10 hospitals had 2085 responses (44% participation rate), with two thirds of patients treated in the public sector. Overall, 92.9% of patients perceived the quality of care that they received to be “very high” and also found the accommodation quality of the hospital to be “excellent”. Key findings included 85% being satisfied or very satisfied with A&E care. A total of 63.6% were treated within three months of entering a waiting list; 11% had waited more than a year to be admitted and 18% had had their admission cancelled or rescheduled more than once. Patients waiting the longest amounts of time were significantly more likely to be public patients. Considerable differences were also found in the levels of satisfaction between those who received medical care and those who had surgery, with the latter group being much less satisfied about treatment and care. In contrast to the ESRI survey, no statistical difference was found in overall length of stay or satisfaction with quality of care between public and private patients. However, the author does urge some caution with the findings of the survey noting that “patients’ satisfaction surveys frequently report extremely high levels of satisfaction” and that “patients are also unlikely to express unfavourable opinions of health care services when they perceive they have a lack of alternative options” (Fallon, 2002).

The 2004 national survey of 4820 patient perceptions conducted by ISQSH reported that overall 93% of patients were satisfied with the services that they received during their hospital stay and 91% indicated that if they had to return to hospital they would prefer to return to the same hospital. The survey also noted that public patients were more satisfied with hospital services than private patients. Previous studies have indicated that publicly funded patients have lower expectations and thus accept lower standard levels than privately funded patients. A total of 90% of patients were satisfied with the way in which their diagnosis was communicated to them and 91% found the information easy to understand.

The first national survey of patient experiences in the 35 hospital emergency departments in publicly funded acute care hospitals was undertaken in 2006 (ISQSH, 2007). A total of 1599 service users took part in the survey: 93% reported that they were treated with dignity and respect; 76% said they were satisfied with the overall service provided; while 86% said they would return to the same A&E department if they needed future treatment. Most patients (79%) said they were clinically assessed within an hour of their arrival at the emergency department and 75% of patients who needed to be examined by a doctor said they were examined within three hours.

Patients who reported that they received less information, advice and pain relief were more likely to be dissatisfied. These patients were also more likely to have experienced longer waiting times with half (51%) waiting more than three hours following initial assessment to be examined by a doctor. The report also concluded that there was some evidence within the results that communication and information provided to patients could be improved in certain areas, such as the level and type of information patients receive about their condition and treatment, as well as tests they receive and information they are given when being discharged from the emergency department.

The first large-scale independent survey of both health and social care services was conducted by University College Dublin and Lansdowne Market Research on behalf of the HSE in 2007. Experiences and opinions were obtained from more than 2700 people who had used services in the previous 12 months (Boilson et al., 2007). Ratings of quality of care were generally positive; 64% of inpatients, 58% of outpatients, 84% of GP patients and 76% of people using other community services rated their experience as being “excellent” or “very good”. A majority (78%) of inpatients, 67% of outpatients, 86% of GP patients and 78% of other community services patients expressed “definite” or “complete” trust in the health professional they encountered. A total of 80% of inpatients, 79% of outpatients and 86% of GP patients felt the information they were given was “about right”.

Physical access

Part M of the Buildings Regulation 2000 sets out requirements under the building code to accommodate people with disabilities. It requires that “adequate provision be made for people with disabilities to safely and independently access and use a building”. It applies to building work such as new buildings, extensions and material alterations, but does not apply to existing buildings unless they are being altered.

A review looking at compliance with the Part M regulations stated that, overall, there is significant evidence that the application of the regulations has been ineffective, due to the limitations of the guidance and the poor levels of control and enforcement. Moreover, a comparison of international technical guidance indicated that Irish technical guidance does not meet the minimum standards currently in use in other jurisdictions (National Disability Authority, 2005).

New measures to improve disabled access have recently been implemented. The Disability Act of 2005 requires that public areas of all public buildings be brought into compliance with Part M of the Buildings Regulation by 2015. The Act also imposes significant statutory duties upon public bodies to make their services and information accessible to people with disabilities where practicable and appropriate. Determination of practicability and appropriateness may be guided by consideration of, for example, level of control and cost. Public bodies are also required to ensure, as far as practicable, that written information and communications which they provide to the public are communicated in an accessible format, where so requested by individuals with visual impairments.

In July 2006, the National Disability Authority launched a Code of Practice on Accessibility of Public Services and Information provided by Public Bodies (National Disability Authority, 2006). This Code of Practice sets out the Authority’s understanding of what is required of public bodies, including health care facilities, under sections 26, 27 and 28 of the Disability Act 2005, and is designed to guide public bodies in meeting their statutory obligations by providing practical advice and examples.

3 Financing

The Irish health care system remains predominantly tax funded. A total of 78.3% of all health expenditure, both public and private, was raised from taxation, including pay-related social insurance (PRSI) and other sources of government income, such as excise duties, in 2006 (OECD, 2008a). The remaining components of total health expenditure are from private sources, in particular out-of-pocket household expenditure on GP visits, pharmaceuticals and public/private hospital stays, as well as payments to private health insurance providers (see Section 3.3 *Revenue collection and complementary sources of funding*).

Gross health expenditure in 2007 by both the HSE and the DoHC was just under €14.4 billion or approximately 25.3% of all government expenditure (Government of Ireland, 2008). The majority of funding allocated to public health services is incremental, based on historical expenditure patterns. Until 2005, the overall level of funding for health services was determined annually in negotiations between the DoF and the DoHC. The DoHC then distributed agreed budgets to the regional health boards and the ERHA. Moreover, since the turn of the millennium, funding had been allocated directly by the DoHC to voluntary (non-profit-making, linked to church) hospitals and other service delivery agencies in the voluntary sector to fund some services for the populations of the individual Health Boards (with the exception of some services in Cork). The ERHA – separately from the DoHC – entered directly into agreements with these agencies.

In 2005 the HSE took over responsibility from the DoHC, not only for managing the health budget, but also for delivering services for the entire public health system. Since 2005 there have been two votes in *Dáil Éireann* related to health regarding the annual budget: one for the HSE and a separate vote covering the residual functions retained within the DoHC, including funding

for the NTPF – a scheme which allows individuals who have been waiting more than three months for elective treatment to be treated in the private sector at the State’s expense (see next paragraph).

In 2007 just over 30% of the population held Medical Cards entitling them to most services free of charge. The remainder of the population has to make out-of-pocket payments for both hospital and primary care services, although additional exemptions apply. Additional support towards the costs of some services, such as dental and optical care, is provided via the Treatment Benefit Scheme operated by the DSFA. More than 50% of the population also has private health insurance which helps to cover some of the out-of-pocket costs associated with public health services (such as the daily hospital bed charges), while also allowing individuals to jump the queue, by being treated as private patients, often within public sector hospitals. To a much lesser extent, private health insurance can cover some of the out-of-pocket costs of primary health care services.

3.1 Health expenditure

In reviewing the trends in Irish health expenditure throughout recent decades, clear patterns can be observed in the changes occurring in particular periods.

Health expenditure trends before the 1990s

In each of the first four decades following the establishment of the Department of Health in 1947, the share of GNP⁹ devoted to non-capital health expenditure increased by over 30% (Wiley, 1998). While the first decade of the Department of Health’s existence was associated with the greatest increase in health expenditure relative to GNP, the most significant period of expansion can be traced to the 1970s. In this decade, the proportion of GNP allocated to non-capital health expenditure increased by 56.8%, from 4.4% in 1970–1971 to 6.9 % in 1979. During this period, public spending increased substantially and health service eligibility and availability were also expanded.

However, developments in the 1980s contrasted sharply with the 1970s as a public expenditure crisis and economic recession were associated with a reduction of 16% in the proportion of GNP allocated to non-capital health expenditure, from 8.1% in 1980 to just 6.8% in 1989. Having adjusted for inflation, current public health expenditure actually declined in real terms (1995 prices) throughout the 1980s by close to 7%. The pressure on health expenditure

⁹ Because of the heavy presence of foreign companies in Ireland, GNP is accepted to be a better measure than GDP.

throughout the 1980s was quite exceptional, following the expansionism of the 1970s, and contrasts with the very different economic experience in Ireland during the 1990s (Wiley, 2005).

1990–2007

If focusing simply on the share of GNP devoted to health, at a superficial level, trends in the 1990s would not look very different from previous years. The decade began with 6.1% of GNP being devoted to public sector health expenditure, an estimate which increased to a high of 7.0% in 1993. There was then a general downward trend to the point where just 6.0% of GNP was allocated to non-capital health expenditure in 1998. It is, however, necessary to look at what lies behind these trends to get the true picture of developments in the Irish economy during this period. Between 1990 and 2000, health expenditure increased by 180% in current terms and by 79% in real terms. As economic performance improved in the late 1990s (see Chapter 1 *Introduction*), the rate of growth in health expenditure began to increase sharply. While health expenditure in nominal terms increased by 59% between 1990 and 1996, in the following six years this rate of increase was estimated to be more than 150% (or almost 90% in real terms) (see Tables 3.1a and 3.1b).

Notwithstanding the substantial increases in the allocation of government funds to health services between 1997 and 2000, health spending as a proportion of GNP only reached a high of 6.5% over this period, mainly due to the concurrent very rapid growth in the Irish economy. A major injection in gross current health expenditure can be seen to have taken place between 2000 and 2001 when expenditure grew by nearly €1.4 billion, as well as in the following year when an additional €1.1 billion was allocated to public health services.

These large increases in public health expenditure, together with a slowdown in the extraordinary rate of economic growth, resulted in publicly funded health services accounting for 7.4% of GNP, rising to 8.4% – or 6.9% of GDP – by 2003 (see Table 3.1b). This represented an increase of 40% in the proportion of GNP allocated to the public health system since 1998, when only 6.0% of GNP was spent on public health services and the highest rate was achieved since 1985. Expenditure has continued to grow substantially, increasing by 62% between 2002 and 2007.

In summary, therefore, the pattern of health expenditure trends in Ireland can be considered quite unusual in international terms. A declining share of GNP devoted to health in the 1980s was associated with a real cut in gross non-capital health expenditure, while real increases in health expenditure in the late 1990s and the 2000s commanded a smaller share of GNP due to the high rate of growth in the economy. However, the level of investment in the health system has continued

Table 3.1a Trends in (estimated) health care expenditure in Ireland 1980–1991
(€ millions)

Public health expenditure	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
Net non-capital expenditure (1)	890.1	1 044.6	1 203.7	1 311.6	1 384.0	1 484.7	1 547.8	1 551.0	1 563.7	1 673.5	1 847.8	2 043.6
Euro Soc Fund	10.4	15.0	21.1	26.3	23.2	24.0	21.7	23.2	22.6	29.1	30.0	31.6
Lottery	n/a	n/a	n/a	n/a	n/a	n/a	n/a	4.4	5.7	6.2	10.9	27.3
Treatment benefits (2)	8.0	10.2	12.1	15.9	18.0	19.4	21.1	21.2	23.1	20.4	19.7	21.6
Total non-capital expenditure	908.5	1 069.8	1 236.8	1 353.8	1 425.3	1 528.1	1 590.6	1 599.9	1 615.1	1 729.2	1 908.4	2 124.1
Health capital expenditure	44.4	56.5	62.5	67.3	70.5	72.4	74.5	73.1	53.7	57.1	56.1	45.6
Lottery capital expenditure	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2.5	3.8	2.5	8.4
Total capital expenditure	44.4	56.5	62.5	67.3	70.5	72.4	74.5	73.1	56.2	60.9	58.7	54.0
Total public expenditure	952.9	1 126.3	1 299.3	1 421.1	1 495.7	1 600.5	1 665.1	1 673.0	1 671.4	1 790.2	1 967.1	2 178.1
Private expenditure												
VHI expenditure (3)	39.2	53.8	82.2	103.2	117.6	131.5	149.1	190.6	209.4	200.6	217.3	234.8
Other non-household (4)	3.7	4.3	5.1	5.5	5.8	6.2	6.3	6.5	6.5	7.0	7.6	8.5
Household expenditure	101.2	118.8	138.3	181.4	199.5	217.1	288.9	293.4	318.1	339.7	366.8	408.3
Private capital expenditure	n/a	n/a	n/a	n/a	n/a	n/a	27.0	47.6	57.9	65.4	55.6	38.7
Total private expenditure	144.1	177.0	225.5	290.1	311.5	354.9	471.3	538.1	591.8	612.7	647.3	690.3
Total expenditure	1 097.0	1 303.3	1 524.8	1 711.2	1 818.6	1 955.4	2 136.5	2 211.1	2 263.2	2 402.9	2 614.4	2 868.4
% GDP (public)	10.2	9.9	9.6	9.6	9.1	9.0	6.7	6.3	5.8	5.5	5.4	5.8
% GDP (private)	1.5	1.5	1.7	2.0	1.9	2.0	1.9	2.0	2.1	1.9	1.8	1.8
Total % GDP (5)	11.7	11.4	11.3	11.7	11.0	11.0	8.5	8.3	7.8	7.4	7.2	7.6
% GNP (public)	10.5	10.4	10.4	10.5	10.2	10.2	7.4	6.9	6.6	6.4	6.1	6.4
% GNP (private)	1.7	1.7	1.8	2.2	2.2	2.3	2.1	2.2	2.3	2.2	2.0	2.0
Total % GNP (5)	12.2	12.1	12.2	12.7	12.3	12.4	9.5	9.2	8.9	8.5	8.0	8.4

Sources: DoHC, 2003b; DoHC, 2006f; Government of Ireland, 2004b; Government of Ireland, 2005; Government of Ireland, 2006b; Government of Ireland, 2007b; VHI Healthcare, 2004; VHI Healthcare, 2005; VHI Healthcare, 2006; VHI Healthcare, 2007a.

Notes: VHI: Voluntary health insurance; GDP: Gross domestic product; GNP: Gross national product; n/a: Not available

(1) Estimates of public capital and non-capital expenditure for 2003–2007 taken from Revised Estimates of Public Services. Figures from 2005 include expenditure by both the MoHC and the HSE (Votes 39 and 40)

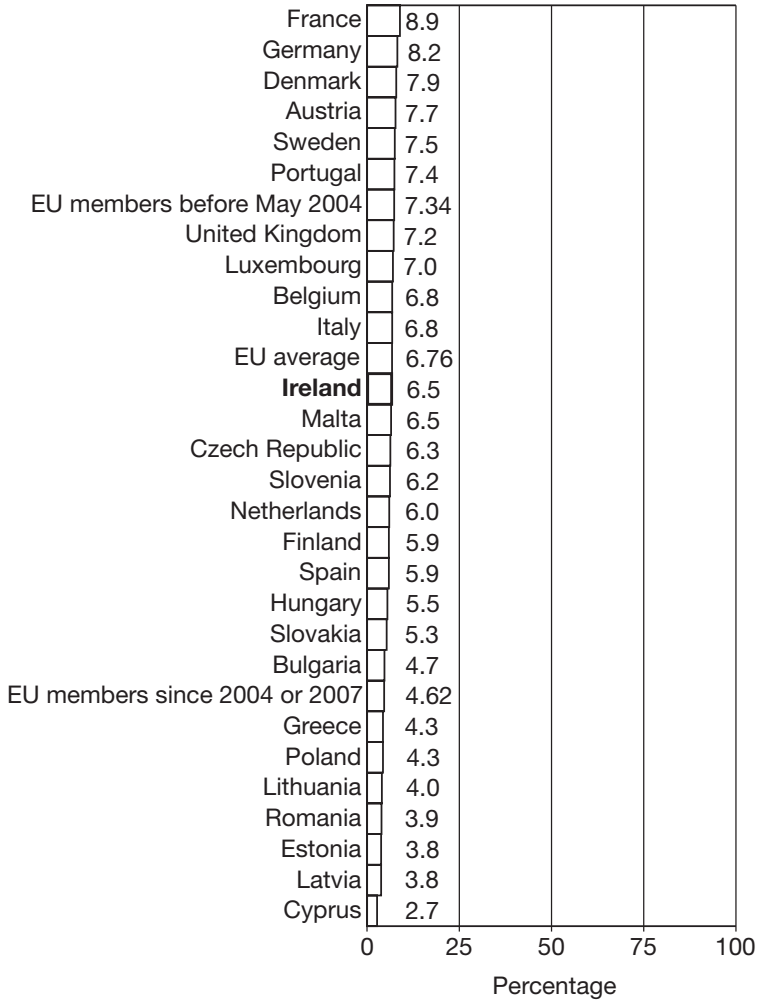
(2) Treatment benefits expenditure for 2003–2007 taken from Revised Estimates for Public Services (Vote 38)

(3) VHI expenditure only for VHI Healthcare. Figures for 2003–2007 taken from VHI Healthcare Annual Reports

(4) Estimates of non-household private expenditure estimated at rate of 0.41% of non-capital public health expenditure used by DoHC

(5) GDP and GNP figures for 2005–2007 based on data from the Central Statistics Office on national income and expenditure

Fig. 3.1 Public sector health expenditure as a share (%) of GDP in the EU27 countries, 2005



Source: WHO Regional Office for Europe, 2008

Notes: GDP: Gross domestic product; EU: European Union; EU27: Countries comprising the EU up to and including the January 2007 accession

Table 3.1b Trends in (estimated) health care expenditure in Ireland, 1992–2007 (€ millions)

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007*
Public health expenditure																
Net non-capital expenditure (1)	2 284.8	2 537.2	2 700.6	2 896.0	2 966.2	3 418.8	3 793.9	4 564.8	5 349.8	6 729.7	7 856.6	8 772.9	9 561.0	10 709.9	11 502.6	13 076.2
Euro Soc Fund	33.8	35.0	35.6	25.5	22.2	21.1	23.2	23.4	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Lottery	38.5	23.4	24.0	23.1	23.0	24.6	25.3	9.1	9.3	9.6	9.9	10.2	10.4	10.7	10.1	11.6
Treatment benefits (2)	22.1	31.5	33.1	35.8	37.6	39.5	43.2	49.7	63.6	62.2	60.8	63.3	70.5	65.5	95.0	91.6
Total non-capital expenditure	2 379.1	2 627.1	2 793.3	2 980.4	3 049.0	3 504.0	3 885.6	4 647.0	5 422.7	6 801.5	7 933.4	8 852.8	9 641.9	10 786.1	11 607.7	13 179.4
Health capital expenditure	41.9	41.9	69.1	116.8	147.1	161.0	179.4	228.2	291.4	371.1	504.6	511.6	505.9	513.8	467.3	549.2
Lottery capital expenditure	14.0	14.0	14.1	5.1	5.1	5.9	7.6	2.5	2.5	2.5	2.5	2.5	2.5	2.5	n/a	2.5
Total capital expenditure	55.9	55.9	83.2	121.9	152.2	166.9	187.0	230.7	293.9	373.6	507.1	514.1	508.4	516.3	467.3	551.7
Total public expenditure	2 435.0	2 683.0	2 876.5	3 102.3	3 201.2	3 670.9	4 072.6	4 877.7	5 716.6	7 175.1	8 440.5	9 366.9	10 150.3	11 302.4	12 075.0	13 731.1
Private expenditure																
VHI expenditure (3)	258.5	283.9	314.5	341.3	370.3	396.8	438.7	459.2	536.3	578.3	660.0	750.0	840.5	896.7	961.4	1 087.9
Other non-household (4)	9.5	10.5	11.2	12.0	12.3	14.1	15.7	18.9	22.1	27.8	32.5	36.3	39.2	46.3	50.6	57.1
Household expenditure	447.2	462.2	478.9	512.1	534.6	585.9	598.1	683.6	765.5	970.1	1 140.9	1 304.9	1 493.4	n/a	n/a	n/a
Private capital expenditure	127.6	81.3	131.0	152.6	202.2	167.6	239.7	372.1	464.5	548.9	376.0	286.0	206.7	n/a	n/a	n/a
Total private expenditure	842.8	837.9	935.6	1 018.0	1 119.3	1 164.4	1 292.2	1 533.8	1 788.4	2 125.1	2 209.4	2 377.2	2 579.8	n/a	n/a	n/a
Total expenditure	3 277.8	3 520.8	3 812.1	4 120.3	4 320.5	4 835.3	5 364.7	6 411.6	7 505.0	9 300.2	10 649.9	11 744.1	12 730.1	n/a	n/a	n/a
% GDP (public)	6.1	6.2	6.2	5.9	5.5	5.5	5.3	5.4	5.6	6.3	6.5	6.9	6.9	7.0	6.8	7.2
% GDP (private)	2.1	1.9	2.0	1.9	1.9	1.7	1.7	1.7	1.7	1.9	1.7	1.8	1.8	n/a	n/a	n/a
Total % GDP (5)	8.2	8.2	8.2	7.8	7.4	7.2	6.9	7.2	7.3	8.1	8.2	8.7	8.7	n/a	n/a	n/a
% GNP (public)	6.8	7.0	6.9	6.6	6.2	6.2	6.0	6.4	6.5	7.4	8.2	8.4	8.3	8.3	7.9	8.5
% GNP (private)	2.4	2.2	2.2	2.2	2.2	2.0	1.9	2.0	2.0	2.2	2.1	2.1	2.1	n/a	n/a	n/a
Total % GNP (5)	9.2	9.1	9.1	8.8	8.4	8.2	7.9	8.4	8.5	9.6	10.3	10.5	10.4	n/a	n/a	n/a

Sources: DoHC, 2003b; DoHC, 2006f; Government of Ireland, 2004b; Government of Ireland, 2005; Government of Ireland, 2006b; Government of Ireland, 2007b; VHI Healthcare, 2004; VHI Healthcare, 2005; VHI Healthcare, 2006; VHI Healthcare, 2007a

Notes: * Provisional out-turn; VHI: Voluntary health insurance; GDP: Gross domestic product; GNP: Gross national product; n/a: Not available

(1) Estimates of public capital and non-capital expenditure for 2003–2007 taken from Revised Estimates for Public Services. Figures from 2005 include expenditure by both the MoHC and the Health Service Executive (Votes 39 and 40, but excludes Vote 41 for Office of the Minister for Children)

(2) Treatment benefits expenditure for 2003–2007 taken from Revised Estimates for Public Services (Vote 38)

(3) VHI expenditure only for VHI Healthcare. Figures for 2003–2007 taken from VHI Healthcare Annual reports

(4) Estimates of non-household private expenditure estimated at rate of 0.41% of non-capital public health expenditure used by the DoHC

(5) GDP and GNP figures for 2005–2007 based on data from the Central Statistics Office on national income and expenditure

to accelerate in recent years. This is in parallel to a relative slowdown in the pace of economic growth, with net non-capital health expenditure increasing from €3.4 billion allocated by the Government in 1997 to an estimated €13.08 billion by 2007. In 2007, 29% of all public current expenditure and 8% of all public capital expenditure were allocated to health (Government of Ireland, 2008). Although private health care expenditure has continued to grow, the significant increase in public funding for the health care system has led to a decrease in its relative contribution to total health spending. Public expenditure as a percentage of total expenditure on health had thus risen from 71.3% in 1996, peaking at 79.5% in 2005 and falling slightly to 78.3% by 2006 (OECD, 2008a).

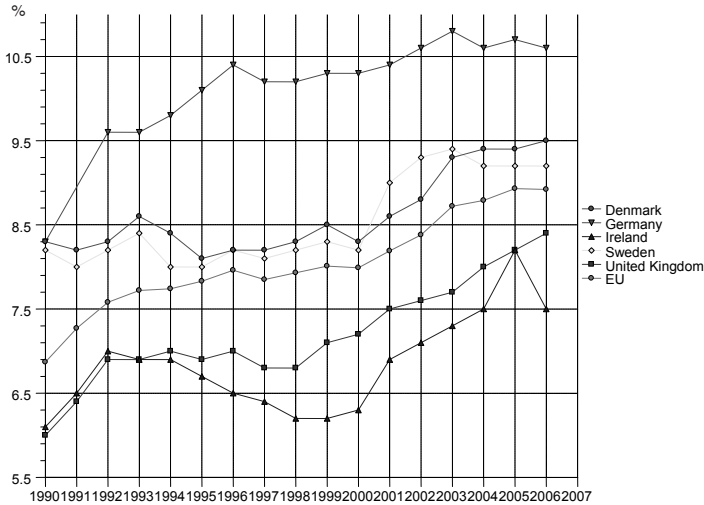
International comparisons

The exceptional growth of the Irish economy in recent years, makes public health expenditure in Ireland appear to be relatively low compared to many other countries within the EU, particularly as these analyses typically use GDP for comparative purposes. This is somewhat misleading. Using the more appropriate indicator of GNP Ireland would consistently exceed the EU average, with approximately 8% of GNP allocated to public health expenditure.

However, it should also be acknowledged that aggregate figures for health expenditure published by the DoHC continue to include some significant expenditure on non-health social welfare services, including much of the Community Welfare Programme (see later). Since 1990 the OECD has made a downward adjustment to Irish expenditure figures to take account of this (OECD, 2007b). Thus, they report just 5.8% of GDP for public health expenditure in 2004 compared with the level of 6.9% reported by the DoHC in Table 3.1b. However, more recent data for 2006 and 2007 exclude expenditure on child welfare services funded through the Office of the Minister for Children.

Similar adjustments are also made in data compiled by the World Health Organization (WHO) in Fig. 3.1, which reports a 6.5% share of GDP on public health expenditure in Ireland in 2005. This is below the EU average public sector share of health expenditure of 6.76% of GDP in 2005. Trends shown in Fig. 3.2 also indicate that between 1990 and 2006 growth in total health expenditure was persistently lower than that of selected western European countries. Again, the lower rate of increase in share of GDP in Ireland compared to these other countries over the period 2002–2005 has been largely due to the pace of economic growth. Turning to Fig. 3.3, total health expenditure per capita (US\$ adjusted for purchasing power parity (PPP)) in Ireland in 2005 was US\$ 3125, for the first time above the EU15 average (US\$ 2882) and well above that of the United Kingdom (US\$ 2598).

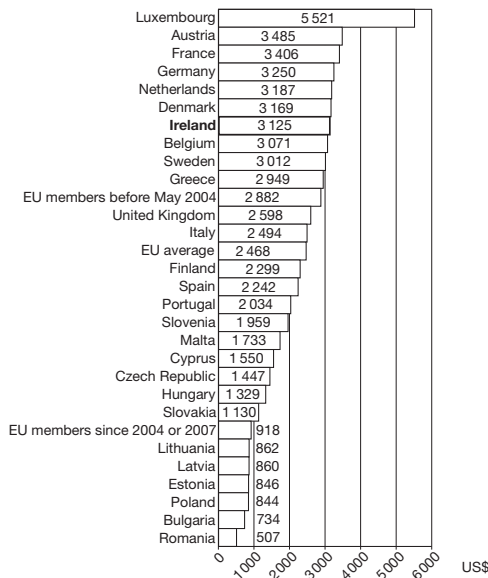
Fig. 3.2 Trends in total expenditure on health care as a share (%) of GDP in Ireland and selected countries, 1990–2006



Source: WHO Regional Office for Europe, 2008

Notes: GDP: Gross domestic product; EU: European Union

Fig. 3.3 Health care expenditure in US\$ PPP per capita in the EU27 countries, 2005



Source: WHO Regional Office for Europe, 2008

Notes: PPP: Purchasing power parity; EU: European Union; EU27: Countries comprising the EU up to and including the January 2007 accession

In terms of public health expenditure as a share of total health expenditure, we can see from Fig. 3.4 that this was 79.5% in Ireland in 2005, higher than that of the EU15 (76.8%) and only surpassed by Luxembourg, the Czech Republic, the United Kingdom, Denmark, Sweden and France.

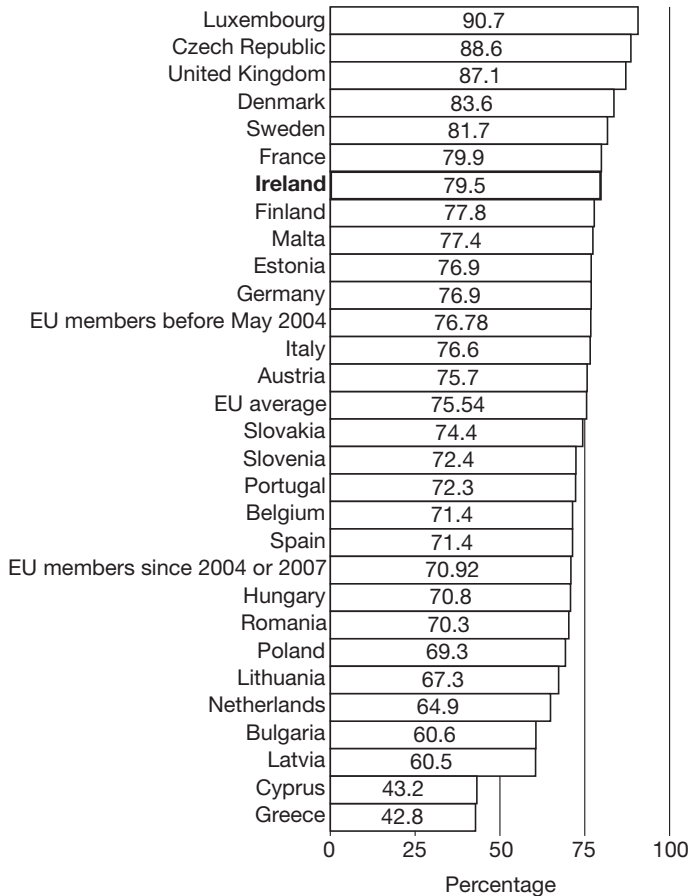
Structure of health care expenditure

Analysing health expenditure trends has been complicated by the establishment of the HSE in 2005, the body now responsible for most expenditure within the health care system. Table 3.2 provides a breakdown of non-capital expenditure by programme between 1998 and 2004 when the budget was the sole responsibility of the DoHC, together with an estimate of how projected expenditure would have fitted under these headings in 2005. Table 3.3 reports expenditure by the HSE from 2005.

Between 1999 and 2005, net non-capital growth in health expenditure was estimated to have risen by 130% from €4574 million to an estimated €10 500 million (Central Statistics Office, 2007e). The General Hospital Programme, which included all services provided in all state and voluntary-sector hospitals, as well as long-stay hospitals and the ambulance service, consistently accounted for the highest proportion of current expenditure. In 2004 the Programme consumed more than €4.5 billion of public health expenditure, representing 45% of the total expenditure allocation, a small fall since 1998 when more than 49% of public current expenditure was allocated to the hospital system. The fact that non-acute areas, such as child care and disability, were targeted for development to some extent accounts for this shift, rather than any diminution of the importance of the General Hospital Programme. By 2006, expenditure under the HSE's National Hospitals Programme covering all 53 HSE and HSE-funded voluntary hospitals accounted for just 38% of HSE expenditure. This reflects the greater attention being paid now to the development of primary, community and continuing care services. The share of expenditure for these services had risen from less than 59% of total estimated expenditure within the notional HSE budget in 2004 to 61.1% in 2007.

Under the former DoHC budget, after the General Hospital Programme, the Community Health Service Programme – which included primary care, dental, oral and ophthalmic services, home nursing, midwifery and family planning/pregnancy counselling services – was the next most significant area in terms of expenditure, accounting for almost 20% of current gross health expenditure. These expenditures are split under a number of categories within the new HSE budget.

Fig. 3.4 Health care expenditure from public sources as a share (%) of total health care expenditure in the EU27 countries, 2005



Source: WHO Regional Office for Europe, 2008

Note: EU: European Union; EU27: Countries comprising the EU up to and including the January 2007 accession

Under the new HSE structure, the Medical Card Scheme (including GP and pharmacy fees, as well as pharmaceutical costs (see Chapter 2 *Organizational structure* and Section 3.2 *Population coverage and basis for entitlement*)), accounted for almost 13% of total expenditure in 2007. Investment in the “Choice of Doctor” scheme within the GMS scheme (see Subsection *Health care benefits*, within Section 3.2 *Population coverage and basis for entitlement*) more than doubled between 1998 and 2005, at a time when the absolute number of individuals covered by the scheme (even after the extension to all those aged over 70 in 2001) decreased by 4% (between 1997 and 2004). Since 2004

Table 3.2 Estimated non-capital health expenditure in Ireland by programme, 1998–2005 (€ millions)

Programme	1998	1999	2000	2001	2002	2003	2004	2005 ⁽¹⁾
Community Protection Programme	99.9	136.0	224.8	314.3	275.3	302.2	334.6	366.2
Community Health Service Programme	687.2	883.5	985.0	1 191.6	1 526.1	1 678.0	1 868.7	2 162.7
Community Welfare Programme	285.5	336.5	445.9	581.4	703.8	774.2	860.0	892.1
Psychiatric Programme	347.5	394.5	433.7	497.1	563.7	619.5	661.4	729.5
Programme for the Disabled	436.6	520.8	651.6	815.9	962.9	1 155.9	1 230.6	1 368.2
General Hospital Programme	1 988.5	2 317.7	2 604.5	3 291.4	3 801.5	4 180.7	4 523.3	4 916.5
General Support Programme	194.8	218.1	264.9	318.3	333.5	407.0	444.8	482.4
Gross total	4 040.0	4 807.3	5 610.3	7 010.1	8 166.7	8 927.8	9 923.4	10 917.8
Total non-capital income	220.9	233.4	251.3	270.8	300.2	334.3	362.9	417.8
Net total	3 819.1	4 573.9	5 359.1	6 739.3	7 866.5	8 593.5	9 560.5	10 500.0

Sources: Central Statistics Office, 2007e; Original data from the DoHC; ⁽¹⁾ Data for 2005 are estimated

the total budget for the Medical Card Scheme has increased by a further 47% in nominal terms. Other primary care services, including the pharmaceutical payment and long-term illness schemes, accounted for more than 10% of total current health expenditure in 2007.

Programmes for people with disabilities, including care provided for people with intellectual difficulties in special homes, as well as assessment, care and rehabilitation made up just over 10% of the Budget in 2007.

In 2004 the Community Welfare Programme accounted for 8.5% of current health expenditure compared with 7% in 1998. Many of these activities were social care and social welfare programmes, including cash payments to people with infectious diseases or visual impairments, the provision of home helps and meals-on-wheels services and grants to voluntary welfare agencies. They also included payments to help support the cost of people living in public and private nursing homes.

The remainder of the programme focused on child protection, foster care and other child services. Since 2005, however, services under this programme have been moved into different categories; for instance, there is a separate budget line for all child health, social care and protection services. A total of €174 million for home helps is included under the programme for older people, which itself has risen in nominal terms by 58% since 2004.

There appear to have been a substantial increase in the level of funds allocated to mental health care, with a 45% nominal increase in funding since 2004. This is consistent with the higher profile that has been given to mental health in the 2000s and in part reflects increasing investment in community-based support. The need for greater investment in community-based supports was highlighted in the 2004 report of the Inspector of Mental Health Services which suggested that there were still substantial gaps in the provision of some community-based mental health services (Carey, 2005). Nonetheless, serious concerns remain regarding resources available to help implement the mental health service reforms set out in the new Mental Health Strategy report *A Vision for Change* (MHC, 2008).

Table 3.4 reports all health system expenditure that remains under the control of the Office of the MoHC. This reached €442 million in 2007 and includes expenditure on research grants, investment in the NTPF, payments under compensation schemes and €125.8 million in support of a range of advisory, accreditation and teaching bodies. These include the ICSB, which received €30.4 million in 2007, compared with €13.7 million in 2006, reflecting the continued rollout of the strategy across the entire country. The new HIQA received €6.4 million in 2007, compared with €1.3 million when operating in shadow form in 2006, while investment in the Mental Health Commission (MHC) has also increased substantially from €6.25 million in 2006 to €17.38m in 2007. Other significant beneficiaries of funding include the Food Safety Authority (€18.7 million), the Postgraduate Medical and Dental Board (€9.8 million) and the Crisis Pregnancy Agency (€8.6 million). A total of 6.9% of expenditure in 2007 was allocated to capital projects including investment in ICT infrastructure.

The NTPF was established in 2002. With an injection of 30 million initially, rising to 91.7 million by 2007, the fund was originally available to adults who had been waiting more than one year and children who had been waiting six months for elective procedures. By 2004 the scheme had been widened to include all those who had been waiting three months or more for treatment. From May 2004 the NTPF became an independent statutory structure. Funds originally earmarked for the then Health Boards were allocated directly by the NTPF (Government of Ireland, 2004c). Since 2005 the NTPF has received its funding direct from the DoHC (see Chapter 6 *Provision of services*).

Table 3.3 Estimated non-capital expenditure by the Health Service Executive, 2004–2007 (€ millions)

	2004	2005	2006	2007
HSE Corporate Administration	1.85	20.25	31.70	64.97
Primary, community and continuing care				
Long-stay residential hospitals	409.92	433.61	392.48	585.98
Community residences and day-care centres	339.94	357.28	371.38	554.48
Nursing home subventions	113.98	141.60	137.01	204.57
Home help services	103.98	113.49	121.40	181.26
Other services for older people	31.99	34.58	32.49	48.50
<i>Subtotal care of older people</i>	999.82	1 080.56	1 054.75	1 574.79
Children residential services	122.52	132.41	160.98	168.97
Immunization	9.08	9.81	11.93	12.52
Foster care	68.07	73.56	89.45	93.89
Orthodontic services	14.52	15.69	19.08	20.02
Other child care services	239.60	258.94	324.19	340.29
<i>Subtotal children and families</i>	453.78	490.42	605.63	635.69
Intellectual disability and autism	622.13	672.37	703.47	883.80
Physical and sensory disability	394.01	425.83	446.53	561.00
Other services for people with disabilities	37.56	40.59	39.79	49.98
General allowances	3.77	4.07	8.63	10.84
<i>Subtotal care of people with disabilities</i>	1 057.46	1 142.86	1 198.41	1 505.63
Long-stay residential care	430.08	464.81	572.19	605.81
Community services	179.20	193.67	269.26	285.06
Psychiatry of later life	7.17	7.75	9.55	10.11
Counselling services	14.34	15.50	19.10	20.22
Other mental health services	86.02	92.96	114.40	121.12
<i>Subtotal mental health</i>	716.80	774.69	984.49	1 042.36
Primary care units and GP cooperatives	117.66	127.17	149.50	213.70
Dental and orthodontic services	130.74	141.30	148.25	211.91
Community welfare scheme	65.37	70.65	-	-
Drugs payment scheme	357.64	378.17	439.84	628.72
Long-term illness scheme	61.32	68.36	78.90	112.77
Other community services	627.60	684.54	454.77	650.07
<i>Subtotal primary care and community health</i>	1 360.32	1 470.18	1 271.25	1 379.69

GP fees for Medical Card scheme	291.45	370.80	370.30	406.92
Pharmacy fees for Medical Card scheme	146.69	165.06	174.79	192.07
Costs of pharmaceuticals, medicines and appliances	685.34	823.86	861.61	1 021.65
Administration of primary care reimbursement centre	14.74	19.13	17.97	21.31
Fund for the development of general practice	27.78	24.67	23.19	27.50
Other primary care (Medical Card) services	-	1.54	1.45	1.72
Subtotal primary care (Medical Card) scheme	1 166.00	1 414.01	1 449.30	1 718.49
Public health nursing services	-	-	326.41	-
Other cross-care group services, including occupational therapy, physiotherapy, speech therapy, home help	-	-	301.30	-
Subtotal multi-care group services*	-	-	627.71	-
Subtotal palliative care and chronic illness*	-	-	74.67	-
Total all primary, community, continuing care	5 754.17	6 372.76	7 093.25	8 203.43
NHO	4 010.58	4 439.67	4 540.71	5 003.53
Ex-gratia awards in relation to long-stay charges	-	22.22	-	-
Long-term charges repayment scheme	-	-	16.49	131.7
Technical adjustments related to transition to HSE vote	-	173.60	-	-
HSE National Shared Services	-	-	33.30	28.46
Total	9 766.60	11 028.50	11 888.40	13 432.09

Sources: Government of Ireland, 2005; Government of Ireland, 2006b; Government of Ireland, 2007b, Government of Ireland, 2008

Notes: HSE: Health Service Executive; GP: General practitioner; NHO: National Hospitals Office; Figures take account of appropriations in aid. Grants to Voluntary Hospitals/Joint Board Hospitals are included in expenditure estimates; Totals may not add up due to rounding errors; 2004 figures are an approximation provided in the estimate of public expenditure as the HSE did not come into existence until 1 January 2005; *Multi-care and palliative care group services subsumed into other headings in 2007 out-turn figures.

Table 3.4 Office of the Minister of Health and Children Expenditure, 2004–2007
(€ millions)

	2004	2005	2006	2007
Administration	39.21	43.27	43.70	47.45
Grants				
Grants to HRB	20.98	27.15	30.35	36.09
Grants to National Cancer Registry Board	1.79	1.87	1.72	2.17
Health Agencies and Others	3.54	3.72	3.76	3.90
Other services				
Subscriptions to WHO and other international bodies	1.03	1.40	1.57	1.55
Statutory and non-statutory inquiries and legal fees	24.34	16.13	4.63	11.95
Developmental, consultative, supervisory and advisory bodies	66.64	76.80	82.97	119.43
Food Safety Promotion Board	6.17	6.37	6.58	6.48
NTPF	44.00	64.00	78.64	91.74
Ireland/Northern Ireland Interreg	0.46	0.89	0.11	0.14
Office of the Ombudsman of Children	0.27	1.02	1.26	2.10
Payments in respect of disablement by thalidomide	0.25	0.28	0.35	0.35
Payments to special account(s) under Section 10 Hepatitis C Compensation Tribunals Acts 1997 and 2002	53.00	63.50	64.29	64.29
Payments to Reparation Fund under Section 11 Hepatitis C Compensation Tribunals Acts 1997 and 2002	8.50	8.50	11.35	11.35
Dissemination of information, conferences and publications	10.07	10.77	3.98	1.93
Payments to the SCA relating to costs of clinical negligence	4.18	2.93	12.03	10.93
Total current expenditure	283.99	327.34	347.25	411.82
Capital grants	11.64	9.77	17.17	30.84
Total	295.63	336.72	364.42	442.66

Sources: Government of Ireland, 2005; Government of Ireland, 2006b; Government of Ireland, 2007b; Government of Ireland, 2008

Notes: HRB: Health Research Board; WHO: World Health Organization; NTPF: National Treatment Purchase Fund; SCA: State Claims Agency

3.2 Population coverage and basis for entitlement

Coverage in the Irish health care system is universal for anyone ordinarily resident within the country. Under the Health (Amendment) Act of 1991, entitlement is based on residency rather than on citizenship or ability to contribute towards general taxation. Guidance on ordinary residence is issued by the MoHC, while the HSE is responsible for determining whether an individual should be considered ordinarily resident. This usually means having lived in Ireland for more than one year, or intending to live in Ireland for at least one year. Individuals retain the right to appeal against an unfavourable decision made by the HSE.¹⁰

All those deemed to be “ordinarily resident”, depending on income and other eligibility criteria, fall into one of two categories. Those in Category I qualify for the PCRS and receive “Medical Cards”, which means that all services other than long-stay care (that is, GP care, dental and optometrist/ophthalmic services, including sight tests, pharmaceuticals, medical appliances and care in a public hospital ward) are free at the point of use. The rest of the population falls into Category II, for which there is free access to publicly funded secondary care services (subject to some charges), but the costs of GP consultations are borne fully out of pocket and there are also contributions to the cost of most other primary and community-based services, including pharmaceuticals (see Subsection *Out-of-pocket payments*, within Section 3.3 *Revenue collection and complementary sources of funding*). Social care services are not automatically covered. Long-term care for older people is subject to charges for the costs of care; however, individuals with Medical Cards in public facilities were previously illegally charged for their medical costs of care for nearly 30 years (see Subsection *Out-of-pocket payments*, within Section 3.3 *Revenue collection and complementary sources of funding*).

Dependants are usually assigned the same category status as their guardians; thus, it is noteworthy that only those children whose parents qualify for Medical Cards also have access to care that is free at the point of use. (Students under the age of 23 in full-time education that are financially dependent on their parents are also considered to be dependants). The rules also mean that many non-EU overseas nationals, for instance students whose courses are of at least one year in duration, are entitled to services. Furthermore, individuals in receipt of a

¹⁰ In addition, the 1991 Act allows the Health Boards (and now the HSE) to exercise discretion on individual cases on the grounds of hardship. Under Section 45(7) of the Act, even where a person is not ordinarily resident, and therefore not entitled to services, they “may, as with anyone else who does not qualify for full eligibility, be given full eligibility for an individual service where the Chief Executive Officer (CEO) of the Health Board [now the Health Service Executive, HSE] considers this to be justified on hardship grounds” (DoHC 2006c).

state pension from another EU Member State and without Irish income are fully eligible for health services under EU Regulation 1408/71 and therefore receive a Medical Card as evidence of this entitlement.

One exception to the residency regulations applies to asylum seekers. In a written answer to the Dáil,¹¹ in 2002 the Minister of Health confirmed that asylum seekers did not have to fulfil the residency or means-testing criteria to receive health care services while awaiting a decision on an application to remain in the country. Instead, they would be entitled to the same range of health services as Category I (Medical Card) holders. In addition to standard services, communicable disease screening is also available on a voluntary basis. One other exception is health care services for prisoners; this remains the responsibility of the Irish Prisons Service rather than the national health care system. Some health care services are provided for members of the Irish Defence Forces whilst on active duty, including support to cover the costs of treatment in overseas hospitals during tours of duty, but the vast majority of care is provided within the state system, on the same basis as the rest of the population.

As at December 2007, 30.22% of the population (1 281 091 individuals) were holders of Medical Cards (Table 3.5) (DoHC, 2008c). While rates of coverage appeared to decline in 2006, this was due to the revised estimate of the total population reported in the 2006 Census; in fact, more than 66 000 additional individuals were covered under the scheme in 2006. This rise in the absolute number of people covered increased by a further 60 000 in 2007 due to the increase in income levels recorded in the means-testing guidelines used to determine eligibility (see Subsection *Health care benefits*, within Section 3.2 *Population coverage and basis for entitlement*). This reversed a decline of approximately 94 000 in the number of Medical Card holders observed over the period 1997–2005. Approximately 50% of the population also subscribe to VHI schemes; these largely are supplemental schemes providing more rapid access to services or a greater degree of privacy for patients seen within public and voluntary hospitals (see Subsection *Health care benefits*, within Section 3.2 *Population coverage and basis for entitlement*).

¹¹ Dáil Éireann Debates, see Dáil Éireann (2002).

Table 3.5 Percentage of the population with a Medical Card, 1980–2007 (selected years)

Year	% Population with Medical Card
1980	35.0
1985	36.7
1990	36.7
1995	35.2
1996	34.5
1997	33.6
1998	32.0
1999	31.1
2000	30.3
2001	31.2
2002	29.8
2003	29.6
2004	28.4
2005	29.5
2006	28.9
2007	30.2

Sources: General Medical Services (Payments) Board, 2005b; General Medical Services (Payments) Board, 2004; General Medical Services (Payments) Board, 2003; General Medical Services (Payments) Board, 2002; General Medical Services (Payments) Board, 2001; HSE, 2007g; HSE, 2006f; DoHC, 2008c

Eligibility reforms

The 2001 Health Strategy included a number of action points relating to eligibility for health and social care services. This included a commitment to review all legislation relating to eligibility for health and personal social services, including income guidelines to increase the number of low-income individuals with eligibility for a Medical Card and, in particular, to prioritize families with children and specifically children with a disability. It also acknowledged that reforms of the system of eligibility for services needed to be accompanied by improvements in access to services (DoHC, 2001b).

In a first step in 2001, all those over the age of 70 became eligible for a Medical Card, irrespective of their income. This led to a significant – but unanticipated – increase in costs for the DoHC, which had severely underestimated the number of additional people that would be encompassed by this extension in coverage (Brennan, 2003). In 2002, further moves to expand the numbers eligible for a Medical Card were put on hold and instead the Government chose to increase the number of hospital beds provided within the acute care sector. Undoubtedly, this policy also reflected greater public concern over more rapid access to services rather than entitlements, and also may have revealed government reservations

over the cost of medical care expansion. In addition, there was recognition that the increased number of people in employment and the improved national economic situation more generally would have a negative impact on Medical Card eligibility.

It was not until 2005 that further significant reforms were introduced. In a move intended to boost the use of primary care services, a new means-tested GP Visit Card was created providing access, free of charge, to GP services for eligible individuals and families. Income guidelines for eligibility were initially set at a rate 25% higher than the income ceiling for a Medical Card; in 2006, this ceiling was revised upwards and is 50% higher at the time of writing than the qualifying level for the Medical Card. Thus, many individuals who would not be entitled to Medical Cards, due to their income levels being too high, now have access to GP consultations without having to pay out-of-pocket fees, which can be as much as €80 per visit. However, uptake of the new card has been somewhat slow. In December 2006 only 51 760 individuals (1.25% of the population) had GP Visit Cards, despite the Government providing funding to cover as many as 200 000 cards. Recognizing this, the DoHC not only up-rated the income levels at which individuals qualify, but also pursued an awareness campaign to encourage those who are eligible to apply for a GP Visit Card (DoHC, 2006h). However, uptake remains slow; by December 2007 the number of people with GP Visit Cards had increased to 75 790 (DoHC, 2008c).

The Health Strategy also included several other aims as part of its “Fair Access” objective. One commitment was to increase access to subventions to help cover the cost of nursing home places. (This lack of nursing home places has also contributed to the shortage of public beds in the acute hospital sector.) The 3-tier rate of subvention was replaced by a 2-tier system in January 2007 and it was anticipated that a further 1800 individuals would thus qualify for support; a new system to fund long-term care was due to be introduced from 2008. An additional 2000 extra home care packages at a cost of €55 million – another goal of the 2001 Strategy – were funded through the 2006 Budget. One commitment that still outstanding was the objective of increasing the number of free GP visits from two to six in the first year of life, in order to cover general childhood illness under the Maternity and Infant Care Scheme. To date, no specific extension in coverage under this scheme has been pursued (DoHC, 2007e).

Means-testing criteria for Medical Card and GP Visit Card

Eligibility for accessing health care services is determined largely on the basis of income and limits on entitlement are set at national level. Table 3.6 lists the income guidelines for eligibility for a Medical Card, which gives free access

to a range of services that were in effect at the end of 2007. Irrespective of these guidelines, the HSE can also exercise discretion with regard to hardship on a case-by-case basis. The income guidelines and the income allowances for children and dependants, which are taken into account for the purposes of assessing eligibility for the Medical Card, were increased by 7.5% in January 2005 and by a further 20% in October of the same year. As noted in the Subsection *Eligibility reforms* (within Section 3.2 *Population coverage and basis for entitlement*), since June 2006 the income guidelines to qualify for a GP Visit Card have been 50% higher than those for Medical Cards (Table 3.7). Again, GP Visit Cards may also be issued in exceptional circumstances, on a discretionary basis, for individuals with ongoing medical conditions that may otherwise lead to undue hardship.

Table 3.6 Weekly rate income* guidelines for a Medical Card with effect from 13 October 2005

Category	Aged under 66	Aged 66–69
Single person living alone	184.00	201.50
Single person living with family	164.00	173.50
Married couple	266.50	298.00
Allowance for first two children aged under 16	38.00	38.00
Allowance for third and subsequent children	41.00	41.00
Allowance for first two children aged over 16 (with no income)	39.00	39.00
Allowance for third and subsequent children over 16 (with no income)	42.50	42.50
Dependants aged over 16 in full-time third-level** education that is not grant aided	78.00	65.00

Source: Citizens Information Board, 2007c

Notes: * € gross less tax and PRSI deductions; PRSI: Pay-related social insurance; **University-level education

1) Reasonable expenses incurred in respect of child care costs and rent/mortgage payments will also be allowed. Weekly travel costs to work (the actual cost of public transport or mileage at 50 cents per mile) are also allowed. However, there is no exact definition of what actually constitutes “reasonable expenses” in relation to housing or child care costs.

2) Assessments for Medical Card purposes for couples are on the basis of the age of the older person. In the case of a married couple where one spouse is aged over 70 years and the other spouse is aged under 70, the spouse under age 70 will be subject to the income guidelines. For couples aged between 70 and 79, the limit is €596.50. For married couples aged 80 years or over, the limit is €627.00.

3) All individuals aged 70 years and over are entitled to a Medical Card, irrespective of income. This card, which is not means-tested, covers the applicant only, and does not cover dependants.

Table 3.7 Weekly rate income* guidelines for a general practitioner Visit Card from 26 June 2006

Category	Aged under 66	66-69
Single person living alone	276.00	302.00
Single person living with family	246.00	260.00
Married couple/lone parent family with dependent children	400.00	447.00
Allowance for first two children aged under 16	57.00	57.00
Allowance for third and subsequent children	61.50	61.50
Allowance for first two children aged over 16 (with no income)	58.50	58.50
Allowance for third and subsequent children over 16 (with no income)	64.00	64.00
Dependants aged over 16 in full-time third-level* education that is not grant aided	117.00	117.00

Source: Citizens Information Board, 2007b

Notes: * € gross less tax and PRSI deductions; PRSI: Pay-related social insurance; *University-level education; In the case of a married couple where one spouse is aged over 70 years and the other spouse is aged under 70, the spouse under age 70 will be subject to the income guidelines; For couples aged between 70 and 79 years, the limit is €895; For married couples aged 80 years or over, the limit is €940.50

Health care benefits

A range of different benefit schemes operate within the Irish health care system, most administered by the HSE. Of these, the National Shared Services PCRS – formerly known as the GMS scheme – is the largest. The Scheme was established in 1972, with the intention of providing a choice of private GPs and pharmacists to all Medical Card (Category I) patients. GPs can choose to enter into PCRS contracts with the HSE to provide services. Similarly, pharmacists are reimbursed for pharmaceuticals supplied to eligible patients under the PCRS. Covering 28.85% of the population, payments to participating GPs and pharmacies in 2006 totalled €1.33 billion (HSE, 2007g).

Most of the remainder of the population, who have Category II status, have to pay out of pocket for GP and other primary care services (unless they qualify for the GP Visit Card, in which case GP consultations are paid for by the HSE) and for the costs of all prescription pharmaceuticals up to a monthly ceiling in the Drugs Payment Scheme. Participation in the PRSI scheme also entitles individuals to some benefits to be claimed against the costs of some services, including dental, ophthalmic and aural services (see later).

Expectant mothers are one exception. Under the Maternity and Infant Care Scheme, expectant mothers – regardless of their eligibility for a Medical Card – are entitled to a free GP examination, if possible before 12 weeks, and a further six examinations during the pregnancy, which are alternated with visits

to the maternity unit/hospital. In cases where an expectant mother suffers from a significant illness, such as diabetes or hypertension, up to five additional visits to the GP may be provided. After birth, the scheme includes two further examinations: the GP will examine the baby at two weeks and both mother and baby at six weeks. Mothers are entitled to free inpatient and outpatient care in respect of the pregnancy and birth and are not liable for any hospital charges.

There is also a Long-Term Illness Scheme, open to individuals with one of a number of predefined chronic conditions, including diabetes, epilepsy, multiple sclerosis, cystic fibrosis, Parkinson's disease and acute leukaemia. This covers the costs of all necessary pharmaceuticals, medicines and appliances, which are listed in a Long-Term Illness Book. At 31 December 2006, 106 307 individuals (2.5% of the total population) were registered under this scheme, at a total cost of €115.5 million (HSE, 2007g).

Under the Health Services (Amendment) Act (HAA) of 1996 many health services are made available without charge to individuals who have contracted hepatitis C from blood or blood products administered within state facilities. The HAA Card gives entitlements to additional services, on more flexible terms and conditions than the Medical Card. It is personal to the individual card holder and does not cover family members (except in the case of access to counselling services). Services covered (even for illness not related to hepatitis) include GP services; pharmaceuticals; surgical aids and appliances; home nursing/home helps; physiotherapy; counselling; and dental, ophthalmic and aural services. In addition, in September 2007, a new Hepatitis C Insurance Scheme was set up. Enacted under the 2006 Hepatitis C Compensation Tribunal (Amendment) Act (No. 22) and administered by the HSE, the Scheme ensures that individuals can obtain life assurance, travel insurance and mortgage protection cover without incurring financial penalties compared to the general population.

A High-Tech Drugs (HTD) Scheme, introduced in 1996, facilitates the supply of certain medicines to eligible patients (for example, those used in conjunction with chemotherapy or organ transplantation) which previously were largely supplied only in hospitals. The cost of medicines dispensed under the HTD Scheme is paid directly to wholesalers by the HSE, with pharmacists receiving a standard patient care fee to cover dispensing. In 2006 some 252 692 items were dispensed, with total payments of €10.51 million made to pharmacies. Payments to wholesalers under the HTD Scheme reached €207.25 million.

There is also a Methadone Treatment Scheme, paid for by the HSE. In 2006 this provided and dispensed more than 217 000 methadone prescriptions to heroin addicts who had made a commitment to end their drug habit. The European Economic Area (EEA)-based scheme provides visitors from other Member States with access to emergency GP services while on a temporary

visit to Ireland. A total of 88 742 prescriptions were issued under this scheme at a cost of €2.1 million in 2006.

Under the Drugs Payment Scheme individuals without a Medical Card can apply for a Drugs Payment Scheme Card which limits out-of-pocket expenditure for an individual or family to no more than €90 (from January 2008) per calendar month for prescribed pharmaceuticals, medicines and appliances. As at 31 December 2006, 1 525 657 individuals (36.03% of the total population) were registered under this scheme (HSE, 2007g).

Coverage policy

There are approximately 4500 licensed drugs, medicines and appliances listed in the Primary Care Reimbursement Services Book that are reimbursable under either the PCRS or Drugs Payment Scheme (see Chapter 2 *Organizational structure* and Subsection *Out-of-pocket payments*, within Section 3.3 *Revenue collection and complementary sources of funding*). A supplementary list of approximately 3600 products is also covered within the Drugs Payment Scheme, but this covers just 2.5% of all prescriptions issued under the Scheme. Both lists can include similar products with significant variations in cost (Brennan, 2003).

Interventions may also be excluded from coverage on the grounds of cost-effectiveness. One of the roles of the new HIQA will be to assess the cost-effectiveness of health care interventions (see Chapter 4 *Regulation and planning* for more on HTA). Under the terms of the new IPHA/HSE agreement governing reimbursement of pharmaceuticals in Ireland, which came into force from September 2006, the HSE may require the assessment of new and existing technologies that may be high cost or have a significant budget impact. In the case of new medicines, assessment may be conducted prior to reimbursement but must be completed within 90 days of the reimbursement application (HSE, 2006c). Prior to this, although there had been no formal requirement to take cost-effectiveness into consideration, more than 50 interventions had been assessed by the National Centre for Pharmacoeconomics (NCPE) at the request of the DoHC (NCPE, 2007).

A small number of pharmaceuticals are explicitly excluded from coverage. They are only available on an over-the-counter basis and must be paid for out of pocket. These include some analgesics such as Panadol, Disprin, Solpadeine and Nurofen; vitamin supplements such as Rubex, Vivioptal, Seven Seas, royal jelly; and products for the treatment of baldness, such as Regaine (Citizens Information Board, 2007e). Other services that are not available at the time of writing through the public health care system include cosmetic surgery, genetic testing, and counselling and *in vitro* fertilization.

Pharmaceuticals provided as part of fertility treatment, however, are covered under the terms of a specific Drugs Repayment Scheme.

The termination of pregnancy remains completely illegal in most circumstances in Ireland. Abortion is only permissible if it meets the conditions set out by the Supreme Court in its judgement on the case of Ms “X” in 1992 (Attorney General versus Ms X). The Supreme Court decided in that case that abortion is permissible in Ireland (and thus within the publicly funded system) under the Constitution if it is established as a matter of probability that there is a real and substantial risk to the life – as distinct from the health – of the mother, which can only be avoided by the termination of her pregnancy. The Court accepted that the threat of suicide constituted a real and substantial risk to the life of the mother. A number of constitutional amendments, which would have extended the circumstances under which termination would be permissible, have been rejected in several national referenda. Books that advocate the procurement of abortion or miscarriage or the use of any method, treatment or appliance for the purpose of such procurement are also prohibited under the Censorship of Publications Acts 1929–1967. At the time of writing, individuals can legally seek terminations outside Ireland (at their own cost), although it should be noted that in Northern Ireland termination is also illegal in most circumstances.

Treatment Benefit Scheme

The Treatment Benefit Scheme run by the DSFA provides some support towards the costs of dental, optical and aural services for non-Medical Card holders who have paid enough weekly PRSI contributions (see Section 3.3 *Revenue collection and complementary sources of funding* for rates of payment). The rules vary according to age, and payments into social insurance schemes while working in many other European countries can also be counted.

Under the Scheme, the DSFA will pay the full cost of an oral examination and gum treatment once a year, and scaling and polishing once every six months. It also pays a contribution towards the cost of fillings, extractions, dentures and root canal therapy as often as required. Some of the costs of optical treatments are also covered, including sight tests, glasses, replacement lenses to existing frames and contact lenses. Half the cost of hearing aids, or repairs to hearing aids, up to a maximum ceiling are also covered under the Scheme (DSFA, 2007).

Cash benefits

There are also a number of cash benefits available, some of which are linked to PRSI and dependent on having made a set number of weekly contributions. In Ireland, employers have no legal obligation to offer sick pay, but those incapable

of working can apply for Illness Benefit (until October 2006 known as Disability Benefit). Rates (from January 2008) vary from €197.80 per week for those previously earning more than €150 per week to the lowest rate of €88.90 for those previously earning less than €80 per week. There are supplemental payments for spouses, depending on income, and child dependants. An Invalidity Pension that is not means-tested of €203.30 per week is paid to those incapable of obtaining work and who previously had been on Illness Benefit for 12 months. A means-tested Blind Pension of a maximum €197.80 per week is also available. Individuals can earn up to €120 per week in rehabilitative employment before earnings affect the level of payment.

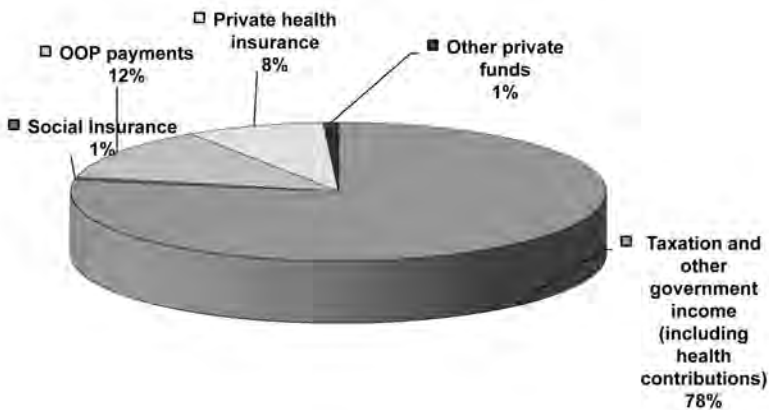
Individuals who have to give up work to provide care for a family member can claim up to 104 weeks of Carers Benefit, set at a weekly rate since January 2008 of €214.70 if caring for one person or €322.10 for two or more people. A Carers Allowance that is not time limited but is means-tested is also available. The first €332.50 per week (€665 in the case of couples) is not taken into account in the assessment of income, with maximum weekly payments of €232 per week for carers over the age of 65 (€348 if caring for more than one person) and €214 (and €321, respectively) for carers aged between 18 and 65. The HSE also administers a Domiciliary Care Allowance paid to carers of a child with severe disability living at home. The income of the child is taken into consideration; for those who qualify, the weekly rate since January 2008 is €299.60. An annual Respite Care Grant of up to €3400 is also paid to full-time carers. The grant does not have to be used to pay for respite care.

All those over the age of 70, as well as some other groups, including those receiving Invalidity or Blind pensions or a Carers Allowance, also qualify for the Household Benefits Package. This covers the normal standing charge for electricity plus up to 2400 units of electricity per year. As at August 2008, €57.00 and €123 can also be deducted from gas bills in summer (June–November) and winter (December–May) months, respectively. In addition to a free television licence, there is also a telephone allowance of €21.40 per month plus value-added tax (VAT) for either one landline or mobile phone. Everyone aged 66 or over in Ireland is also entitled to travel free of charge on public transport. Since April 2007 the scheme has been extended to include travel in Northern Ireland. Other cash benefits include Maternity Benefit, which since March 2007 is paid for 26 weeks to expectant mothers with sufficient PRSI contributions. Payments range between €221.80 and €280 per week. There is also a one-off Bereavement Grant of €850, paid directly to the person responsible for paying the funeral bill, available to qualifying individuals.

3.3 Revenue collection and complementary sources of funding

Looking at Fig. 3.5, it is clear that the Irish health system is primarily financed through general taxation, supplemented by an earmarked “health contribution” collected alongside the PRSI and along with out-of-pocket payments towards the costs of some services. Expenditure on health via the social insurance component of PRSI is minimal. The DSFA, through the Treatment Benefit Scheme, linked to the payment of health contributions (see Subsection *Health care benefits*, within Section 3.2 *Population coverage and basis for entitlement*), accounted for €91.6 million of public sector health expenditure in 2007. Private health insurance, which has both complementary and supplemental elements, accounted for just 8% of total health expenditure in 2006. Public funding for capital projects is largely derived from general government revenue, supplemented by a small contribution from the national lottery (Table 3.1b).

Fig. 3.5 Total health expenditure by source of funding, 2006



Source: OECD, 2008a

Note: OOP: Out-of-pocket (payments)

Table 3.8 provides trend data on sources of public sector current health expenditure between 1980 and 2007. When focusing on the public sector alone, it is clear that the contribution of general taxation to public health expenditure decreased from 92% in 1980 and reached a low of 80.6% in the

¹² The PRSI contribution is made up of a number of different components including: i) social insurance payable by the employee and employer at the appropriate percentage rate (the rate varies according to the earnings of the employee and reflects the benefits for which the person is insured) ii) a 2–2.5% Health Contribution, payable by the employee (where applicable); iii) 0.70% National Training Fund Levy.

year 2000. Funding received from the European Social Fund also ended in 1999. This decline in reliance on exchequer revenue was offset by an increase in the use of charges for public health services in 1987 (see Subsection *Out-of-pocket payments*, within Section 3.3 *Revenue collection and complementary sources of funding*). In contrast, between 2000 and 2003 much of the additional investment in public health services was funded through general taxation.

Since 2003, the share of public sector current health expenditure from general taxation has declined. This is, in part, an artefact of the transition to two separate budgets for the DoHC and the HSE. As Table 3.9 indicates, revenue from charges for private and semi-private hospital care and receipts related to superannuation were not included as appropriations in the DoHC health vote in 2003, although an appendix to the Budget indicates that €166 million in charges, as well as a further €168 million in other unspecified income were also raised (Government of Ireland, 2004b). Moreover, from 2006, the Office of the Minister for Children, covering a large proportion of non-health child welfare services, was allocated its own separate budget, having previously been part of the DoHC budget. There also has been an increase in revenue from the EU Member States as part of reciprocal arrangements for the use of health services; this reflects the general increase in EU visitors to Ireland and accounts for between 3% and 4% of public health expenditure at the time of writing.

Table 3.8 Sources of funds for public health service current expenditure, 1980–2007 (selected years)

	Exchequer Φ	Other appropriations	Receipts under EU regulations
	%	%	%
1980	92.0	6.5	1.3
1990	87.7	9.7	2.6
1997	89.0	8.5	2.6
1998	87.6	9.5	3.0
1999	85.2	11.8	3.0
2000	80.6	16.0	3.5
2001	83.9	13.4	2.8
2002	85.0	11.6	3.2
2003	84.7	11.8	3.5
2004*	80.4	16.1	3.5
2005*	80.6	15.4	4.0
2006*	81.1	15.6	3.3
2007*	81.9	14.8	3.3

Sources: DoHC, 2006f ; Government of Ireland, 2005; Government of Ireland, 2006a; Government of Ireland, 2007b; Government of Ireland, 2008

Notes: Φ Excise duties received from tobacco products are included in other appropriations; EU: European Union; *Figures for 2004–2007 are taken from Revised Estimates for Public Services and include both expenditure under the HSE and DoHC Budget Headings; Figures up to 2003 are for the DoHC alone; The Budget for the Office of the Minister for Children from 2006 onwards is not included in the table

Table 3.9 Additional revenue appropriations set towards cost of current health expenditure, 2003–2007

Revenue source	2003	2004	2005	2006	2007
Health contributions	855.9	950.5	1116.7	1188.4	1298.2
Excise duties on tobacco products	167.6	167.6	167.6	167.6	167.6
Births, deaths and marriage certificates	0.4	0.5	0.4	0.7	0.4
Recoupment of certain Ophthalmic Services Scheme costs from the Social Insurance Fund	4.01	4.1	–	9.5	5.7
Recoupment of certain Dental Treatment Services Scheme costs from the Social Insurance Fund	9.1	4.9	–	17.0	9.1
Recovery from United Kingdom Department of Health for share of the Leopardstown Park Hospital	-	-	0.7	-	0.2
Charges for maintenance in private and semi-private hospitals	-	224.0	174.4	231.7	266.7
Dormant accounts – economic and social disadvantage/ disability	-	-	-	-	1.0
Superannuation	-	168.0	156.5	176.6	192.0
Miscellaneous receipts	0.09	98.0	135.6	119.8	105.1
Total	1037.1	1617.6	1751.9	1911.3	2046.0

Sources: Government of Ireland, 2004b; Government of Ireland, 2005; Government of Ireland, 2006b; Government of Ireland, 2007b; Government of Ireland, 2008

Compulsory sources of financing

More than three quarters of all funds for the public health care system come from non-earmarked general taxation collected at the national level; in total, net receipts from all sources of taxation in 2007 were in excess of €47.5 billion. VAT (31%), Income Tax (29%), Corporation Tax (13%) and Excise Duty (13%) account for 86% of total net tax receipts. The remainder is made up of customs, agricultural levies, capital gains and acquisitions, and stamp duty on property sales (Office of the Revenue Commissioners, 2008). Some excise duties levied on tobacco products are earmarked for health and allocated to the HSE budget; this amounted to €167 million in 2007.

The basic rate of income tax in 2007 was 20%, with an upper rate of 41% for remaining income depending on personal status (Table 3.10). Credits offset against tax also vary according to personal circumstances. In the case of those over the age of 65 years, such credits are substantial, being €38 000 per annum for a married couple compared with €10 420 for a married couple of working age. The tax credit for an individual in 2007 was €5 210. There are two rates of VAT – 13.5% and 21% – which are applicable depending on the product or service. Many privately purchased health-related products and procedures, including much medical equipment, hearing aids, cosmetic surgery and the services of most medical professionals including dentists and opticians are exempt from this charge. Others, such as glasses and contact lenses, and occupational health services, are charged at a rate of 21% (Office of the Revenue Commissioners, 2007).

Table 3.10 Personal allowances and income tax bands, 2007 (€)

Personal circumstances	Tax year 2007 €
Single/Widowed without dependent children and under 65	34 000 @ 20%, Balance @ 41%
Single/Widowed qualifying for one parent family tax credit	38 000 @ 20%, Balance @ 41%
Married couple – one spouse with income	43 000 @ 20%, Balance @ 41%
Married couple – both spouses with income	43 000 @ 20% (with an increase of 25 000 max), Balance @ 41%

Source: Office of the Revenue Commissioners, 2007

PRSI health contributions

As part of the PRSI most employers and employees pay a small earmarked “health contribution” which is allocated directly to the HSE. Funds raised through health contributions are not insignificant – they accounted for more than 10% of gross current health expenditure in 2006. At the time of writing, this is paid at a rate of 2.5% on all earnings over €100 100 and 2% on all earnings below this level, with the exception of individuals with a Medical Card, as well as all those whose gross earnings are less than €500 per week.

Voluntary health insurance

A total of 51.2% of the Irish population – 2.245 million people – had some form of private insurance coverage at 31 December 2007. Total premium income has risen from €821.9 million in 2002 to €1 477.8 million in 2007 (HIA, 2008). All health insurance premiums are tax deductible at source at the standard income tax rate of 20%.

Private health insurance fulfils two roles in Ireland: first, it acts as a complement to the public health system, providing coverage against charges levied on non-Medical Card holders for inpatient bed use, together with a more limited reimbursement of some out-of-pocket charges in the primary care sector. The overwhelming majority of individuals with private health insurance would otherwise have to pay these charges. A consumer survey undertaken for the HIA in 2005 found that 14% of adults with either a Medical Card or GP Visit Card also had private health insurance (Insight Statistical Consulting, 2008). Second, private health insurance fulfils a supplemental role to the public system, as subscribers can bypass waiting lists for inpatient services by obtaining a private bed and consultant treatment within a public hospital or undergo full treatment in a private facility. All health insurance schemes operate on the basis of open enrolment with lifetime cover and community rating, whereby everyone – regardless of age or health status – is charged the same premium for the same insurance package.

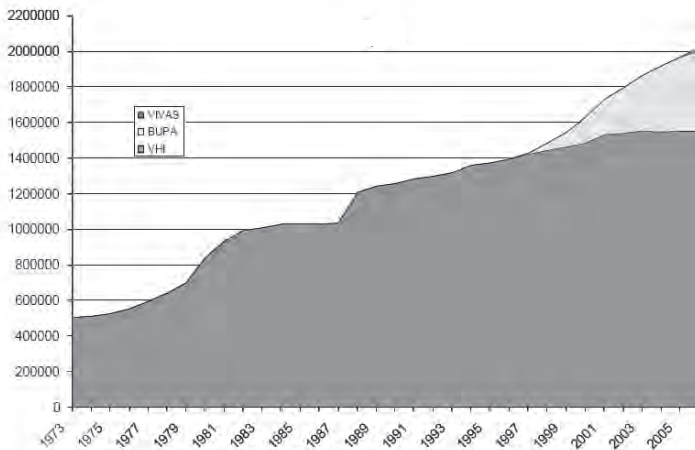
By far the largest provider of insurance is VHI Healthcare (commonly known as “the VHI”). This was established under the 1957 Voluntary Health Insurance Act, as a non-profit-making, semi-state private insurance body. The primary concern at the time was ensuring that the 15% of the population not then covered by the State for hospital services would have the opportunity to buy private health insurance against this risk if they so chose.

Until the mid-1990s, VHI operated as a virtual monopoly. The only competition came from “restricted schemes”, open only to employees of various professions and their families. In September 2006, 11 such schemes were in operation, covering 2.6% of the population (93 900 members). These included the Electricity Supply Board Staff Medical Provident Fund, with approximately 30 000 members. The two other principal schemes serve the Police (St Pauls Garda Medical Aid Society) and prison staff (Prison Officers Medical Aid Society).

With the emergence of the European single market in the mid-1990s, the Irish Government was required to open up the market for health insurance and allow free competition. This was achieved under the Health Insurance Act of 1994. BUPA Ireland entered the market in 1997, operating until 2007 when it withdrew and its business was taken over by QUINN-healthcare (see later). A third player, the private health insurance company Vivas, entered the market in October 2004. In September 2006, “the VHI” had more than 1.5 million members, giving it a 75% share of the open enrolment health insurance market. BUPA Ireland (now QUINN-healthcare) had 459 000 members (22.2% of the market) and Vivas¹³ 57 000 (2.8%) (HIA, 2007a). As Fig. 3.6 illustrates, private health insurance enrolment has grown steadily since the early 1970s. Two significant upward shifts in insurance coverage can be observed: in 1988, following the introduction of daily charges for all inpatient beds in public hospitals in 1987; and in 1997, following the entry of BUPA Ireland into the market.

Work-based group schemes, under which employers deduct health insurance premiums for employees directly from their salaries, are a major feature of private health insurance in Ireland. In a consumer survey in 2005 this accounted for 45% (compared with 49% in 2002) of all private health insurance (Insight Statistical Consulting, 2005). VHI Healthcare traditionally gave a discount (of 10%, when the Health Insurance Act was passed in 1994) for members who joined as part of a group scheme. This 10% group scheme discount was incorporated into legislation as the maximum discount that could be offered on an adult health insurance premium. However, as all three insurers now offer the 10% discount to members who join online, there is effectively no difference in

¹³ On 15 May 2008 Vivas was acquired by Hibernian, Ireland’s largest insurer. The company began trading under a new name Hibernian Health in July 2008.

Fig. 3.6 Long-term growth in private health insurance, 1973–2006

Source: HIA, 2007a

price between the individual and group schemes. Approximately one quarter of those participating in work-based schemes benefit from their employer paying all or part of the health insurance policy premium (HIA, 2007a).

Benefits

All open enrolment private health insurance plans in Ireland, other than those that solely cover public hospital inpatient daily charges or ancillary health services, must comply with the 1996 Minimum Benefit Regulations. These specify in detail minimum levels of monetary payment that must be covered in terms of hospital charges (inpatient and day-patient services), hospital charges relating to special procedures, consultants' fees (inpatient and day-patient services) and hospital charges and consultants' fees (outpatient services) (Office of the Attorney General, 1996).

A range of schemes are offered by the three insurers, all of which as standard provide cover for a semi-private room (that is, a room with up to five beds) and most also cover a private room in a public hospital.¹⁴ The HIA regularly collates and updates information on the different plans and publishes it on its web site. As of 10 October 2007, the cost per month, based on the adult group rate (after tax relief) for the most basic of plans of the three insurers was €27.61 for QUINN-healthcare's "Essential Scheme"; €27.66 for Vivas Health's "Me Level 1"; and €38.59 for VHI Healthcare's "Plan A". The lowest-cost plans of

¹⁴ Restricted schemes provide fewer options but offer broadly similar plans to those offered in open enrolment schemes. Those enrolled in restricted schemes are free to opt out and join open schemes.

the three providers, which also cover in full a semi-private room in a private hospital (excluding the high-tech Blackrock Clinic, Mater Private, Galway Clinic and the Beacon Hospital), are €43.74 for QUINN-healthcare's "Essential Plus"; €43.13 for the Vivas "Me Level 2"; and €55.39 for VHI Healthcare's "Plan B". The most expensive plans cover in full a private room in one of the high-tech private hospitals and have monthly premiums of €150.40, €153.50 and €169.63 for QUINN-healthcare, Vivas and VHI Healthcare, respectively. The basic plans of all three insurers cover in full the inpatient fees of participating consultants (in excess of 90% of all working consultants).

All three insurers also provide time-limited cover for hospital stays for a range of mental health and stress-related problems, including 100–180 days of inpatient psychiatric treatment per annum and 91 days of inpatient care for alcohol and substance abuse problems in any 5-year period. All plans provide emergency overseas cover of a minimum ranging between €50 000 and €65 000 per annum in hospital costs, as well as covering repatriation costs where necessary. All schemes provide a number of maternity benefits. These include between €830 and €860 in assistance with doctors' fees while in hospital, as well as between €2000 and €3500 towards the cost of private hospital accommodation or assistance with home births.

Differing degrees of outpatient cover are provided by the various plans. These benefits are very limited under the basic plans of all three insurers and are subject to payment of an excess. For instance, benefits under the Vivas "Me Level 1" plan include up to €55 per consultant visit, plus up to €450 for emergency dental care, while magnetic resonance imaging (MRI) and computerized tomography (CT) scans are fully covered in approved treatment centres. Also covered is €30 per GP, dentist and physiotherapist visit (up to three times per year for each benefit). An excess of €150 applies to this plan. Similarly, some of the benefits under QUINN-healthcare's Essential scheme include free MRI, CT and positron emission tomography (PET) scans, mammograms, DEXA scanning (for osteoporosis), breast and colon screening, as well as emergency dental care related to accidental external impact of up to €510 per annum. The plan also provides coverage towards outpatient consultant fees (up to €51 per consultation); a small amount of support for other outpatient and primary care services; and coverage towards further services, including €20 per GP visit, up to €25 per annum for dental consultations, and optical cover of up to €20 per annum. An excess of €250 applies to the plan. VHI's most basic plan does not provide any outpatient or primary care coverage, but its "First Plan" Levels 1 and 2, which cost €44.80 and €50.43 per month, respectively, provide benefits of €20 and €30 for up to 25 visits per year for GP, dentist and physiotherapist visits and for up to 12 visits a year for complementary and alternative therapists (including dieticians, speech and language therapists, and

chiropractors). Optical costs of up to €55 or €100 every two years are also covered, along with outpatient consultant expenses of up to €60 and €75 for up to 25 visits per annum. An excess of €1 applies to these VHI plans.

Dental insurance

As indicated, coverage for dental care is very limited under most plans. VHI is still the only one of the three principal private health insurers to offer a separate dental insurance plan. VHI DeCare Dental covers up to 70% of dental charges annually for less than €16 per month for an adult, or less than €7 per month for a child. It covers 100% of yearly exams and cleaning; 70% of costs for fillings, space maintainers, sealants, extractions and treatment of gum disease; 50% of costs for crowns, root canal treatment and many other major dental services; 25% of costs for dentures and one emergency dental care session worldwide per annum. There is an annual limit on coverage of €500 for crown treatment (subject to excess of €100) and €1000 for other dental services (VHI Healthcare, 2007b).

Other health-related insurance products

A consumer survey in 2005 indicates that more than 20% of the population have chosen to purchase other private health insurance-related products (Insight Statistical Consulting, 2005). These include hospital cash plans which may pay out a fixed amount for each day in hospital to help offset daily hospital bed charges, while some also pay compensation related to loss of earnings during illness and/or include limited cash payments towards the costs of primary care services such as GP visits, or visits to dentists, opticians, health screening, and so on. Approximately 21% of people with private health insurance also hold hospital cash plans, reflecting the fact that they are considered as a complement to, rather than a substitute for, private health insurance (HIA, 2007a).

Another product available is critical illness cover, which pays out a tax-free lump-sum cash payment if the subscriber is diagnosed with a specific illness or disability covered by the policy (for example, cancer, stroke and other serious conditions) to help offset any long-term disability costs. Most of these plans are purchased as a supplement to life assurance or mortgage protection policies. They act as a complement to private health insurance and approximately one third of those with private health insurance also have these plans (Insight Statistical Consulting, 2005).

A total of 31% of people with private health insurance also have income protection insurance (Insight Statistical Consulting, 2005). This provides a

guaranteed income for individuals in the event that they are unable to work because of poor health but does not provide cover for private medical services.

Competition, risk equalization and the Irish insurance market

Section 10.3 *Competition, risk equalization and the Irish insurance market* outlines in detail the complex history and key debates over competition and risk equalization in the Irish health insurance market. This section gives a brief insight into this highly contentious issue.

The 1994 Health Insurance Act, which opened up the insurance market to competition, required that products offered by any new insurance provider had to be consistent with the existing conditions of community rating, open enrolment and lifetime cover. Thus, competition would be based on the differences in the package of benefits offered (over and above Minimum Benefit Requirements) and differences in premium rate(s). The Act also provided for the introduction of a risk-equalization mechanism, if the Government determined this to be necessary. This is a mechanism for dealing with differences in health insurance companies' costs due to differences in the risk profiles of their subscribers. Essentially, companies who have healthier-than-average subscriber profiles would be required to make a cash transfer to those companies whose subscribers have worse-than-average health risk profiles.

The potential and actual use of risk equalization has proved to be highly contentious, particularly as the legal status of the VHI and its subscriber profile of substantially older policy holders would enable it to benefit financially from any risk-equalization scheme. The Government's proposal stated that if the difference in risk profiles between insurers was between 2% and 10% then the scheme could be enacted by the Minister of Health if it were recommended by the HIA. Where differences were greater than 10% the scheme would be enacted by the Minister after consultation with the HIA, unless there were compelling reasons for not doing so. A formula for transfers developed by the HIA would take account of age, gender and health status. This approach to the risk-equalization scheme has been the subject of a number of legal challenges at the EU level. BUPA argued that any transfers of funds to the semi-state organization (the VHI) would constitute a form of state aid. However, in 2003 the European Commission (EC) concluded that for Ireland's risk-equalization scheme this was not the case (EC, 2003).

In December 2005 the Government announced that risk equalization would be introduced from 1 January 2006. In December 2006, following the High Court judgement, BUPA Ireland announced its staged withdrawal from the Irish health insurance market, stating that the payments it was required to make under the risk-equalization scheme were already costing more than €1

million a week, and that the €161 million it would be required to pay to the VHI over the next three years would far exceed its estimated surplus of €64 million (BUPA Ireland, 2006). Its business was bought by the Quinn Group in April 2007. Meantime the Health Insurance (Amendment) Act in February 2007 removed the 3-year exemption from risk equalization for new entrants into the market. In response to several reports on this issue (Barrington, Creedon & Dowling, 2007; Competition Authority, 2007; HIA, 2007b), the Government approved a number of reform measures in April 2007, aimed at expediting the creation of a level playing field in the health insurance market and introducing pro-consumer measures to facilitate choice between insurers (Harney, 2007b).

Both BUPA Ireland and QUINN-healthcare, in four separate legal proceedings, challenged the legality of the risk-equalization scheme. Initially, BUPA claimed that the scheme would make competition unworkable (BUPA Ireland, 2006) and although this was dismissed by the High Court in November 2006, BUPA lodged an appeal to the Irish Supreme Court, to be heard in 2008.¹⁵ At the European level, BUPA also challenged a decision by the EC that the Irish risk-equalization scheme does not constitute a state aid. In February 2008 the European Court of First Instance dismissed BUPA's claim stating that "such a mechanism [as the Irish risk-equalization scheme] is a necessary and proportionate means of compensating the insurers required to cover, at the same price, all persons living in Ireland, independently of their state of health".

The VHI is to become a conventional insurer authorized by the Financial Regulator by the end of 2008; at this time, it will also have to fulfil the solvency requirements for insurers. Legislation is being introduced to ensure that the VHI establishes subsidiaries to operate its ancillary activities, including travel insurance and health care clinics. This legislation will remove the final powers of the Minister of Health over product development and pricing.

The Government also agreed to implement immediately the various pro-consumer measures outlined in the Barrington Group report that did not require legislation. These included providing health insurance customers with clear statements of consumers' rights and standardized premiums renewal notices; requesting companies with payroll deduction schemes to offer at least two companies' products to employees; and having group schemes put out to tender on a regular basis. The waiting periods imposed on older people at the time of writing were also to be reviewed to ensure that they comply with equality legislation. In response to the Barrington Group report and in order to encourage competition, the Health Insurance (Amendment) Act of 2007 allowed risk-

¹⁵ At the time of writing (July 2008) the Supreme Court announced that it had ruled in favour of BUPA and concluded that the risk-equalization scheme for health insurance is based on a wrong interpretation of the law and should be set aside. The long-term implications of the ruling remain unclear, with the DoHC stating that it would seek legal advice which would take some time.

equalization payments to be discounted by 20%. There will also be consultation on draft regulations for Lifetime Community Ratings to encourage individuals to enter the market at a younger age. Such consultation will consider defining what level of health insurance should be subject to community rating (Harney, 2007b). Finally, the HIA stated that it would explore the feasibility of introducing a prospective risk-equalization scheme. The Government continues to have an open mind over the future ownership status of the VHI.

Out-of-pocket payments

Out-of-pocket payments for services form an important element of health care funding in Ireland, accounting for approximately 13% of all health care costs (OECD, 2007b). As mentioned in Section 3.2 *Population coverage and basis for entitlement*, Medical Card holders are entitled to all GP care, dental and optometrist/ophthalmic services (including sight tests), pharmaceuticals, medical appliances and care in a public hospital ward without charge. Individuals and their families with Category II status have to pay out of pocket for GP services (unless they qualify for a GP Visit Card) and for pharmaceuticals up to a maximum ceiling of €90 per month (see Subsection *Health care benefits*, within Section 3.2 *Population coverage and basis for entitlement*). They also have to pay privately for dental and ophthalmic services, although some help for these costs may be available via the Treatment Benefits Scheme.

While a large proportion of people also hold VHI to cover the cost of services not provided free of charge by the State, insurance policies only provide limited coverage for primary care and lifestyle interventions. For example, there are no set charges for GP services and these will vary; fees may be between €50 and €80 per visit. Private health insurance plans typically only offer payouts of between €20 and €30 for each GP visit (often up to a specified annual limit), leaving the patient to pay the difference out of pocket. Some services are not covered at all under the health system, such as *in vitro* fertilization, and must be paid for out of pocket (see Section 3.2 *Population coverage and basis for entitlement*).

Hospital charges

For individuals without a Medical Card, a charge of €66 (at 1 January 2008) per day is levied for inpatient or day care at a public hospital, subject to a maximum ceiling of €660 in any year. A charge of €66 is also levied for attendance at a hospital A&E department without a referral letter from a GP. Exemptions exist for those subsequently admitted to hospital to receive treatment for prescribed infectious diseases, to utilize maternity services, or who are under six weeks of age, referred by child health clinics or by school health examinations.

This charge is also not levied for subsequent visits for the same condition. As long as a patient obtains a referral for inpatient and outpatient services, no charges are levied for diagnostic tests such as X-rays, laboratory tests and exercise tests. Patients being treated in private or semi-private beds have to pay significantly higher daily charges (Table 3.11); they also have to pay consultant fees, although in practice most private patients have private health insurance to cover the cost of accommodation and consultant fees.

Table 3.11 Additional charges for private care in public/voluntary hospitals (€) at 1 January 2008

Hospital category	Private	Semi-private	Day care
HSE Regional Hospitals and Voluntary and Joint Board Teaching Hospitals	€758	€594	€546
HSE County Hospitals and Voluntary Non-Teaching Hospitals	€506	€407	€362
HSE District Hospitals	€217	€185	€161

Source: Citizens Information Board, 2008

Note: HSE: Health Service Executive

Long-term care charges

New arrangements relating to charges for people residing in public long-stay care homes were introduced by the HSE in July 2005. These charges generally apply to all individuals, including Medical Card holders, although there are exemptions for people under 18, women receiving maternity services, individuals involuntarily detained under mental health legislation and people who contracted hepatitis C as a result of infected blood products or transfusions in Ireland.

The Health (Charges for Inpatient Services) Regulations of 2005 provide for different charging arrangements, depending on the level of nursing care. For those in premises where nursing care is provided on a 24-hour basis, the maximum weekly charge for care is €120, or the person's weekly income minus €35, whichever amount is lower. The second group consists of those receiving inpatient services in premises where nursing care is not provided on a 24-hour basis. In these facilities the maximum weekly charge is €90, or the person's weekly income minus €55, or 60% of the person's weekly income, whichever of the three calculations is the lowest. While everyone must be able to keep at least €35 of their weekly income, the HSE may also reduce or waive a charge imposed on a person in order to avoid undue hardship.

There is only a limited supply of HSE-owned long-term care facilities; this means that many individuals have to find long-term care within the private

sector, with a small number of private care homes also being contracted by the public sector. The 1990 Health (Nursing Homes) Act ensured that all individuals in private nursing homes would be eligible to apply for means-tested subventions towards the costs of their care. Prior to the establishment of the Act, subventions were only available in “approved” private nursing homes, and approvals had been restricted not on the grounds of quality but rather due to fiscal constraints. Subventions do not cover all the costs of places in private nursing homes and are subject to means-testing, taking into account assets such as savings, property, life assurance and shares, as well as income. Assets disposed of in the five years prior to applying for the subvention may also be taken into account. Private residences are not taken into account if a spouse, relative registered with a disability, or child – aged under 21 years or in full-time education – still resides in the household. The HSE may, at its discretion, refuse to pay any subvention if an individual’s assets exceed €36 000 or if their principal residence is valued at more than €500 000 in Dublin (or €365 000 elsewhere) and their annual income is not less than €10 400. The Nursing Homes (Subvention) Amendment Regulations of 1998 removed the assessment of children’s ability to contribute towards the cost of care of a parent. Tax relief is also available on payments for nursing care.

Until 31 December 2006 there were three rates of subvention depending on the level of dependency. These have been replaced by one maximum weekly rate set at €300. However, higher “enhanced” payments can be made, in circumstances in which even with the maximum subvention the individual cannot make up the shortfall in the costs of their care. They are made at the discretion of local health offices of the HSE. In some circumstances this could mean that the HSE will meet all the costs of care.

Repayment for illegal charges

Prior to 2005, patients holding Medical Cards were charged not only for the “hotel” costs but also for the medical costs of inpatient services. This was in spite of a legal judgement in 1976 (Maud McInerney, a Ward of Court (1976–7) ILRM 229) which made clear that charges for people with “full eligibility”, that is, Medical Card holders, should only be for shelter and maintenance. Long-term nursing care charges, according to the Health (Charges for Inpatient Services) Regulations of 1976 (SI No.180/1976), were only to be levied on those individuals who did not have Medical Cards. At the time there were concerns about the impact of the McInerney judgement on Health Board finances. A Department of Health circular (Circular 7/76) invited Health Board CEOs to regard Medical Card holders as “not coming within the definition of ‘full eligibility’ once they were being maintained in an institution where the

services provided include ‘medical and surgical services of a general practitioner kind’”. This practice, according to an independent report by John Travers into long-stay charges, was to “ensure that persons who had been accorded the status of ‘full eligibility’ before entering a Health Board long-stay care institution became subject to charges once they had become long-stay care patients of the institutions and in receipt of ‘inpatient services’” (Travers, 2005). Thus, individuals had their Medical Cards withdrawn and were charged for services, contrary to repeated advice by the Legal Advisor to the Department of Health (Travers, 2005). The situation became even more acute after Medical Cards were extended to all those aged over 70 years in 2001, regardless of income; yet, Health Boards continued to withdraw Medical Card status. Finally, in 2004 the DoHC sought legal advice from the Attorney General who ruled that the imposition of such charges on Medical Card holders was indeed outside the scope of existing legislation.

The Health (Amendment) Bill 2004 was intended to provide a statutory basis for the imposition of charges on those to whom inpatient services were being provided in public long-stay institutions. The legislation also deemed that it was lawful to retrospectively levy an (additional) charge for long-stay care received prior to the enactment of its provisions. The Bill was subsequently referred to the Supreme Court by the President to determine its constitutionality in December 2004 and the Court found the legislation to be unconstitutional in part, namely in terms of the provisions which sought to retrospectively legitimize payments for long-term care. The provisions that provided for prospective charging of inpatients were found to be lawful. The ruling thus indicated that the Government should pay back to patients any retrospective charges it had required them to pay. The Court did not consider that exposing the State to such repayment obligations would constitute an extreme financial crisis or cause a fundamental disequilibrium on public finances. However, the Court indicated that the State had available to it a defence of the Statute of Limitations, that is, a 6-year limit (which the Government has utilized). A repayment scheme was launched in May 2005, which it was estimated would benefit 20 000 people still alive and a further 40 000 to 50 000 estates at what was thought initially to be a cost of €1 billion (DoHC, 2005b). This was subsequently revised downwards to approximately €420 million.

Reform of long-term care charging

In January 2008, a new way of accessing and charging for long-term care in Ireland was due to come into effect, although this was subsequently delayed. This proposed new system, “Fair Deal on Nursing Home Care”, was announced in December 2006 by the Minister of Health, acknowledging certain problems

with the current system. The Minister recognized that individuals on the same income can end up with vastly different health care costs and that, even with subventions, the cost of private nursing home care is unaffordable for many; some family members pay as much as €35 000 per annum for a parent's care. The Minister cited one of the worst aspects of the system as the imputed 5% income from the value of an individual's home that is taken into account in the assessment of means as this cannot be translated into disposable income (Harney, 2006).

The new system is intended to be "clear, fair, uniform and anxiety free." It is to end the difference in support between those in private and public beds, as well as ensuring that a) contributions are clearly based on an assessment of means and assets by the HSE, and b) that these contributions will always be below disposable income. Only those with high dependency needs will be eligible for nursing home care; others will be eligible for community care with support through home help packages.

Under the new system, older people will contribute no more than 80% of their disposable income towards the costs of care. There will be no need for family members to voluntarily contribute towards the costs of care; instead, a charge will be made against the older person's home to a maximum of 15% of its value. If a spouse lives in the house this is reduced to 7.5%; in all cases the charge is deferred until an individual's and their spouse's estate is settled. Moreover, unlike the system at the time of writing, in which 5% of the value of one's house must be contributed in cash for every year of residence in a nursing home, under the new system charges made against property will not be made after three years, regardless of how long someone will be in a nursing home. This, it is claimed, will mean that in future no one will have to (re-)mortgage or sell their homes. At the time of writing, it is unclear when legislation detailing the new system will be introduced.

Charges for social care services

Access to social services in Ireland is means-tested, and individuals may have to contribute towards the costs of services, such as home helps or meals-on-wheels.

3.4 Pooling of funds

Figure 2.1 illustrates how funds flow through the health care system in Ireland. A book of estimates for overall government expenditure for the forthcoming financial year is produced each November; each budget heading is called a “vote” (so-called because it is voted on in the *Dáil*), which sets out in detail its budget. Until 2005 this overall level of funding for health services was determined annually following negotiations between the DoF and the DoHC. In April or May, the DoF would begin assessment of the costs of maintaining all public services at existing service levels to inform the preparation of the government budget. The DoHC would also submit an estimate of its budgetary requirements for the forthcoming year, in line with the proposed overall governmental budget. After the “vote”, the DoHC would distribute these specified budgets to the Health Boards and the ERHA. Funding was also allocated directly by DoHC to voluntary hospitals (usually non-profit-making hospitals with religious links) and other service delivery agencies in the voluntary sector to fund some services for the populations of the individual Health Boards (with the exception of some services in Cork). The ERHA separately entered directly into agreements with these agencies.

A major change occurred in 2005, when the HSE took over responsibility from the DoHC, not only for managing the health budget, but also for delivering services for the entire public health system. The review of the Commission on Financial Management and Health Systems chaired by Niamh Brennan had previously recommended that all resource allocation decisions be made within a new HSE and that new budgetary and accounting procedures be enacted (Brennan, 2003). Major weaknesses noted in her report included lack of information on the individual patient costs for treating patients across different settings or in different areas, making it difficult to look at the relative cost–effectiveness of delivering services across the country, or to plan the mix and location of services. The Brennan report had also noted that individual consultants were not accountable for financial management and, therefore, had no incentives to manage their activities in a cost-effective manner.

Since 2006 there have been three votes in *Dáil Éireann* with regard to health and children in the annual budget. One was for the HSE, which includes a specified level of funding for each of the eight HSE and voluntary hospital groups that make up the NHO Networks, as well as for primary care services. While some capital expenditure is detailed in the HSE budget each year, much of the capital budget is linked to the objectives outlined in the 6-year NDP current at the time of writing (see later). Most of the remaining health-related budget is contained within the budget of the Office of the MoHC

(see Table 3.4), including funding for the NTPF, a scheme which allows individuals who have been waiting more than three months for elective treatment to be treated in the private sector at the State's expense. The third vote covers the Office of the Minister for Children and largely covers social welfare, early intervention and child care programmes.

Some commentators had suggested that the new Health Act that established the HSE in 2004 might have invoked a change in the negotiation process for budget setting, with a direct role for the HSE in this process (Tussing & Wren, 2006). Previously, the DoHC had been responsible for negotiating the budget with the DoF, and while the Health Boards had no formal input into this process, informal contact with the DoHC was the norm. Amendments in the Health Act of 2007 clarified the situation, confirming that the Minister of Health still retains responsibility for negotiating the overall health budget. However, HSE minutes indicate that – as with the Health Boards – submissions to inform the negotiation process are prepared for the DoHC several weeks before the budget is finalized (HSE, 2006e). After funds are allocated in the vote, within 21 days the HSE must submit a National Service Plan (NSP) to the MoHC. This sets out how funding from the HSE budget vote will be allocated to health and personal social services, inter alia providing information on each health and social care service funded during the Plan's duration. The Plan must also reflect the priorities of the Minister of Health on service development. The Minister must approve the Plan, may issue directions in relation to the Plan, and may impose amendments. Once approved, the Plan must be laid before both Houses of the *Oireachtas* and be published.

The MoHC, as head of the DoHC, retains primary responsibility for the development of government health policy and strategic direction of the health system, including making provision for sufficient resources for services in the annual budget and ensuring that government policy and resources are reflected in the plans of the HSE and in their delivery. The DoHC may, for instance, indicate that there should be spending on specific activities meeting overall health strategy priorities. Previous examples of such priorities have included a one-off contribution to the improvement of neonatal care following an all-island study carried out as part of the North–South cooperation measures, funds linked to the National Cancer Strategy to address service pressures in oncology or to deal with extra pressures on older people's services (including additional funds for the nursing home subvention scheme), along with palliative care and the “Winter Initiative”.

One important consequence of the HSE having its own separate vote, setting out a detailed budget for health spending, is that there is limited scope for financial flexibility in the way that the budget is managed. In the past, while the onus was on Health Boards to keep expenditure within the level set out in their

budgets, it was possible to request additional funds from the DoHC in a range of very limited circumstances, which included, for example, unanticipated national pay awards, unforeseen demand on the Drugs Payment Scheme, professional indemnity insurance and the cost of proceedings of Tribunal Inquiries.¹⁶ The DoHC was also able to hold back funds from the Health Boards and ERHA, and then allocate them to those areas where there has been an overspend. The HSE does not have the same flexibility to move funds easily between budget headings (although it does maintain contingency funding), meaning that publicly owned hospitals have fixed budgets.

This need to balance the budget can cause difficulties; in late 2007 a Financial Breakeven Strategy was put in place by the HSE to ensure break-even on the 2007 vote. This included cost-containment measures “designed to ensure that all non-direct costs/discretionary spending is minimized to year end and that existing front-line services will continue to be delivered in line with Service Plan targets” (HSE, 2007e). These measures included the temporary suspension of recruitment in September 2007. Given the complexities involved in managing the health services and the obligation on the HSE to provide the most effective services possible within the scope of approved resources, some adjustment to service objectives may be required as the year progresses in order to remain within the budget. The HSE delivers the most effective quantity and quality of services possible within its approved allocation and after year end, the HSE reports on how its allocation was actually spent and what was actually achieved, explaining (and if necessary justifying) departures from the initial service plan. It should be noted that any underspend or additional revenue generated by HSE hospitals in the financial year must be returned to the Exchequer. These restrictions on financing, however, do not apply to the publicly funded voluntary hospitals, which remain free to retain additional revenue and any efficiency savings made. It also remains the case that the fixed per diem charge for the treatment of private patients only covers about half the cost of all services provided to these patients (Brennan, 2003). Effectively, this implies that the State is providing a subsidy for services provided to private patients within public facilities.

Value-for-money targets

The annual HSE budget also takes account of value-for-money targets. The Social Partnership Strategy 2003–2005, “Sustaining Progress” (Government of Ireland, 2004a), focused on a range of issues required to make the economy more competitive, environmentally sustainable, efficient

¹⁶ Tribunals are public inquiries led by a judge which look into adverse events, alleged malpractice and inappropriate actions in the public sector.

and socially acceptable. The Strategy was agreed by a large number of parties, including the Government, trade unions, employers' associations, religious bodies and the National Women's Council. One of the key objectives was that public expenditure should be managed in a cost-effective way, with a focus on key priorities and value for money. Value-for-money examinations are carried out by the Comptroller and Auditor General (C&AG) and aim to establish whether resources have been acquired, used or disposed of economically and efficiently. Examinations can also investigate whether public bodies have appropriate systems, practices and procedures for evaluating the effectiveness of their activities. From 2004, value-for-money savings targets have been set and deducted from the final budgets.

Under the DoF Value for Money and Policy Review Initiative announced in 2006, a number of health topics were selected for review in the period 2006–2008 using established evaluation criteria for Value for Money and Policy Reviews. These are: relevance, efficiency, effectiveness, impact and continued relevance, and they were represented in the detailed terms of reference. A further cycle of such reviews will take place in the period 2009–2011. The new round will concentrate more on the effectiveness of the delivery of outputs and outcomes of policies, and not just on efficiency issues.

In addition, as part of 2009 Budget, the MoHC announced details of a Multi-Annual HSE Value For Money Programme, in acknowledgement of the need for a multiannual strategic approach to driving value and productivity. This is detailed in the 2009 HSE NSP.

3.5 Purchasing and purchaser–provider relationships

The majority of the budget for the HSE vote is not determined using any resource allocation formula, but instead seeks to estimate future expenditure, taking account of the previous year's actual expenditure pattern, national agreements on salaries, demographic changes, value-for-money targets and other factors, such as inflation and anticipated revenue from charges levied to public and private patients. Thus, the substantive basis of the budget remains historical with fixed allocations made to public and voluntary hospitals. However, a small, but increasing proportion of the budgets of some acute hospitals are adjusted on the basis of case mix and volume of activity (see later). Payments to primary care services provided to Medical Card holders are also made on a capitation basis (see Section 3.6 *Payment mechanisms for health system personnel*).

The case-mix programme

As a means of better analysing and developing a resource allocation system reflecting the volume of services provided, the DoHC formally established a National Case-Mix project in June 1991, whereby patients in acute care hospitals are classified using diagnosis-related groups (DRGs). From 1993, a case-mix performance-related element was introduced into acute hospital budget allocations. The 2001 Health Strategy recognized the need to link funding more closely with performance and service outcomes. Expansion of the case-mix system was seen as a way of moving towards a system where funding is based on service outcomes and considers value for money. The programme has expanded incrementally. In 2007 the 37 largest acute care hospitals – responsible for 95% of acute hospital admissions nationally – had 50% of their budgets allocated on the basis of “peer group-related performance” in relation to 2006 costs and activity, increasing from 20% in 2004 (Casemix Unit, 2003; Casemix Unit, 2005).

Data on activity are taken from the Hospital In-Patient Enquiry (HIPE) system. This is the principal source of national data on discharges from acute public hospitals in Ireland. It is a computer-based health information system which collects clinical and administrative data on deaths and discharges from the 61 public and 2 private hospitals. Management of the system has been contracted by DoHC to the ESRI where the HIPE and National Perinatal Reporting Unit is responsible for overseeing the collection, coding, input, quality, processing and reporting of data from participating hospitals. The data collected are based around the minimum basic data set (MBDS) recommended by the EU in 1982. Morbidity data are coded in international classification of diseases (ICD) ICD-10-AM (4th ed.) and then “grouped” into 665 DRGs.

Consultant-driven, patient-related cost data are then taken from the HIPE for 37 participating hospitals and allocated to 13 cost “buckets” (theatre, imaging, pharmaceuticals, and so on). Patient-related cost and activity data are merged to give a cost per case for each DRG in each hospital and nationally. Hospitals are benchmarked against their peers and those with costs lower than the national mean gain funding, while those with costs higher than the mean lose funding. One of the limitations addressed in a review of the case-mix system was day cases; many of these had been excluded from analysis, as the list for included cases has not been updated since 1997. For instance, medical non-surgical cases have not been included and, moreover, the reimbursement rate for some cases appears to be insufficient (Casemix Unit, 2004). One consequence was an increase in the blending rate, from 10% to 20% for day cases in the case-mix programme for the 2005 allocations.

In 2005, despite the fact that 30% of the budget was performance related, only €7.5 million was required to be redistributed out of a total of €3 billion in expenditure – indicating that hospital performance is relatively similar. In the same way, for the adjustment made in 2006, where 40% of allocation was based on peer group-related performance, just €7.44 million was redistributed, with 14 of the 37 hospitals receiving net gains. The biggest gain was made by Cork University Hospital (€1.9 million) and the most substantial “loss” by Mayo General Hospital (€1.25 million) (DoHC, 2006a).

The system is relatively unique internationally, in that it is the peer group of hospitals which sets the “mean” for performance targets and the system is budget neutral, that is, any funding deducted from hospitals is redistributed to those whose performance indicates that the additional funding will be used to good effect. It is hoped that the case-mix system might “be applied to all acute hospital encounters and all acute and sub-acute hospitals by the end of the decade” (Grealy, 2004). Modernization of the case-mix system has already included developing links with the Australian case-mix system, which the Australian Department of Health and Ageing has viewed as being “the most open, transparent, government-sponsored system internationally, with significant clinical involvement” (DoHC, 2004d).

In parallel with development of the case-mix system, steps also have been taken at the individual hospital level to improve financial management. For example, the Adelaide and Meath Hospital (incorporating the National Children’s Hospital) introduced a financial management system to provide complete user-specific information on financial, budgetary, costing and statistical systems while allowing for both clinical and non clinical performance measurement. The system sought to transform financial management into a dynamic process where hospital management teams are enabled and empowered by the delegation of decision-making to the point at which a service is provided to the patient. It was praised by the MoHC in October 2004 as helping to focus on patient-centred delivery (DoHC, 2004c).

Capital projects

Capital expenditure is guided by the NDP 2007–2013 (Government of Ireland, 2007a), which is managed by the DoF. In total, more than €184 billion is to be invested in the nation’s infrastructure. This includes €4.9 for health projects, of which €4.5 billion comes direct from Exchequer funds, with €415 from public–private partnerships. The plan includes €2.1 billion in funding to help provide the infrastructure for 500 Primary Care Teams by 2011, as well as the extension of community care services to help older people remain independent for as long as possible. A total of €2.4 billion is to

be invested in “hospital infrastructure, including A&E units; acute hospital bed capacity; infection control standards of care and efficiency; and (co-)location of private hospital facilities on public hospital sites to free up to 1000 additional public hospital beds and to maximize the potential use of public hospital sites. Major projects will also include a new National Children’s Hospital in Dublin (Government of Ireland, 2007a). Improving access to services in cross-border regions is also highlighted as a key area of focus. A total of €490 million has been earmarked for investment in improving ICT within the health system.

Within the separate social inclusion stream of the NDP, a further €9.7 billion will be invested in the development of living-at-home programmes (€4.7 billion) and improvements in residential care (€5 billion) for older people. “Living at home” home care packages will deliver a wide range of services based on existing pilot schemes, including nursing services, home care attendants, home helps and therapists, including physiotherapists and occupational therapists. Respite/day care services will be extended to evenings and weekends. The previous 2000–2006 NDP allocated €3.3 billion for health-related capital investment, including an additional 1300 inpatient and day treatment places and investment in acute mental health wards in general hospitals as part of the shift away from long-stay psychiatric hospitals.

The HSE has drawn up a capital expenditure plan for the period 2006–2010, taking account of the allocation from the NDP included in the annual vote, plus receipts from the proceeds of capital sales of €36 million to be used for mental health capital projects. A total of €3.48 billion is being spent over this period (HSE, 2006g). The HSE is also developing appropriate systems for assessment of ongoing capital requirements and the monitoring and control of capital expenditure. An annual capital plan has been prepared and sent for approval by the DoHC (HSE, 2006e). The Brennan Commission in 2003 had previously highlighted the problem of maintaining contract commitments by the then Health Boards to unapproved capital expenditure projects, which amounted to €115 million (Brennan, 2003). Consequently, procedures have been tightened.

3.6 Payment mechanisms for health system personnel

Payment of general practitioners

GPs are self-employed, working in single practices or some form of joint practice or cooperative arrangement. While there are some who work exclusively either in the public or private sphere, the majority of GPs treat both private and public sector patients. Medical Card and GP Visit Card holders must register with a specific GP; most of the remaining population do not need to register as they can seek services from any GP, subject to payment of a fee.

Those GPs providing public sector services enter into a contract agreement with the National Shared Services PCRS (located within the HSE) with fees based primarily on weighted capitation, plus additional fees for special services, such as for out-of-hours home visits and administering influenza vaccinations. In 2006, capitation fees ranged from €49.13 for a male between the ages of 5 and 15 years living within three miles of the practice to €239.84 for a woman aged 70 years living over 10 miles from the practice (HSE, 2007g). One anomaly in the capitation fee schedule is the much higher fee set for those aged over 70 years who have been issued with a Medical Card since 2001 (having previously not qualified because their income levels were too high). In 2006 this was €627.13, more than four times higher than the fee received for a 70-year-old man already in receipt of a Medical Card living within three miles of the practice. In effect, this could mean that practices in more affluent areas of the country will benefit much more substantially from the extension of Medical Card coverage than practices in more deprived areas (see also Chapter 6 *Provision of services*).

Some GPs working solely in the private sector may enter into contracts with the HSE to provide publicly funded care for their private patients when they reach the age of 70 or if patients are infected with hepatitis C, as well as – more generally – providing public maternity, infant and vaccination services on behalf of the HSE. GPs are paid on a fee-for-service basis for private patients. Private insurers will refund some expenditure on primary care/outpatient services after payment of a deductible, or in the case of fees for GP consultations, the insurers will make a fixed cash payment to the patient, typically between €20 and €30,¹⁷ with the full consultation fee perhaps being between €60 and €80.

¹⁷ The VHI operates schemes whereby, after an excess of €1 has been paid, they will pay €20 or €30; BUPA Ireland (later healthcare) will pay €20 (subject to an excess of up to €250, depending on the scheme) or will cover half of all expenses up to a fixed ceiling in a year (without excess).

Since 1993, GPs providing services under the former GMS scheme (now PCRS), had been able to participate in an Indicative Drug Target Savings Scheme which was intended to contain the cost of pharmaceutical prescriptions. GPs were issued with an annual prescribing target determined on the basis of national practice patterns, modified to take account of demographic characteristics prevailing within each GP's practice. Any savings made as a result of achieving the target were divided so that 50% would go to individual GPs and 50% to the local GP unit of the HSE. All savings were to be invested in the development of general practice. The scheme is suspended at the time of writing, following an independent review reporting that just 2.75 % of the 2200 GPs who look after patients with Medical Cards came in under target on their prescribing budget. The savings for the year fell to €670 462, well below those achieved when the scheme first commenced. This reflects a decrease in the use of generic prescribing (Barry, 2007). Speaking to the Irish Times, a HSE spokesman stated that the HSE and the Irish Medical Organisation (IMO) "are both actively reviewing some of the initial findings already made by the review with a view to achieving cost-effective prescribing among GPs" (Houston, 2007).

Payment of pharmacists

Retail pharmacists receive from the PCRS a flat-rate dispensing fee, plus reimbursement for the costs of medicine, for Medical Card holders and also for residents from EEA countries. Pharmacists also negotiate discounts with wholesalers for medicines they provide under the Medical Card Scheme. Non-Medical Card holders receiving pharmaceuticals under the Drugs Payment Scheme pay up to €90 per month to pharmacists who are entitled to a dispensing fee and a 50% mark-up on the costs of the medicines prescribed. The Brennan Commission raised concerns about the difference in costs between the Medical Card and Drugs Payment Schemes; pharmacists have no incentives to contain costs for Drugs Payment Scheme patients. The costs per claimant for Medical Card holders also vary across regions. In 2006, costs of the GMS scheme ranged from €674.46 in the North Western HSE Area to €894.65 in the Midland HSE Area (HSE, 2007g). The Commission was particularly concerned that no systematic review to examine differences in costs was being conducted.

Hospital consultants

Consultants (specialists) in public and voluntary hospitals are employed under the "Common Contract for Medical Consultants" and are paid on a salaried basis. Consultants operating purely in the private sector are paid on a fee-for-service basis. The majority of hospital consultants in public hospitals

(over 90%) also have private practice privileges and are paid on a fee-for-service basis for treatment of private patients. Fees for private patients paid out by the three principal health insurers are set out in fee schedules. Inpatient consultations are almost always covered by private health insurance; outpatient consultations may require a co-payment from the patient, depending on their insurance package. Private income for consultants is substantial: as far back as 2002, private earnings from insurers were estimated to be €192.5 million or an average gross fee income of €127 000 per annum per consultant (Brennan, 2003).

The mixed method of funding consultants had led to several inefficiencies and perverse incentive structures within the health system. These fundamental weaknesses in the Common Contract were referred to by the Brennan Commission (Brennan, 2003) as meaning that “resource management responsibilities are not being systematically and uniformly discharged because of the absence of appropriate mechanisms for planning outputs and budgets and monitoring expenditure”. They noted that:

- consultants are not required to account for the cost of resources consumed as a direct consequence of their clinical decisions;
- existing arrangements allow consultants to pursue both public and private practices (including during the 33-hour scheduled commitment under the consultants’ public contract); and
- the mixing of public and private treatments also restricts the time available to clinicians to pursue resource management issues.

A fundamental problem in the allocation of consultants’ time has been the lack of an explicit requirement for consultants to personally manage patients; instead they can delegate care to non-consultant hospital doctors (NCHDs) under their supervision. The Brennan Commission recommended that the Common Contract should explicitly recognize the responsibility of consultants to manage resources to which they are entitled in order to conduct their practice within agreed budgets at department, specialty and individual consultant levels. It also recommended that there should be core hours of attendance, as well as active management by consultants of resource allocation against agreed practice, specialty and department service plans and budgets. A further recommendation was that where there are competing public and private practice demands on consultants’ time and resources, the former should always take priority.

Following the Brennan Commission report in 2003, protracted negotiations to try and reform the Consultants’ Common Contract took place for nearly two years and broke down on several occasions. An independent chairman, Mark Connaughton, brought proposals to restart the talks in June 2006, but it was only in September 2007 that full talks finally resumed. After further negotiations

and delays, contract proposals were finally accepted by the memberships of the Irish Hospital Consultants Association (IHCA) and IMO in May and June 2008, respectively. The new system features three types of contract. Under a Type A contract, consultants are paid a public salary (up to €240 000 per annum) and have no possibility of earning private fee income, while Type B contracts (up to €220 000 per annum) allow consultants to engage in privately remunerated professional medical practice on public and co-located hospital campuses, but state that at least 80% of their clinical/patient output must be public patients. Type C contracts (up to €175 000 per annum) will apply only in exceptional situations and will allow the appointee to treat private patients outside the public hospital campus. There are also provisions for additional payments for weekend working, being on call, and so on.

Other key features of the agreement include a standard working week of 37 hours for all consultants, with an extended working day (8am–8pm), Monday to Friday. As a senior professional employee, a consultant may also be required to work up to five hours structured overtime on Saturdays and Sundays in order to expand access for patients/clients to services provided by consultants. Consultants are to be led and managed by fellow clinicians. This will entail the appointment of Clinical Directors to manage clinical services, budgets and lead the development of services for patients. As part of their contract they will now work in teams to deliver consultant-provided (rather than consultant-led) services to patients. A contract implementation group is to oversee the implementation of new contractual arrangements. In future, new appointees to consultant posts will have to be eligible for entry onto the Register of Medical Specialists maintained by the Medical Council or already be entered onto that Register.

Consultants are not obliged to switch to one of the new contracts, but the new salaries compare favourably with those under the former system. As of March 2008, the maximum basic salary under the former contract for those consultants who limit private practice to public hospitals only (Category I)¹⁸ – including all psychiatrists, geriatricians and consultants in palliative care – was €186 548 (DoHC, 2008a). Category II consultants at best had an annual salary of €166 516, while academic consultants earn significantly more: pay scales for Category I consultants who are professors, lecturers and college lecturers range between €199 811 and €240 085.

¹⁸ Category I consultants are also required to restrict their private practice to public hospitals only, whereas Category II consultants can also engage in off-site private practice, for example in purely private hospitals.

Other health sector personnel

The majority of other hospital and primary care staff, including NCHDs, nurses and midwives working in the public sector, are salaried. The HSE Employers Agency negotiates on behalf of all public health service employers with trade unions and other bodies regarding pay and conditions across the health service. It represents all publicly funded health service employers. The Consolidated Salary Scales are published by the DoHC to reflect national pay increases set out in the relevant national social partnership agreements (“Towards 2016” at the time of writing) and other special pay increases, such as benchmarking and public sector review body increases. They cover all nationally agreed health sector grades including medical, dental, nursing, social care, support and administrative grades. The scales are highly detailed and include increments for long service, geographical location and qualifications (DoHC, 2007b).

At the time of writing, starting salaries for student nurses are approximately €24 059, while senior staff nurses can earn up to €46 515, nurse clinical managers up to €62 502, nurse tutors up to €63 554, advanced nurse practitioners up to €70 173 and nursing directors up to €87 128. Salaries for NCHDs include those of House Officers up to €55 561, €61 282 for Registrars and €81 399 for Senior Registrars. Social worker salaries range between €36 215 for a junior team member and €66 033 for a social work team leader.

4 Regulation and planning

4.1 Regulation

Overall responsibility for the health care system lies with the Government, under the direction of the MoHC in accordance with legislation enacted in the *Oireachtas* (legislature). The Minister is responsible for the strategic development and overall organization of the health service, including the setting of statutory regulations and orders. The DoHC provides support to the Minister and the Government by advising on the strategic development of the health system, evaluating the performance of the health system and working across sectors to promote health and well-being. Ultimately, the DoHC is charged with the responsibility of holding the health care delivery system accountable for its performance.

Since 2005 the HSE has had full operational and financial responsibility for managing the public health system. Each year an annual national health service plan is prepared by the HSE. This must be approved by the MoHC within 21 days and is guided by the 2001 Health Strategy, legislative acts and government priorities. This detailed plan, running to almost 200 pages for 2008, sets out how the health budget will be allocated to hospitals, primary care and other services, and also indicates measures put in place to monitor and control implementation (HSE, 2007f). This includes a ceiling on employment levels within the health system.

Historically, issues of service quality and quality initiatives have been ad hoc and fragmented. Health had been a relatively low priority on the political agenda during the 1980s and early 1990s, where economic recovery was the key issue. It was only with the issue of the contamination of blood products that such concerns came to prominence both on the political agenda and in

the public consciousness. More recent high-profile inquiries, such as that at Our Lady of Lourdes Hospital in Drogheda, highlight the need for effective surveillance and monitoring systems.

For the public sector, the independent HIQA, which came into being in 2007, is responsible for setting and monitoring compliance with standards, monitoring health care quality, providing programmes of accreditation for independent health care providers, and conducting investigations where there may have been serious risks to the safety of patients or staff within the health (and social) care system.

Regulation of the private insurance market

As indicated in Chapter 2 *Organizational structure* and Chapter 3 *Financing*, voluntary health insurance plays an important role in health care and over half of the Irish population are covered by some form of private insurance scheme. The three open enrolment insurers, together with the closed enrolment schemes, are all monitored by the HIA. This was established in February 2001 under the Health Insurance Act of 1994 to regulate the private insurance market following the enactment of the European Third Non-Life Insurance Directive.

With an income of €2.01 million in 2007, raised through a levy of 0.14% of all basic health insurance premiums paid to either commercial or restricted undertakings in Ireland (HIA, 2008), the HIA has a number of functions. These include evaluation and analysis of returns made under risk-equalization regulations, as well as more general developments in the private health insurance market. The HIA makes recommendations on risk equalization between insurers, maintains a register of insurers, and monitors all schemes to ensure that they comply with Minimum Benefit Regulations. The HIA also assists consumers of health insurance with complaints and puts information on different insurance products into the public domain.

Quality assurance and accreditation

Awareness of quality concerns in the health system

The 2001 Health Strategy recognized that there was a need for a more comprehensive and coordinated national and local programmes. The strategy identified a number of weaknesses in the system including:

- inadequate and poorly integrated information systems to support the measurement of inputs and outcomes on a quantitative or qualitative basis within the health system;

- insufficient investment in the development of intellectual and organizational capacity to carry out comprehensive research and analysis of policy options;
- lack of an overriding national structure responsible for the development, dissemination and evaluation of the impact of agreed national quality protocols and standards;
- a lack of mechanisms between employers and professional regulatory bodies for identifying the scope of – and boundaries between – the role of the regulators to assure individual competence, as well as that of the employers to manage performance at work; and
- concerns about a “blame culture” in which quality audits and evaluations make individual practitioners feel isolated and vulnerable.

At the same time, public and political awareness of quality issues in health care had been heightened as a result of tragic blood transfusion scandals, when it transpired that more than a thousand haemophiliacs, pregnant women and others had been infected with HIV and with hepatitis C. This led to the establishment of the high-profile Finlay and Lindsay tribunals, which reported their findings in 1997 and 2002, respectively (Finlay, 1997; Lindsay, 2002).

Quality assurance mechanisms

HIQA was established in part as a response to the weakness in the system. It is responsible for setting national standards for the provision of health and social care services, except Mental Health Services. These standards incorporate minimum standards for quality and safety for a given service, as well as developmental standards to support moving towards excellence. They are being developed by expert working groups based on evidence and best practice within Ireland and internationally. Detailed standards being implemented at the time of writing include those for: independent assessment of needs for people with physical and intellectual disabilities, symptomatic breast disease, residential care settings for older people, infection prevention and control and hygiene.

Multidisciplinary teams of professional and lay reviewers monitor whether standards are being met by undertaking site visits. They also work with health care organizations to identify areas for improvement and recognize good practice. Reports of Quality Assurance Reviews are published on HIQA’s web site, together with an action plan from the service provider outlining a programme to address the recommendations of the report.

HIQA recently organized the Hygiene Services Quality Review, the most comprehensive review of its kind ever undertaken in Ireland (HIQA, 2007c). A series of unannounced visits, which were conducted by HIQA's assessors, focused on corporate management, service delivery and included interviews with staff, managers, patients and visitors. The Review set new benchmarks for hospitals to aim for, on behalf of their patients. Individual detailed reports have been provided to each hospital to inform them of areas of strength and areas for further improvement. Hospitals were rated as being "very good", "good", "fair" or "poor". No hospital was rated as "very good" and seven (14%) were rated as "good". A total of 35 hospitals (68%) achieved a "fair" rating, while nine (18%) hospitals were rated as "poor". The Review concluded that hospitals can and should do better in terms of improving hygiene.

HIQA also has responsibility for most accreditation mechanisms for publicly funded health care services in Ireland. The former **Irish Health Services Accreditation Board** has been subsumed into HIQA. Under this board two accreditation scheme frameworks have been developed in consultation with international experts, for acute and palliative care, respectively – each with three different grades of accreditation. While participation in the accreditation scheme is voluntary, over 95% of all acute care and 33% of all palliative care organizations have applied for accreditation at the time of writing (HIQA, 2007a). Organizations which receive accreditation status must demonstrate that they have an extensive organization-wide risk-management approach in order to maximize patient safety; make use of a quality system which actively seeks to identify problems within the provision of care and rectify them; and be predominantly compliant with all key aspects of health service provision identified in the two scheme frameworks (Irish Health Services Accreditation Board, 2004). Each completed accreditation sets out strengths and areas for improvement. It also specifies priority actions to be taken; these can be the subject of follow-up inspections. The **Social Services Inspectorate**, operating since 1999, has also been subsumed within HIQA. It is responsible for registering and inspecting all residential services for older people, people with disabilities and children in need of care and protection.

Until 2005 the *Comhairle na nOspidéal* (The Hospital Council) was a statutory body set up under the Health Act of 1970. Its main functions were to regulate the number and type of appointments for consultant medical staff in hospitals, and to specify qualifications for such appointments. It also advised the MoHC on matters relating to the organization and operation of hospital services and published reports relating to such services. The *Comhairle* and its functions were subsumed into the HSE.

Regulation of health care professionals

In terms of regulating health care professionals, a number of professional associations and statutory bodies play a role in Ireland, largely maintaining registers, as well as running and/or accrediting training and education.

Since 1979, the **Medical Council** (*Comhairle na nDoctuirí Leighis*) has been responsible for the standards of education and training for undergraduate and postgraduate medical students. It also maintains the register of doctors, sets professional standards and implements disciplinary procedures. It is funded through annual registration fees. Since 1995 the Medical Council has undertaken annual inspections of medical schools. All doctors on the specialist registers of the Medical Council must participate in 50 hours of continuing medical education/continuing professional development every year, or 250 hours over a 5-year period. The scheme is to be extended to include all doctors on the general register and they will be asked to demonstrate that at least 25 hours of continuing medical education/continuing professional development have been participated in, for the purposes of clinical audit or peer review processes. The **Irish College of General Practitioners (ICGP)**, founded in 1984, is the recognized body for the accreditation of specialist training in general practice in Ireland and is recognized by the Medical Council and the Postgraduate Medical and Dental Board as the representative academic body for the specialty of general practice.

An Bord Altranais (Nursing Board), with a budget of more than €5.8 million in 2005 raised largely through retention and registration, education and examination fees, has legislative responsibility under the 1985 Nurses Act for the registration of nurses in Ireland (An Bord Altranais, 2006a). This includes a number of different disciplines: general, midwives, psychiatric, sick children, public health, intellectual disability and tutors. It also provides verification of qualifications to allow Irish nurses to work outside the country. The Board is required to assess, every five years, the adequacy and suitability, effectiveness and efficiency of hospitals and institutions for nurse training, and to ensure that all Board regulations and European Directives are complied with. The Board also approves a number of post-registration education courses for continuing medical education. The Government gave its approval for the publication of the draft heads of a new Nurses and Midwives Bill in November 2007 to facilitate a public consultation process. The purpose of the Bill will be to modernize the regulatory framework for nurses and midwives and to enhance patient safety and the protection of the public. The Bill will be consistent with the Government's commitment to strengthen and expand the provisions for the statutory regulation of health professionals.

Under the Pharmacy Act of 2007, a new **Pharmaceutical Society of Ireland** was established, replacing the old society that dated back to 1875 (see Chapter 5 *Physical and human resources*). The new society maintains the register of pharmacists and pharmacies in Ireland, is responsible for the assessing and accrediting degree courses, inspecting pharmacies, drawing up codes of conduct and quality assurance, processing complaints and acting as the competent authority for the recognition of qualifications outside of Ireland.

Under the Dentists Act of 1985 the **Dental Council** (*An Comhairle Fiacloireachta*) is responsible for the registration of dentists and accreditation of courses. The **Opticians Board** (**Bord na Radharcmhastoiry**) fulfils a similar role for ophthalmic and dispensing opticians. Under the 1956 Act it also regulates the prescribing, dispensing of prescriptions and sales of spectacles. Set up in 2000, following the 1993 review of the Ambulance Service, the **Pre-Hospital Emergency Care Council** is responsible for the accrediting institutions training emergency medical technicians, while the **National Council for the Professional Development of Nursing and Midwifery**, set up in 1999, has the same role for specialist postgraduate nursing/midwifery courses. Since 1995 the **National Social Work Qualifications Board** accredits training courses and validates international qualifications in social work.

The **Health and Social Care Professionals Act 2005** provides for the establishment of a system of statutory registration for the following 12 health and social care professionals: clinical biochemists, dieticians, medical scientists, occupational therapists, orthoptists, physiotherapists, podiatrists, psychologists, radiographers, social care workers, social workers, and speech and language therapists. This new system of statutory registration will apply to the 12 professions regardless of whether they work in the public or private sectors or are self-employed, and is the first time that fitness-to-practise procedures will be put in place for these professionals on a statutory basis.

The **Health and Social Care Professionals Council** now has overall responsibility for the regulatory system and a committee structure to deal with disciplinary matters. There is to be a registration board for each of the professions to be registered, with administrative support to be provided by the Council. The Council was launched by the MoHC in March 2007 and has 25 members, including the Chairperson. A suitable organizational structure is being put in place and it is hoped to have some of the registration boards in place by the end of 2008.

Recent reform: the Medical Practitioners Act of 2007

The new Medical Practitioners Act of 2007 will make continuing professional development and education compulsory under the auspices of the Medical Council.

It will also ensure that competence assurance will be given a statutory basis. This new legislation is intended to reduce the risk of events, such as that which took place at Our Lady of Lourdes Hospital in Drogheda, from being repeated. Serious gaps in monitoring and surveillance structures were highlighted in an inquiry into peripartum hysterectomies at Our Lady of Lourdes Hospital. This inquiry had been established by the Government in 2004 following the decision of the Medical Council to remove Dr Michael Neary from the Register of Medical Practitioners after finding him guilty of professional misconduct. The Inquiry examined how the rate of peripartum hysterectomies performed at the Lourdes Hospital in Drogheda from 1974 to 1998 compared with that in other hospitals. It also looked at how existing monitoring and reporting systems functioned and what had been done in recent years to improve quality control procedures.

The report concluded that the rate of 188 peripartum hysterectomies during the 25-year period was “truly shocking”. The rate of caesarian hystorectomies at the hospital was 1 per 37 caesarian sections compared with between 1 per 300 and 1 per 254 elsewhere. No concerns were raised with the Health Board about this until 1998; moreover, an unidentified person or persons had undertaken a deliberate, careful and systematic removal of certain historical records, together with master (key) cards and patient charts. The report concluded that the isolation of the unit played a role in the lack of awareness about what constituted good practice and went on to say that any isolated institution which fails to have in place a process of outcome review by peers and benchmark comparators could produce a similar outcome to that which occurred in the Lourdes Hospital.

Mental health

Mental health is the only area of the health care system that does not fall under the auspices of HIQA. Instead, responsibility rests with the Mental Health Commission (MHC), a statutory body set up under the Mental Health Act of 2001 and launched in April 2002. Its primary functions are to “promote, encourage and foster the establishment of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under the Act” (MHC, 2003). It includes an Inspectorate of Mental Health Services (replacing the former Inspectorate of Mental Hospitals) which legally must visit and approve annually all mental health service facilities. This can include unannounced visits to facilities where the Inspectorate previously has had concerns. The MHC also runs mental health tribunals which review all decisions on the involuntary detention of individuals. The MHC has 13 members; as well as health service

professionals it must also include a social worker, a lawyer, three individuals from voluntary bodies – of which two must have or have had a mental illness – and a member of the general public.

In assessing mental health services, the MHC makes use of a quality framework that it has developed in consultation with stakeholders (MHC, 2006). This is applicable to all mental health services, including services for children and adolescents, adults, older people, people with learning disabilities and mental health problems and the forensic mental health services. It applies in all settings, whether at home, in the community or in institutional settings. There are eight themes within the framework:

1. provision of a holistic, seamless service and full continuum of care provided by a multidisciplinary team;
2. respectful, empathetic relationships between people using the mental health service and those providing them;
3. an empowering approach to service delivery;
4. a high-quality physical environment that promotes good health and upholds the security and safety of service users;
5. access to services;
6. family/chosen advocate involvement and support;
7. staff skills, expertise and morale; and
8. systematic evaluation and review of mental health services underpinned by best practice.

In total, 24 standards have been developed for these themes, with 14 initially implemented in 2007.

Complementary and alternative medicine practitioners

Following on from a commitment in the Health Strategy 2001, a report was prepared by the Institute of Public Administration which set out a number of the issues involved in the regulation of complementary practitioners (O'Sullivan, 2002). As a result, a National Working Group was established in 2003 to advise the Minister of Health on the regulation of complementary and alternative medicine (CAM) practitioners. The Report of the National Working Group on the Regulation of Complementary Therapists made a number of recommendations to strengthen the regulatory environment for complementary therapists, including improved voluntary self-regulation for the majority of therapies and statutory regulation for Acupuncturists, Traditional Chinese Medicine practitioners and Herbal practitioners (Garvey, 2006).

However, the group also found that the sector was fragmented and did not have governance structures. In response to the Report, it was decided that the DoHC would support greater voluntary self-regulation for all therapies in the first instance (DoHC, 2006i). Alongside the publication of the Report, an *Information guide for the public* was also launched. It offers guidance for members of the public when choosing to visit a complementary therapist. In line with the Report's recommendations, facilitated work days have been provided for a number of complementary therapy professional associations to develop and harmonize common basic standards of practice, education and training. In addition, the Higher Education and Training Awards Council is developing standards for complementary therapy education courses.

Regulation of medicines and medical products

Under the Irish Medicines Board Act of 1995 and in line with European Directives, the Board is responsible for the licensing of the manufacture, preparation, importation, distribution and sale of medicinal (and veterinary) products. Total income in 2006 was €20.12 million, of which €15.97 million was generated through fees (IMB, 2007a). Since 2001 the IMB has also been responsible for the surveillance of active implantable, *in vitro* diagnostic and general medical devices, coupled with self-regulation by manufacturers.

The IMB conducts inspections at sites of manufacture and distribution of medicines and by means of random sampling of products both pre and post authorization. It is also responsible for assessing the quality, safety and efficacy of products (and blood donation/testing), as well as investigating any adverse effects and reactions. The IMB is also the competent authority for the regulation of traditional herbal medicines. This is in line with EC Directive 2001/83/EC, transposed into Irish law in 2007. This legislation is designed to provide an appropriate legal framework for placing traditional herbal medicinal products on the market within the EC. It introduced a simplified registration scheme that gives traditional herbal medicinal products recognition and enhanced status, while aiming to protect public health (IMB, 2007b).

Advertising of medicinal products is governed by statutory regulations. The 2007 Medicinal Products (Control of Advertising) Regulations ban the advertising of products that do not have either market authorization or (in the case of herbal medicines) a certificate of traditional use. The regulations also ban the direct-to-consumer advertising of prescription-only medicines. There are also restrictions on the advertising and marketing of prescription pharmaceuticals to people qualified to prescribe or supply. These include a prohibition on the "supply, offer or promise to such persons of any gift, pecuniary advantage or benefit in kind, unless it is inexpensive and relevant to the practice

of medicine or pharmacy.” However, a reasonable level of hospitality may be offered at sales promotion events (Houses of the Oireachtas, 2007).

The HSE has established a National Corporate Pharmaceutical Unit to negotiate with industry regarding pharmaceutical prices. Prices for pharmaceuticals are governed by agreements between the HSE and Irish Association of Pharmaceutical Manufacturers of Ireland (APMI) and IPHA with the latest agreement coming into effect in September 2006 (see Section 6.6 *Pharmaceutical care*).

4.2 Planning and health information management

Developments in planning functions

As described earlier, primary responsibility for the development of health policy rests with the DoHC, while executive functions for service provision are the responsibility of the HSE. In some limited cases responsibility can rest with other agencies.

National Health Strategy

Until the creation of the HSE there was no national planning office for the health care system. A number of strategic planning documents guided service development, most notably the National Health Strategy, *Quality and Fairness – A Health System for You*, which set out 121 specific objectives for the health care system, intended to guide development and reform within the Irish health services over a period of 7–10 years (DoHC, 2001b).

The Strategy continued to develop the commitment to the principles of equity, quality and accountability which have underpinned previous Health Strategy statements, but with an additional focus on placing the patient at the centre of future reform. The reforms set out centred on six main areas: strengthening primary care provision, development of the acute hospital system, improved funding, better planning and training for the health care workforce, review of current health care structures, and improvement of health information systems.

Key proposals of the Health Strategy, *Quality and Fairness 2001*, included:

- the integration of primary care provision through support for the development of interdisciplinary teams;
- expansion of Medical Card income limits to enable more families to gain entitlement to a Medical Card;
- expanding acute hospital capacity by 3000 beds over 10 years;
- a commitment that, by the end of 2004, all public patients will be scheduled to commence treatment within a maximum of three months of referral;
- establishment of a National Hospitals Agency to undertake planning for hospital service provision and coordinate actions to reduce waiting lists;
- the establishment of HIQA to ensure service provision meets nationally agreed standards;
- continuation of tax-based funding for the health system; and
- audit of the functions and structures of all health agencies, including the DoHC.

Other strategy documents

The proposed new developments in the area of primary care put forward in the National Health Strategy were explored in more detail in a separate document *Primary care: A new direction* in 2001 (DoHC, 2001a). Starting with the establishment of a National Primary Care Task Force, a total of 20 actions were specified for the achievement of the strategy objectives over a 10-year period. These actions included the development of Primary Care Teams and networks, the preparation of needs assessments for these teams; improving information and communication infrastructure; piloting community-based diagnostic centres; improved integration of primary and secondary care; and the development of a quality assurance framework at the primary care level.

The commitment in the National Health Strategy to the development of an additional 3000 hospital beds over the next 10 years was further developed in a subsequent report, *Acute hospital bed capacity*, published in January 2002 (DoHC, 2002a). A number of national disease- and population-specific strategies have also been published, including the *Cardiovascular health strategy 1999*, *Traveller health national strategy 2002–2005* and the *National health promotion strategy 2002–2005* (DoHC, 1999a; DoHC, 2000; DoHC, 2002b).

An update on the 1984 national Mental Health Strategy, *Planning for the future* (Department of Health, 1984), was also produced following the completion of the work of the Expert Group on Mental Health Policy. The Expert Group published their report *A Vision for Change* early in 2006 (Expert Group on Mental Health Policy, 2006). The report adopts a holistic

approach to mental illness and recommends a multidisciplinary approach to addressing the many biological, environmental and psycho-social factors that contribute to poor mental health. Among its many recommendations on how services should be managed and organized in future is that all remaining long-stay mental hospitals in Ireland should be closed. The HSE has accepted this policy as being the driver for service change and modernization. An independently chaired implementation monitoring group, to oversee the implementation of the recommendations, was established in March 2006 (DoHC, 2006g).

A national strategy for action on suicide prevention, *Reach out*, was also launched in September 2005 (HSE, 2005d). The 10-year strategy sets out a range of actions to be taken by various governmental and nongovernmental agencies targeted at both the general population and specific high-risk groups.

The “Agreed Programme of Government” between coalition partners also continues to set out a number of specific objectives for the health system. In the latest agreement between Fianna Fáil, the Green Party and the Progressive Democrats in 2007, objectives for the health system include development of a National Strategy for Tackling Obesity, implementing a nationwide programme of personal health checks, further development of cancer services and further information on how funds in the NDP 2007–2013 will be used for health services (Fianna Fail, Green Party & Progressive Democrats, 2007).

Health system reform

In the report of the Commission on Financial Management and Control Systems in the Health Service, two major structural weaknesses in the health service were identified. First, that “no single institution or person” was responsible for the day-to-day management of the service as a single integrated national entity”, and second, that “there is an absence of clear accountability relating clinical and other budgets to output”. The consequences of these weaknesses were inadequate planning/costing, unapproved capital expenditure, unauthorized staff numbers, non-imposition of charges, accounting failings and poor record keeping (Brennan, 2003).

The creation of a single HSE, coupled with a revision of the structures and activities of the DoHC, were intended to improve both strategic planning and service delivery. In 2005 the HSE published its *Corporate plan* setting out its aims, objectives and strategic direction until 2008 (HSE, 2005b). In particular, the plan set out the response of the HSE to the National Health Strategy and took account of other national policies and priorities. The plan also sets out key action points and deliverables against which to measure performance. A new *Corporate plan*, covering the period 2008–2011, was approved by the Minister of Health in September 2008.

In the meantime, the DoHC published its *Statement of strategy 2005–2007* (DoHC, 2005e). This set out major strategic actions that the Department would undertake, including the strengthening of regulation and governance; a greater emphasis on evaluation and performance; reform of key contractual relationships, for instance with consultants and GPs; and the implementation of health-related actions within all aspects of public policy. A summary of key actions related to five high-level objectives is set out in Table 4.1. A detailed list of key actions and proposed legislation, together with performance indicators to monitor success, is also specified in the report.

Table 4.1 High-Level Objectives and specific actions for the Department of Health and Children, 2005–2007

High Level Objective	Specific actions from 2005 – 2007
<i>High performance</i>	Completing the reform of health structures and accountability arrangements, restructuring the Department, implementing the NHIS, agreeing new contracts with key health professionals and introducing new, as well as amending existing legislation, as part of a continuous process of reform.
<i>Responsive and appropriate care</i>	Overseeing specified priority service improvements in line with government policy and monitoring implementation, as well as focusing on developing policy frameworks, monitoring standards, evaluation and an emphasis on continuous improvement.
<i>Fair access</i>	Extending eligibility for Medical Cards, reviewing and amending current eligibility legislation, addressing waiting times for public patients and supporting the implementation of legislation for people with disabilities.
<i>Better health for everyone</i>	Embedding a “population health” approach to health policy within the Department and supporting its use in the health system as part of a “whole of Government” approach.
<i>Supporting wider government programmes and international health policy</i>	Working closely with other public agencies in pursuit of wider government policy and with the relevant bodies to represent Ireland’s interests in the formulation of health policy at international level.

Source: DoHC, 2005e

Note: NHIS: National Health Information Strategy

Capital planning

Capital expenditure is guided by the NDP 2007–2013 (Government of Ireland, 2007a) which is managed by the DoF. The HSE is responsible for the management of this budget and has drawn up a Capital Expenditure Plan for the period 2006–2010 (HSE, 2006g). The plan was drawn up by a Planning Group, including senior representation from the NHO, the PCCC Directorate, Estates and Finance. The Director of Estates has the authority to sanction, approve, procure and manage all projects and schemes, related contracts and

professional services within the agreed capital plan and budget and within a control framework. Systems for the assessment of ongoing capital requirements and the monitoring and control of capital expenditure are being developed by the HSE. An annual capital plan is also prepared, which is sent for approval to the DoHC (HSE, 2006e).

Staffing

Under Section 22 of the Health Act of 2004, the grades and number of employees in each grade within the HSE must be approved by the MoHC with the consent of the Minister of Finance. Since 2002 a ceiling on the number of employees in the public health service has been set by the DoF and is revised from time to time in consultation with the DoHC and the HSE. The actual number of staff employed in the health services is monitored against this ceiling under an employment control framework agreed with the HSE.

Local service planning

Before 2005, annual service plans were prepared by Health Boards in response to the letter of determination issued by the DoHC, which set out their budget for the year. These plans set out the services to be delivered within this budget during the year. Service plans and annual reports were then drawn up in line with national strategies. Since 2005, in accordance with the Health Act of 2004, the HSE has been responsible for service planning and the allocation of resources, although it must stick to the budgets set out in the annual budgetary vote (see Chapter 3 *Financing* on resource allocation). Its first NSP, which runs along broadly similar lines to the Health Board plans, was published in mid-2005 (HSE, 2005c). It detailed how objectives set out in the HSE Corporate Plan (2005–2008) (HSE, 2005b) were to be achieved on an annual basis. The NSP, in turn, is supported by detailed business plans, identifying how the objectives and actions in the plan will be achieved at each level of the health delivery system. An NSP for each of the years 2006, 2007 and 2008 has been approved by the Minister of Health and laid before both houses of the *Oireachtas*. Performance Monitoring Reports (PMRs) on the NSP, including performance indicators, are submitted to the Department on a monthly basis.

Health technology assessment

HIQA is responsible for developing HTA in Ireland. To date, HTA activities have been modest. In the past there was no formal requirement to take cost-effectiveness into consideration, but for any new chemical entity introduced after August 1997, it was at the discretion of the DoHC to require the

submission of an economic evaluation to the NCPE, established in Dublin in 1998. More than 50 interventions have been assessed by the NCPE through this mechanism (NCPE, 2007). These have included publications on the cost-effectiveness of Beta blockers for patients with severe heart failure statins for secondary prevention of coronary heart disease and lipid-lowering therapy. Cost of care studies have also been undertaken for the treatment of acute myocardial infarction, heart failure and stroke.

HIQA will assess the clinical and cost-effectiveness of the medicines, devices, diagnostics, and health promotion used in the health care system. It will work in close cooperation with the NCPE, which has already developed guidelines on HTA. HIQA is also a member of the European Network for Health Technology Assessment. Its assessments will include the evaluation of social and ethical issues, quality of life and quality of end of life, as well as cost-effectiveness in relation to health technologies. The outcomes of assessments will be used to help the MoHC make informed decisions on the desirability and effectiveness of investing in new therapies, pharmaceuticals, equipment or health promotion activities. Assessments will also be used to advise on the rationale for continuing with existing practices to ensure that people are not being treated with outdated therapies, pharmaceuticals or procedures.

Although as yet no formal priority setting process for HTAs is in place, the first two HTAs commissioned include an assessment of the cost-effectiveness and benefit of combining the existing ICSP with a national human papilloma virus (HPV) vaccination programme, compared to the existing screening programme aimed at preventing cervical cancer. This is being conducted by the NCPE. The second, with a maximum budget available of €150 000 is examining the cost-effectiveness and resource implications of a population-based colorectal cancer screening programme.

Information systems

A National Health Information Strategy was published in 2004 (DoHC, 2004a). Its core aims are “to rectify present deficiencies in health information systems and to put in place the frameworks to ensure the optimal development and utilization of health information”, in order to implement changes set out in the Health Service Reform Programme. The Strategy also set out a health resources planning system to help address deficits in workforce planning, time management, staff retention and recruitment, benchmarking and management information.

HIQA is at the heart of the National Health Information Strategy and already has begun to evaluate, interpret and publish information on health and social care services on its web site. HIQA is developing standards for the collection and sharing of information across health and social services and

for the interoperability of information systems. The Authority is also charged with identifying gaps in the collection and sharing of information and making recommendations on the corrective action to be taken. As part of a drive towards the greater use of ICT across the health system, HIQA will also collaborate with key stakeholders on the development and implementation of electronic health records and a unique identifier for health and social care services in Ireland. This need for collaboration is important; at the time of writing HSE ICT services enable over 800 business applications, cover more than 2 500 locations, field 275 000 help desk calls per annum, cater for 76 data centres/computer rooms and support over 50 000 users who require availability around the clock, every day of the year. This fragmented approach to ICT may be unsustainable (Ryan, Lios Geal Consultants & Healy, 2007).

In addition, the introduction of the electronic National Patient Treatment Register (PTR) provides detailed information to the entire population on real-time waiting times for both adults and children for more than 7 500 procedures. GPs and their patients can make use of data from the PTR in deciding which hospital to refer a patient to (see Chapter 6 *Provision of services*). A national project, healthlink.ie, promotes electronic communication between the primary and secondary care sectors. As of December 2007, 549 GP practices with 1220 GPs were linked to 18 hospitals.

An island-wide body, Ireland and Northern Ireland's Population Health Observatory (INISPHO), has been established within the Institute of Public Health to improve base line data on health inequalities and health status. A range of online data is provided by this Observatory. The Government also provides financial support to make the Cochrane Library evidence-based health care available free of charge to all living in Ireland.

The Health Protection Surveillance Centre, formerly known as the National Disease Surveillance Centre, is a non-statutory organization responsible for monitoring communicable diseases. In addition, it provides training, undertakes research, disseminates information to the public and provides policy advice to government departments. It also operates the Computerized Infectious Disease Reporting system (CIDR), in partnership with the HSE, Food Safety Authority of Ireland, the Food Safety Promotion Board and the DoHC.

There have been some setbacks in the development of electronic information systems. The PPARS project was intended to support Personnel administration, Payroll, Attendance monitoring/control, Rostering, Recruitment and Superannuation functions in an integrated manner and to be capable of interfacing and integrating with existing systems in health agencies, where appropriate. Work on the system began in 1997 but after many problems and millions of euros it was eventually abandoned 10 years later in favour of a different computer system.

The Health Information Portal, launched by the DoHC in 2004, aimed to provide a single entry point to a range of health-related information and resources, similar in scope to the NHS Direct System in the United Kingdom. However, the web site (www.healthireland.ie) is no longer available, and a range of technical problems came to light through documents obtained under the Freedom of Information Act (Ó Cionnaith, 2006).

A €56 million, 10-year contract was awarded to iSOFT to develop an electronic patient record system. This has been hampered by a significant restatement of iSOFT's accounts to actual earned income and not contracted income; this has led to discussions between the DoF and iSOFT over insurance and credit support guarantees in the iSOFT contract (Ryan, Lios Geal Consultants & Healy, 2007).

Research and development

While HIQA and the HSE have some research objectives, the lead agency for medical research in Ireland is the publicly funded HRB which promotes, funds, commissions and conducts medical, epidemiological and health services research. With a budget of €45 million in 2006 it dispensed 74 research grants and 23 career development awards (HRB, 2007a). It is also the lead body in implementing the government strategy "Making Knowledge Work for Health" and has a "particular mission to encourage research that translates into improved diagnosis, understanding, treatment and prevention of disease and improves efficiency and effectiveness of the health services" (HRB, 2007b). Other sources of domestic funding include Science Foundation Ireland, Enterprise Ireland, the Higher Education Authority, the Irish Council for Science, Engineering and Technology, and the Irish Council for Humanities and the Social Sciences.

A recent review was undertaken of the state of health research in Ireland (Advisory Council for Science, 2006). In particular, it called for the immediate development of an integrated national strategy on health research that could contribute to Ireland's knowledge economy. The report also called for a Head of Research to be put in place within the DoHC and noted that funding for research is low by international standards – approximately €90 million in 2004, equivalent to 1% of the total health budget estimate, compared with the United Kingdom's National Health Service (NHS) Research and Development (R&D) Programme, which accounts for more than 1.6% of the NHS budget. Significant investment in research and key infrastructure will be required, alongside attractive career structures and incentives. Hospitals are another sector in which there has been insufficient emphasis on research. The report argues that hospitals have lost out on opportunities for linking with industry and developing and translating intellectual property (IP) into new diagnostics, devices and therapies.

According to the review, hospitals need to develop research strategies and to integrate research as a clearly stated component of their mission and work with universities' technology transfer offices to develop procedures to ensure IP is effectively captured, protected and exploited. Moreover, the approvals process for clinical trials operating in Ireland at the time of writing is fragmented, slow and under-resourced, and should be substantially streamlined, making use of a cadre of professional staff possessing the relevant technical expertise.

5 Physical and human resources

5.1 Physical resources

Infrastructure and capital stock

Public Hospitals

In 2007 there were 53 hospitals providing acute care within the HSE's NHO Networks in Ireland (Table 5.1). This includes two specialist hospitals for children, the national rehabilitation hospital and the Royal Victoria Eye and Ear Hospital. Eight are teaching hospitals, with six in Dublin and two others, one each in Galway and Cork.

Trends in acute hospital activity

Between 1997 and 2006 the number of inpatient beds available increased by 13.1% to 12 574, while there was an increase of 128% in the number of day cases, with bed numbers having increased by 96.2% to 1197. (However, this

Table 5.1 Publicly funded acute hospitals: number of hospitals/beds available, average length of stay, and day cases, 2005

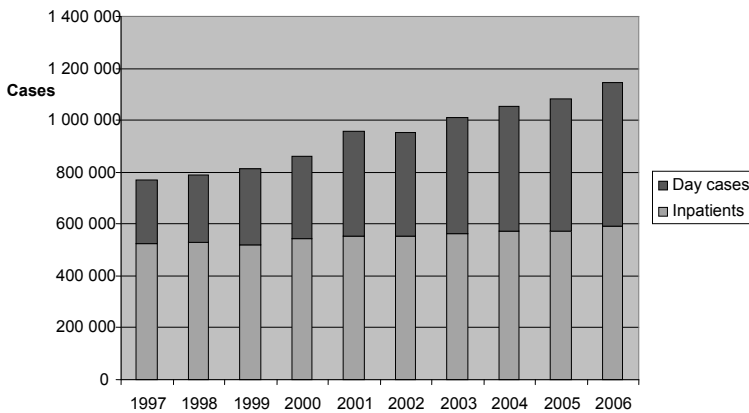
HSE Area	Number of hospitals	Average number of inpatient beds available	Average length of stay (days)	Average number of day beds available	Day cases
Dublin/Mid Leinster	15	3 627	7.3	361	164 519
Dublin/North-East	11	2 728	7.3	317	107 042
Southern	14	2 950	6.0	254	113 441
Western	13	2 789	5.8	321	124 829
Total	53	12 094	6.6	1 253	509 831

Source: Central Statistics Office, 2007d

Note: HSE: Health Service Executive

represents a slight decrease of 4.5% compared with the number of day beds available in 2005). Improved and less invasive medical practice is largely responsible for the rapid growth in the proportion of activity carried out on a day-patient basis. By 2006 almost as many patients were treated on a day-case basis as were admitted to hospital (Fig. 5.1).

Fig. 5.1 Inpatient and day-case activity acute hospitals, 1997–2006



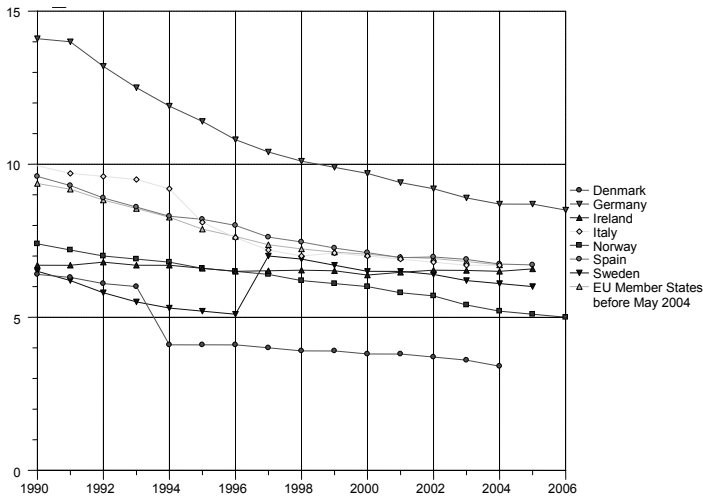
Source: DoHC, 2007c

Average length of stay for inpatients has changed little since the late 1990s. In 1997 this was 6.5 days, while in 2006 it was 6.3 days (DoHC, 2007c). Figure 5.2 compares trends in WHO data on length of stay in Ireland with data recorded for other European countries. This indicates that Ireland remains close to the EU15 average for length of stay, but is unusual compared to the selected countries in not having a down trend. Even in Denmark, where rates were lower than those in Ireland in 1990, the average length of stay has continued to fall. The recent Acute Bed Review commissioned by the HSE, which involved a survey of patients in 27 acute care hospitals, indicated that there is scope for a further reduction in hospital use. The review found that 13% of patients did not meet validated criteria for admission, while 39% of patients on the day of the survey did not meet the criteria for treatment in an inpatient setting (Balance of Care Group & P A Consulting Group, 2007).

National specialist services

National specialist health services are situated in Dublin and the immediate vicinity (Box 5.1). Some very specialist services such as lung transplantation have been performed at the Freeman Hospital in Newcastle in the United

Fig. 5.2 Average length of stay, acute care hospitals only, Ireland and selected EU countries, 1990 to latest available year



Source: WHO Regional Office for Europe, 2008

Note: EU: European Union

Kingdom, although local capability is increasing, as evidenced by the opening of the National Lung Transplantation Unit at the Mater Hospital in Dublin in March 2004. This unit is capable of performing two to three transplants per annum, until theatre facilities are fully completed. A total of 230 heart transplants have been performed at the hospital since 1985. Other specialist services include renal transplantation, which is provided at the Beaumont Hospital.

Box 5.1 National specialist services

- Lung transplantation: Mater Hospital supported by St Vincent’s Hospital
 - Adult cystic fibrosis: St Vincent’s University Hospital
 - Liver transplantation: St Vincent’s University Hospital
 - Cochlear implants: Beaumont Hospital
 - Metabolic screening: The Children’s Hospital, Temple Street
 - Bone marrow transplantation: St James’s Hospital
 - Spinal injuries: Mater Hospital, National Rehabilitation Hospital
 - Paediatric cardiac services: Our Lady’s Hospital for Sick Children
 - National Centre for Medical Genetics: Our Lady’s Hospital for Sick Children
 - Renal transplantation: Beaumont Hospital
 - Haemophilia: St James’s Hospital
- Source: Authors’ own compilation

District/community hospitals

District/community hospitals contain units for medicine, minor surgery and frequently for obstetrics and paediatrics. Some of these hospitals also accept casualty patients. Lengths of stay are much longer than those for the acute care hospitals, with an average of 47.9 days per patient in 2005, an increase of 37% since 1997 (Table 5.2). However, there is a great variation in length of stay for these hospitals, indicating wide variation in activity; data from 2003 for all 40 hospitals indicate that for some the average length of stay was more than 150 days, whereas for others it was less than 30 days. In all cases, the bed occupancy rate is high, averaging at 86% nationwide.

Table 5.2 District/community and non-acute hospital summary statistics, 1997–2005

	1997	1998	1999	2000	2001	2002	2003	2004	2005
Inpatient beds available	2 383	2 384	2 394	2 375	2 343	2 252	2 172	2 175	2 165
Inpatients discharged	20 325	20 332	20 085	20 202	17 654	16 085	15 233	14 466	14 176
Bed days used	709 431	707 815	709 164	719 321	706 977	703 383	700 881	687 927	679 639
Average length of stay	34.9	34.8	35.3	35.6	40.0	43.7	46.0	47.6	47.9
% occupancy	81.6	81.3	81.1	82.8	82.7	85.6	88.4	86.6	86.0
Outpatient attendances	43 315	45 728	45 990	46 093	41 371	40 860	44 037	37 443	32 005

Source: DoHC, 2007c

Private hospitals

There are also a small number of purely private hospitals in Ireland, which do not offer public services, although some may provide non-acute services for public patients through arrangements with the NTPF (see Chapter 6 *Provision of services*). In an effort to help “free up capacity for public patients and deliver new public acute beds in the quickest and most efficient manner”, in July 2005 the Government announced the construction of up to eight additional private hospitals to be co-located within the grounds of public hospitals. It is hoped that this will help ensure that the number of private patients occupying beds within public hospitals does not exceed 20% of all beds. These new private facilities may also be used to supplement service provision for public patients. Six co-location sites providing 914 beds were approved at the end of 2007. Each will have one A&E department. The private hospitals will facilitate medical training and R&D; accept direct admissions to medical and surgical admission units from primary care centres and GPs on a 24-hour a day, 7 days a week basis; comply with physical design requirements to fit with the public hospital; have joint clinical governance, shared information and records management,

performance management and documented service level agreements, where these are undertaken; and participate in the public HIPE and case-mix information systems (Harney, 2007a).

Psychiatric beds

By 2007, 3692 psychiatric inpatient beds were available in the country (Table 5.3). The figures include 83 beds for individuals detained under court order at the Central Mental Hospital in Dundrum and 176 for those residing at a facility for people with intellectual disabilities. There has been a continued decline in the provision of psychiatric beds since the 1960s when more than 20 000 beds were available (see Chapter 6 *Provision of services*). However, despite guidance which states that where psychiatric beds are provided they should be in general hospitals, only just over 25% of residents are in such facilities.

In 2006 the Government announced that a replacement Central Mental Hospital is to be built in Thornton, County Dublin. This is to be adjacent to the Mountjoy Replacement Prison Complex. The existing hospital had been criticized for having little or no structural change since it had been built in 1850, making it unsuitable for the provision of a modern forensic service (DoHC, 2006e).

Table 5.3 Psychiatric inpatients and beds by facility type, 2007

Approved centre type	Number of residents (%)	Rate of residents per 100 000 over 18 population	Beds (%)	Rate of beds per 100 000 over 18 population
Psychiatric hospital	1633 (49.3%)	50.9	1871 (50.7%)	58.4
General hospital, Psychiatric unit	840 (25.4%)	26.2	946 (25.9%)	29.8
Independent service provider	584 (17.6%)	18.2	607 (16.4%)	18.9
Central mental hospital	81 (2.4%)	2.5	83 (2.2%)	2.6
St Joseph's	176 (5.3%)	5.5	176 (4.8%)	5.5
Ireland	3314	103.4	3692	115.2

Source: MHC, 2008

Note: St Joseph's is a facility for people with learning disabilities

Long-stay care

Table 5.4 provides a breakdown of the type of beds available for long-term care in Ireland, from a survey conducted on 31 December 2006. The vast majority of these beds are for older people, although a small number are for children and for other people with special needs. A total of 10.2% of beds are for limited long-stay care, including rehabilitation and convalescence, as well as 135 beds

for palliative care provided in five specialist units, and 58% of beds at the time of writing are provided in the private sector where individuals may have to make significant payments towards the costs of care (see Subsection *Out-of-pocket payments*, within Section 3.3 *Revenue collection and complementary sources of funding*).

Table 5.5 provides information on changes in long-stay bed numbers between 1997 and 2005, as well as in the demographics of service users (DoHC, 2007c). Although caution must be exercised because these are survey data, there appears to have been little change in the number of long-stay care residents over this period, although the 85+ age group, already the largest single group in 1997, had increased its share of total bed occupancy from 37.7% to 41.5% by 2005. Moreover, the severe dependency group, which had the largest share of beds in 1997, had increased from 36.7% to 40.8% by 2005, with a peak at 42.3% in 2004. The number of beds in private nursing homes increased by more than 3000 between 2004 and 2006.

Table 5.4 Number of beds available and percentage of beds occupied in long-stay units at 31 December 2006

Category	HSE extended care unit	HSE welfare home	Voluntary home/hospital for older people	Voluntary welfare home	Private nursing home	Total
Extended/Continuing care	4 785	1 300	1 140	295	12 405	19 925
Psychiatry of old age	268	70	27	0	553	918
Chronic young sick	106	0	80	25	88	299
Unspecified	47	36	249	0	239	571
Total long-stay beds	5 206	1 406	1 496	320	13 285	21 713
Limited-stay beds						
Rehabilitation	242	70	193	0	56	561
Convalescence	226	23	34	1	197	481
Palliative	84	6	9	0	36	135
Respite	561	65	123	16	309	1074
Other limited stay	94	0	0	20	120	234
Total limited-stay beds	1 207	164	359	37	718	2 485
Total undesignated	0	24	0	0	31	55
Total beds	6 413	1 594	1 855	357	14 034	24 253
% of beds	26.4	6.6	7.6	1.5	57.9	100.0
Total residents	5 900	1 414	1 713	319	12 109	21 455
% of residents	27.5	6.6	8.0	1.5	56.4	100.0
% occupancy	92.0	88.7	92.3	89.4	86.3	88.5

Source: DoHC, 2008b

Table 5.5 Long-stay care: summary statistics, 1997–2005*

	1997	1998	1999	2000	2001	2002	2003	2004	2005
Number of beds	20 890	19 670	11 224	18 309	21 949	23 059	23 825	23 772	21 478
Number of patients resident at 31/12	18 981	17 820	10 167	16 603	19 886	20 959	21 169	21 404	19 320
% of beds occupied	90.9	90.6	90.6	90.7	90.6	90.9	88.9	90.0	90.0
Age distribution (as % of total)									
Under 40	0.5	0.8	0.9	0.8	0.9	0.6	0.7	0.7	0.6
40-64	4.6	4.5	4.4	4.6	4.9	4.5	4.5	5.4	5.0
65-69	5.0	4.9	4.7	4.7	4.3	4.2	4.1	4.1	4.4
70-74	9.7	9.0	10.5	9.6	8.6	8.6	8.3	8.6	8.6
75-79	17.1	17.4	18.1	17.5	16.9	16.5	16.0	15.1	15.5
80-84	25.4	26.0	25.4	24.9	25.4	25.6	25.5	25.2	24.2
85+	37.7	37.4	36.0	38.0	38.9	40.0	40.9	40.9	41.5
Level of dependency (as % of total)									
Low	12.8	11.8	11.3	11.0	9.4	9.6	9.2	9.2	9.4
Medium	21.5	20.9	19.5	20.5	20.0	19.9	19.0	18.8	18.6
High	28.9	29.0	29.8	29.8	29.3	30.1	30.6	29.7	31.1
Maximum	36.7	38.3	39.5	38.6	41.2	40.3	41.2	42.3	40.8
Response rate (%)	86.6	77.0	46.9	68.3	84.9	87.3	87.3	85.4	80.0

Source: DoHC, 2007c

Note: * The low figures in 1999 were due to an absence of response from the Eastern Regional Health Authority

Information and communication technology

ICT plays an increasingly important role in Irish society. Just over 797 000 (54.9%) of households had a home computer in June 2005, while 655 000 households (45.1%) had access to the Internet. ICT also has an important role to play in the health system, as part of the National Health Information Strategy. There are plans to develop an electronic health record system and extend the use of ICT across the system, although some of these have been subject to problems and delay (see Chapter 4 *Planning and regulation*). The National PTR can be accessed electronically by health service professionals and patients to ascertain length of waiting times for different elective procedures. GPs can then use this to help their patients obtain treatment as quickly as possible, by matching them with hospitals with spare capacity.

Medical equipment, devices and aids

Data on access to medical equipment are not easy to obtain, but the VHI Board maintains a directory of approved MRI centres in both public and private facilities. As of 15 November 2007 there were 37 centres listed by the VHI,

while Vivas lists 41 approved MRI units in Ireland in 2007. Data from the Radiological Protection Society of Ireland suggest that in 2006 there were 54 CT scanners in the country. The VHI lists 23 approved CT scanning centres, compared with Vivas, who list 7 approved CT scanning centres and 6 joint PET-CT scanning centres.

5.2 Human resources

Number of health care personnel and trends

Table 5.6 provides an overview of whole-time equivalent (WTE) employees within public health services in Ireland as at December 2006. Across all sectors there were 106 273 WTE employees, of which approximately one third were nursing staff, while management and administration accounted for over 16%. Overall employment has increased by 56.7% since 1997, with the largest increases being in the employment of ancillary paramedical health and social care professionals. Table 5.7 provides information on the geographical spread of health care personnel, which indicates that most HSE staff are in the Eastern and Southern Areas, while an additional 22.9% of all staff are employed by voluntary hospitals, most of which are located in Dublin (Eastern area).

Table 5.6 Employment in public health services, 1997–2006

Grade/category	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Medical/Dental	4 976	5 153	5 385	5 698	6 285	6 775	6 792	7 013	7 266	7 712
Nursing	27 346	26 611	27 044	29 177	31 429	33 395	33 766	34 313	35 248	36 737
Health and social care Professionals	5 969	6 422	6 836	7 613	9 228	12 577	12 692	12 830	13 952	14 913
Management/administration	8 844	9 480	10 599	12 366	14 714	15 690	15 766	16 157	16 699	17 262
General support staff	20 705	21 973	22 928	25 216	13 803	13 729	13 838	13 771	13 227	12 910
Other patient and client care	n/a	n/a	n/a	n/a	14 842	13 513	13 647	14 640	15 586	16 739
Total	67 841	69 640	72 793	80 070	90 302	95 679	96 501	98 723	101 978	106 273

Source: DoHC, 2008b

Notes: Figures refer to whole-time equivalents excluding staff on career break and excluding home helps; management/administration includes staff who are of direct service to the public and include consultants' secretaries, outpatient departmental personnel, medical records personnel, telephonists and other staff who are engaged in front-line duties.

Table 5.7 Numbers employed in public health services by Health Service Executive Area, December 2006

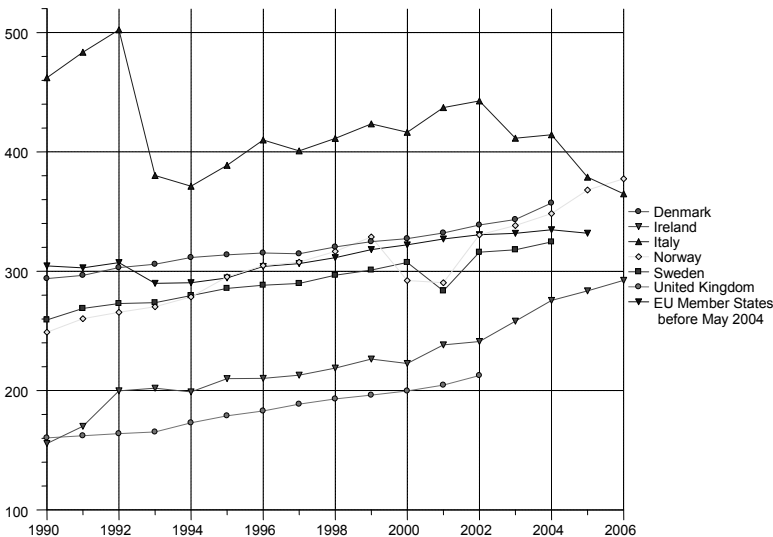
Region	Health sector	Medical/dental	Nursing	Health and social care professionals	Management / administration	General support staff	Other patient and client care	Total
Eastern	HSE	890	3 999	2 582	2 703	1 576	2 211	13 961
	Voluntary Hospitals	2 405	8 472	3 005	3 564	3 089	1 695	22 230
	Disability services	65	1 231	1 281	550	611	1 777	5 516
	Subtotal:	3 360	13 703	6 868	6 817	5 276	5 683	41 707
Midland	HSE	380	2 012	726	940	278	1 521	5 856
	Voluntary Hospitals		73	126	29	28	154	410
	Disability services							
	Subtotal:	380	2 085	852	968	306	1 674	6 266
Mid-Western	HSE	461	2 299	815	1 219	600	1 151	6 545
	Voluntary Hospitals	37	131	26	71	51	24	340
	Disability services	4	394	268	110	110	463	1 348
	Subtotal:	502	2 824	1 109	1 400	760	1 638	8 232
North-Eastern	HSE	526	2 490	787	1 377	669	1 276	7 125
	Disability services	1	173	64	26	88	178	529
	Subtotal:	527	2 663	850	1 403	757	1 454	7 654
North-Western	HSE	462	2 397	715	1 248	1 020	1 197	7 038
	Disability services		95	8	16	53	120	292
	Subtotal:	462	2 492	723	1 264	1 073	1 317	7 330
South-Eastern	HSE	654	3 536	1 046	1 440	1 746	607	9 030
	Disability services	4	158	111	72	68	362	775
	Subtotal:	658	3 694	1 157	1 512	1 814	968	9 805
Southern	HSE	799	4 167	1 438	1 675	1 508	1 340	10 926
	Voluntary Hospitals	216	687	167	364	208	147	1 788
	Disability services	12	393	362	120	164	676	1 726
	Subtotal:	1 026	5 247	1 967	2 158	1 880	2 163	14 440
Western	HSE	792	3 784	1 190	1 656	975	1 446	9 843
	Disability services	5	246	196	84	69	395	995
	Subtotal:	797	4 030	1 386	1 739	1 045	1 841	10 838
	Grand total	7 712	36 737	14 913	17 262	12 910	16 739	106 273

Source: Personal communication, DoHC, 2008

Physicians

Overall the number of all physicians in Ireland per 100 000 population is low by western European standards, at 292 compared with 331 in the EU15 in 2006 (see Fig. 5.3). However, the number of physicians per 100 000 population has been increasing steadily since the late 1990s, from a rate of 213 in 1997. This is consistent with trends seen in many other European countries.

Fig. 5.3 Number of physicians per 100 000 population in Ireland and selected European countries, 1990–2006 (or latest available year)



Source: WHO Regional Office for Europe, 2008

There are approximately 2750 GPs in Ireland, of which 2515 are members of the ICGP and thus are included in OECD estimates of doctors per 1000 population. In Ireland this figure was 0.5 in 2005 (OECD, 2007b). This is the lowest rate reported in the OECD countries and compares with 0.7 per 1000 population in the United Kingdom, 0.8 in Norway, 1.0 in Germany, 1.7 in France and 2.1 in Belgium.

In December 2006, 2315 GPs were participating in the GMS Choice of Doctor Scheme, and thus were providing services for all Category I patients (HSE, 2007g). This includes 220 GPs outside the GMS scheme, who were registered to provide services under the Primary Childhood Immunization Scheme, the HAA of 1996 and the Methadone Treatment Scheme (see Table 5.8).

An increasing proportion of the GP workforce is female (around one third), which may have long-term implications for working arrangements and practices, demanding greater flexibility (Graham & De La Harpe, 2004). The GP workforce is also ageing. A survey conducted in 2000 by the ICGP reported that the number of GPs aged between 26 and 35 had fallen from 17% to 14%, while those aged between 45 and 55 had increased from 29% to 35% (Payne, 2001). This change in the workforce is occurring at a time when there is a need to increase the number of active GPs if the goals set out in the Government's Primary Care Strategy are to be attained. Consequently, in September 2003 the ICGP urged the Government to make working conditions more attractive and to invest more resources in general practice (Shanahan, 2003).

Table 5.8 Number of agreements with National Shared Services Primary Care Reimbursement Board at 31st December 2006

Health Service Executive	Doctors	Pharmacists	Dentists	Optometrists
East Coast Area	213	135	103	45
South West Area	301	210	189	85
Northern Area	256	172	148	45
Midland	135	86	71	45
Mid-Western	218	146	114	44
North-Eastern	164	136	112	56
North-Western	137	88	63	31
South-Western	225	165	129	54
Southern	409	238	311	74
Western	257	154	174	73
National	*2315	#1530	+1414	552
Corresponding figures for 2005	2257	1430	1394	531

Source: HSE, 2007g

Notes: * Includes 220 general practitioners (GPs) who do not hold General Medical Services (GMS) scheme agreements and who were registered as providing services under the Primary Childhood Immunization Scheme, the HAA of 1996, Heartwatch and the Methadone Treatment Scheme at year end; # 12 pharmacies that do not hold GMS scheme agreements and that were registered as providing services under non-GMS schemes at year end; + 201 dentists who are employees of the Health Service Executive and who provide services under the Dental Treatment Services Scheme

Consultants and non-consultant hospital doctors

In December 2006 there were 2096 WTE consultants (specialists) in Irish hospitals and a total of 2144 approved permanent consultant posts. This represents a 60% increase since 1997, when only 1310 WTE consultants were in place, but is still far lower than the number of NCHDs,¹⁹ estimated at 4648 (DoHC, 2007c) (Table 5.9). The number of additional consultant posts approved by the NHO between 2000 and 2006 was 704, compared to just 345 over the period

¹⁹ These are medical graduates in subconsultant, (mainly) training posts, including House Officers, Interns and Registrars.

from 1987 to 1999 (HSE, 2007a). However, the number of NCHDs in post over the period 1997 to 2006 increased by 64.6%, a slightly greater rate than that for consultants.

Both the Hanly Report (2003 National Task Force on Medical Staffing) (Hanly, 2003) and the 1993 report on Medical Manpower in Acute Hospitals (the Tierney Report) called for a significant increase in the number of consultant posts while substantially reducing the number of NCHDs. While consultant posts have increased, there has been no decrease in NCHD posts and in fact they have increased by more than 1000 since 1998 alone. Indeed, the number of NCHD positions increased at a slightly higher rate than that of consultant posts during 2004. However, in 2006 an additional 188 consultant posts were approved, of which 125 were new posts and 63 replacement posts. This was the highest number of additional consultant posts ever approved in one year. Yet, while the number of consultants has increased, they still represented just 31.08% of total medical staff in 2006, still below the rate seen in 1997.

Figure 5.4 shows the trend in the number of additional approved consultant posts between 1987 and 2006. In 1996, the consultant-to-population ratio was one consultant per 2800 individuals, dropping to one consultant per 2000 individuals at the time of writing. There has been virtually no change in the geographical distribution of consultant posts since the late 1980s and 48% of all consultants still work in the Eastern region of Ireland. This is unsurprising, given that this is where most of the voluntary hospitals and specialist national services are provided (see Table 5.10).

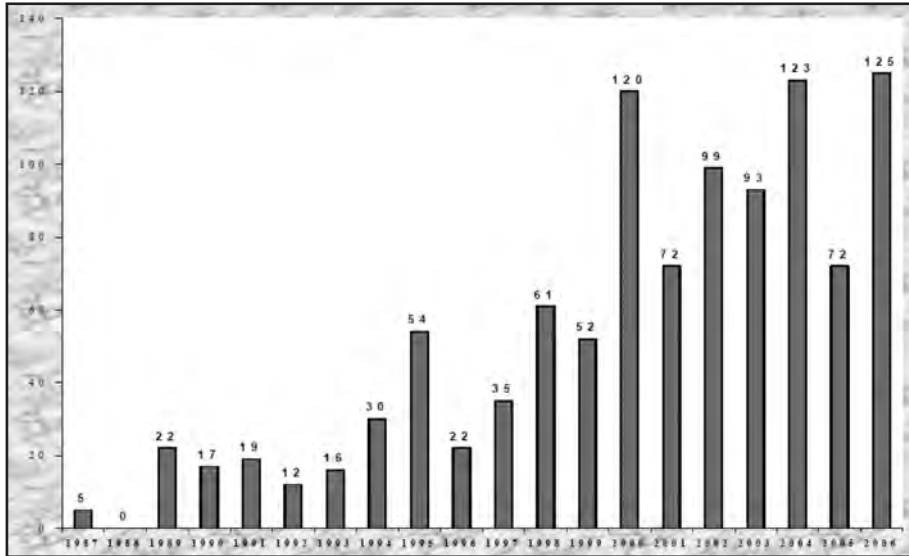
Table 5.9 Consultant and non-consultant hospital doctors employed within the public health service, 1997–2006

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Consultants	1 310	1 321	1 375	1 435	1 574	1 693	1 756	1 873	1 968	2 096
NCHDs:										
House officer/ Senior House officer	1 377	1 442	1 448	1 481	1 615	1 727	1 708	1 764	1 902	1 910
Intern	369	375	383	414	440	466	471	485	486	502
Registrar	1 078	1 156	1 215	1 167	1 240	1 308	1 241	1 250	1 387	1 508
Senior registrar/Specialist	n/a	n/a	66	287	431	593	668	699	701	729
Subtotal NCHDs	2 824	2 973	3 112	3 349	3 726	4 094	4 088	4 198	4 376	4 648
Total	4 134	4 294	4 487	4 784	5 300	5 787	5 844	6 071	6 344	6 744
Consultants as % of all employees	31.69	30.76	30.64	30.00	29.70	29.26	30.05	30.85	31.02	31.08

Source: DoHC, 2007c

Note: NCHD: Non-consultant hospital doctor; n/a: Not available

Fig. 5.4 Annual net increase in consultant posts, 1987–2006



Source: HSE, 2007a

Table 5.10 Geographical distribution of hospital consultant posts, January 2005

Area	Filled	Vacant Approved	Unprocessed	Under consideration	Total
Eastern	764	140	6	2	912
Midland	66	15	2	0	83
Mid-Western	104	20	1	0	125
North-East	101	24	0	0	125
North-West	87	15	1	1	104
South-East	136	18	0	1	155
Southern	203	37	2	1	243
Western	168	30	1	1	200
Total	1629	299	13	6	1947

Source: HSE, 2005a

Table 5.11 provides information on consultants by specialty as at December 2005. The increase in consultant posts by specialty since the turn of the millennium has not been even, and specific national strategies – such as that for cardiovascular diseases – have influenced the number of specialist posts created. In particular, the NHO noted in 2004 that a substantial number of specialists in obstetrics and gynaecology were required (Comhairle na nOspidéal, 2004). Some specialty groups, for example, biochemistry (for which there are five posts) and genito-urinary medicine (two posts) had no consultants at the end of 2005.

The average age of new consultants taking up appointment in Ireland remains high. In 2003 it was 39 years and in 2004 it was 40 years of age. There has been a gradual change in the proportion of male and female consultants from 87% male, 13% female in 1990 to 74% male, 26% female by 2005. In 2003, 62% of new consultants were male and 38% female.

Table 5.11 Hospital consultants employed in the public sector by specialty, December 2005 (whole-time equivalents)

Specialty group	Permanent consultant posts
A&E	46
Anaesthetist	298
Biochemist	0
Cardiologist	42
Cardio-thoracic surgeon	13
Chemical pathologist	5
Child psychiatrist	28
Clinical pharmacologist	2
Dermatologist	21
Endocrinologist	21
Gastroenterologist	19
General adult psychiatrist	234
Consultant/General physician	122
General surgeon	138
General surgeon breast	2
General surgeon vascular	7
Genito-urinary medicine	0
Geriatrician	49
Haematologist	32
Histopathologist	81
Immunologist	2
Infectious diseases	11
Consultant in oral and dental radiology	1
Consultant in restorative dentistry	1
Consultant in special care dentistry	1
Learning disability psychiatrist adult	4

Learning disability psychiatrist child	2
Medical geneticist	1
Medical oncologist	25
Microbiologist	22
Neonatologist	13
Nephrologist	19
Neurologist	18
Neurophysiologist	6
Neurosurgeon	9
Obstetrician and gynaecologist	102
Ophthalmic surgeon	49
Oral and maxillo facial surgeon	3
Oral surgeon	2
Orthodontist	14
Orthopaedic surgeon	83
Otolaryngologist	36
Paediatrician	86
Paediatric surgeon	5
Palliative medicine	11
Plastic surgeon	15
Radiation oncologist	12
Radiologist	170
Rehabilitation medicine	7
Respiratory medicine	22
Rheumatologist	19
Transplant surgeon	4
Unclassified	11
Urologist	21
Total	1967

Source: Authors' own compilation

Note: A&E: Accident and emergency

Nurses

An Bord Altranais (the Nursing Board) has legislative responsibility under the 1985 Nurses Act for the registration of nurses in Ireland. This includes a number of different disciplines: general, midwifery, psychiatry, sick children, public health, intellectual disability and tutors. The Board is required to assess every five years the adequacy and suitability, effectiveness and efficiency of hospitals and institutions for nurse training, and to ensure that all Board regulations and European Directives are complied with.

In 2002, the Pre-Registration Programmes in General Nursing (RGN), Psychiatric Nursing (RPN) and Mental Handicap (Learning Disability) Nursing (RMHN) were offered for the first time at university degree level. The successful completion of the 4-year degree programme leads to registration with the Nursing Board (RGN or RPN or RMHN) and the award of a Bachelor of Science (BSc) Degree in Nursing from the higher education institution. A total of 13 institutions, in association with 45 health care agencies, offered 1640 places in 2002. In 2006 new direct entry undergraduate midwifery and children's nursing degree programmes were introduced. The direct entry midwifery programme offers 140 places per annum and the integrated children's/general programme offers 100 places per annum. Since 2006 there has been an annual intake of 1880 students (see Table 5.12).

Table 5.12 Available places on undergraduate nursing degree programmes

General	1057
Psychiatric	343
Intellectual disability	240
Midwifery	140
Children and general (integrated)	100
Total	1880

A working group with representatives from nursing unions and health service employers, as well as officials from the DoHC, was established to address two very important recommendations of the Commission on Nursing relating to the effective utilization of the professional skills of nurses and midwives (Commission on Nursing, 1998). One recommendation was that the health service providers and nursing organizations examine opportunities for an increased use of care assistants and other non-nursing staff. The working group recommended that the grade of Health Care Assistant be introduced as a position within the health care team to assist and support the nursing and midwifery functions. The recommendation was endorsed by the MoHC.

A review of prescribing and administration of medicinal products by nurses and midwives also took place. This included the evaluation of 16 pilot initiatives in a variety of health care settings for nurse and midwife prescribing.

Following this successful pilot, on 1 May 2007 the Medicinal Products (Prescription and Control of Supply) Regulations Amendment (Statutory Instrument (SI) 201 of 2007) and the Misuse of Drugs Regulations of 2007 (SI 200 of 2007) were enacted. These instruments provide the legal authority for nurses and midwives to prescribe medicines and some controlled pharmaceuticals in certain circumstances. Nurses/midwives must be employed by a health service provider, and the medicinal product must be one that would be given in the usual course of the service provided. A new division on the Register of Nurses has been established for nurse prescribers. Registration and education requirements include a stipulation that the nurse/midwife must have three years of post-registration clinical experience and must undergo a further education programme of six months' duration with theoretical instruction of no less than 168 hours and a clinical component of at least 96 hours. The Royal College of Surgeons in Ireland (RCSI) and the University of Cork provided the first programmes for 52 students from April 2007. To maintain registration authorization, nurse prescribers will have to demonstrate evidence of continued competence; *An Bord Altranais* is developing this process at the time of writing (*An Bord Altranais*, 2007b).

In 2006 there were a total of 78 552 registered nurses (including those working in the secondary care sector) in Ireland, of which 62 639 were active. Approximately 8% of all nurses are male (*An Bord Altranais*, 2006b). After general nursing, midwifery and psychiatric nursing are the most common specialisms (see Table 5.13). Since the late 1990s the number of nurses registered in Ireland has risen sharply and in 2005 was well in excess of that seen in many other European countries (see Fig. 5.5). However, some caution should be exercised when considering these figures: in 2006 it was estimated that the total number of active nurses was 52 600, as not all nurses are working in either the public or private health sectors (*DoHC*, 2008d).

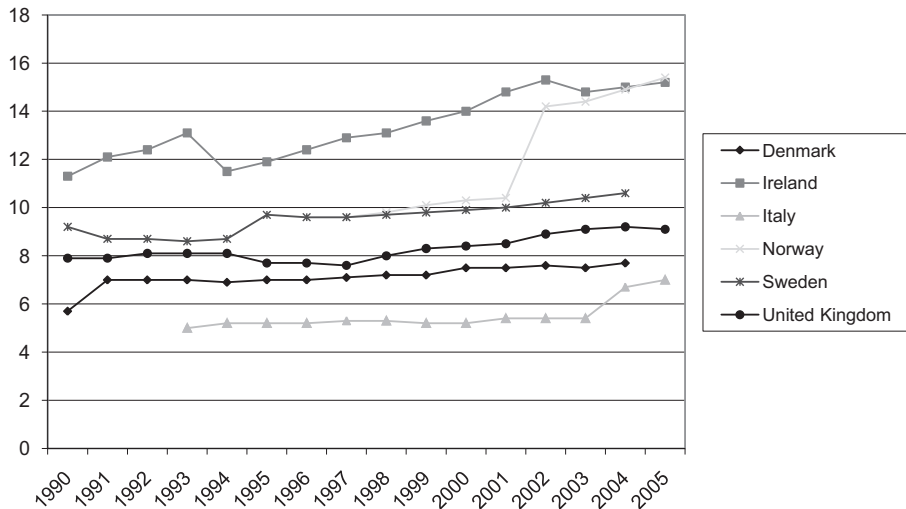
Table 5.13 Qualifications registered with *An Bord Altranais* at 31 December 2006

	Female	Male	Active	Inactive	Total
General	66 638	3 087	55 127	14 598	69 725
Psychiatric	8 450	3 593	9 471	2 572	12 043
Children's	4 787	57	3 905	939	4 844
Intellectual disability	4 110	499	3 981	628	4 609
Midwifery	17 250	25	13 101	4 174	17 275
Public health	2 796	1	2 239	558	2 797
Tutor	566	105	522	149	671
Other	582	26	259	349	608
Total	105 179	7 393	88 605	23 967	112 572

Source: *An Bord Altranais*, 2007a

Note: A nurse may be registered in more than one division of the Register

Fig. 5.5 Number of nurses per 1000 population in Ireland and selected European countries, 1990–2005 (or latest available year)



Source: OECD, 2007b

Psychiatric nursing

Although there were more than 9470 active registered psychiatric nurses in Ireland in 2006, it is estimated that over 65% of psychiatric nursing personnel in public service are aged 45 years or over and only 14% are under the age of 34. This may suggest a serious shortage of psychiatric nurses in the near future. The FÁS Healthcare Skills Monitoring Report (2005) projected a demand for 6829 psychiatric nurses in 2015, whilst predicting that there will be a national supply of 6694 psychiatric nurses, resulting in a projected shortfall of 135 nurses (Foras Áiseanna Saothair, 2005).

Psychiatrists

By the end of 2005 there were 234 consultants in adult psychiatry across the country, compared with 185 in 1991. At the start of 2005, there were 21 consultants of “old age” in psychiatry in Ireland, the first only appointed in 1989. Forensic mental health services are limited, with resources concentrated in the eastern HSE area at the Dundrum Central Mental Hospital. Two special interest posts in the Mid-Western (Limerick) and Southern (Cork) regions have been set up. The postgraduate training programme used by the Royal College of Psychiatrists in the United Kingdom is still used in Ireland, although it is tailored by the Irish Psychiatric Training Committee to meet local conditions.

Pharmacists

Although theoretically, anyone in Ireland with the necessary qualifications can set up as a pharmacy, in practice access is strictly controlled, as it is necessary to have a community pharmacist contract with the HSE in order to make a business viable. A total of 1530 pharmacies had public contracts at the end of 2006 (HSE, 2007g). By the end of 2007, in total 1621 pharmacies – including 60 based in hospitals – were registered with the Pharmaceutical Society of Ireland.

Prior to 1996 a pharmacist²⁰ could apply to the Health Boards to open a pharmacy under the terms of the 1970 Health Act, and different Health Boards took different approaches to assessing applications. In 1996 a formal contract application system was introduced as part of an agreement with the Irish Pharmaceutical Union. New procedures took into account population size, catchment areas and the impact on the viability of existing pharmacies. Following a critical external report, *Regulatory reform in Ireland*, published by the OECD (OECD, 2001), the Pharmacy Review Group was set up in 2001 to review these regulations, with a particular emphasis on maximizing competition within the sector. Of the 1268 pharmacies operating in 2001, 74% were owned by companies (Pharmacy Review Group 2003). However, the market was still fragmented; the largest operator Unicare/Gehe had only a 4.3% share of the market (52 outlets), followed by Boots PLC 2.3% (28 outlets) and the McSweeney Group 1.8% (22 outlets) (Indecon International Economic Consultants, 2003). Subsequently, the Health (Community Pharmacy Contractor Agreement) Regulations of 1996 (SI 152 of 1996) were revoked in January 2002. However, EU derogation rules introduced in 1987 still applied to pharmacists wishing to practise in Ireland, making it impossible for pharmacists, including Irish citizens educated in other EU or EEA countries, to own, manage or supervise a pharmacy that is less than three years old.

An independent review prepared for the Pharmacy Review Group in 2003, including a survey of 427 pharmacists, indicated that there was a shortage of pharmacists, with 59.5% of respondents indicating that they had difficulty in filling posts for community pharmacists (Indecon International Economic Consultants, 2003). Yet in 2004 Ireland's ratio of approximately 88 pharmacists per 100 000 people was, in fact, better than the EU15 average of 81 per 100 000 (WHO Regional Office for Europe, 2007). A further report (Indecon International Economic Consultants, 2003) concluded that removing the derogation would be a positive step towards helping to reduce the shortfall in pharmacists and improving access in rural areas.

²⁰ This also applies to a licentiate of Apothecaries Hall under the 1791 Apothecaries Act (35 George III, Chapter 34) or a legal entity such as a company.

The Pharmacy Review Group's report, published in 2004, recommended opening up Ireland to further competition in the pharmacy sector, with the safeguard that no single entity should be able to have more than 8% of the community pharmacy contracts in any one of the former Health Board areas. Among the Review Group's other recommendations were the separation of prescribing and dispensing premises, a performance review of pharmacies every five years and the removal of EU derogation once a new Pharmacy Act was introduced. The Review Group report met with a critical reaction from the Irish Pharmaceutical Union, which warned that the recommendations threatened the future of independent pharmacies and the availability of medicines in some parts of the country (IPU 2004). In June 2005 the MoHC announced that the Government had approved new pharmacy legislation intended to increase competition and raise standards in the pharmacy sector. Most of the recommendations of the Pharmacy Review Group had been accepted, with the exception of restricting the number of pharmacy contracts that may be granted to a single entity operating in any area (DoHC, 2005c).

The Pharmacy Act of 2007 represented the first complete overhaul of the regulation of pharmacy in Ireland in 130 years (Pharmaceutical Society of Ireland, 2007). It removed the EU derogation, which will also apply to pharmacists from non-EU/EEA countries, subject to a language test. The Act also introduced, for the first time, fitness-to-practise provisions, to ensure the highest standards are met by pharmacists and to safeguard the safe and effective delivery of pharmaceutical services to all citizens. These provisions fall under the auspices of a new independent Pharmaceutical Society of Ireland.

Other professionals

A total of 1414 dentists and 552 optometrists had contracts with the HSE to provide services under the GMS scheme at the end of December 2006 (HSE, 2007g) (see Table 5.8). There are approximately 700 optometrists registered with the Association of Optometrists Ireland (Association of Optometrists Ireland, 2007).

Dentists are required to complete five years of dental school training before beginning practice. Both Trinity College Dublin and University College Cork offer courses in dentistry, although many students travel to the United Kingdom. The first two years of the course are spent on the university campus studying basic medical science. The last three years are spent in the Dental School and Hospital. The majority of dental graduates enter general practice, providing a complete service to patients in diagnosing, treating and preventing oral and dental disease, correcting irregularities and replacing missing teeth. A large proportion of graduates enter the public dental service which provides

care for medically entitled patients and children through the public health clinics operated by the HSE. A small number of graduates will find opportunities in the dental hospitals as house officers or registrars, perhaps with postgraduate qualifications leading to consultant positions.

Planning for health care personnel

Improved workforce planning

The need for improved workforce planning was signalled in the National Health Strategy and action has commenced on strengthening this function within the HSE and the DoHC. This has been supported by research undertaken by the Irish National Training and Employment Authority (FÁS) into the labour market in health care, which identifies current and future shortages of health care skills up to 2015 (Foras Áiseanna Saothair, 2005). A joint committee on workforce planning was established in 2006 with representatives of the DoHC, DoF and Department of Education and Science, as well as the HSE. The group's initial task is to review future human resource requirements in disability, care of older people and cancer services. The FÁS is also undertaking a more detailed analysis of a smaller number of professions due for completion in 2008. Health sector analysis has now been included in the work programme of the Expert Group on Future Skill Needs, reflecting the importance of the health sector in the national economy. Work has also commenced on a national workforce planning strategy in conjunction with the HSE.

One key issue has been the European Working Time Directive (EWTD). The EWTD requires that, from 1 August 2004, both consultants and NCHDs work for not more than an average of 58 hours per week on a hospital site. Furthermore, these doctors can no longer be required to work for more than 13 hours per day on site, and certain other rules regarding minimum rest and break periods must be put in place. By 1 August 2007 the number of hours worked should be no more than an average of 56 hours per week on site. This limit must reduce to an average of 48 hours by 1 August 2009. The EWTD does not apply to self-employed individuals, including GPs.

The need for Ireland to fully comply with the EWTD for NCHDs and to implement appropriate hospital planning, as well as medical training and education measures, led to the establishment of the National Task Force on Medical Staffing under the chairmanship of management consultant David Hanly in 2002 (Hanly, 2003). (See Chapter 6 *Provision of services* for further details).

Subsequent to this report, a number of initiatives have been put in place, as described here.

- A national coordinator and support team have been appointed, draft rosters and hours recording systems developed, and extensive work undertaken by health agencies at local level.
- Training principles and advice on safe, EWTD-compliant, rosters have been provided to employers by the postgraduate medical training bodies and the Medical Council.
- The National EWTD Implementation Group (NIG) has been established to give guidance to Local Implementation Groups (LIGs) and to oversee pilot projects.

Full implementation is dependent on industrial relations agreement. Discussions under the auspices of the Labour Relations Commission are ongoing at the time of writing.

It is still too early to judge the impact of the National Health Strategy and the recommendations of the Task Force on Medical Staffing. This latter report estimated that there should be 2200 NCHDs in training in Irish hospitals – a decrease of 44% compared to current levels – while the number of consultant posts should ultimately be increased to 3600 posts. Overall, this would increase the number of doctors working in the acute health system by 125. In order to meet these targets, 767 undergraduates in medicine would be required annually for several years. However, meeting this target may prove problematic without significant additional investment, given that at the time of writing, only approximately 300 home and other EU nationals are training in medicine in Irish universities. The majority of non-EU nationals still leave the country upon completion of their training and many Irish graduates are also going abroad because of problems in career structures in the Irish system. The increasing feminization of the workforce may also mean that more flexible working hours and job-sharing arrangements may be necessary, which, again, may increase the overall number of doctors required. Moreover, since 2007, entry to medicine has been a graduate-only system and the impact that this will have on the number of doctors is yet to be determined. The new system will mean that the time required to become a doctor may be even longer, deterring some individuals, and there are also concerns about the need to change methods of teaching and training to deal with a more mature group of graduates. It will take some time to see what effect the changes recommended in the Fottrell and Buttimer reports (Postgraduate Medical Education and Training Group, 2006; Working Group on Undergraduate Medical Education and Training, 2006) (see later) will ultimately make both to the number of students training and the ability of the system to retain the workforce.

Psychiatric nurses and skill mix

One key area of the workforce in which changes in staffing and skill mix are required is mental health care. The Government's report on the strategy for mental health, *A Vision for Change*, places great emphasis on moving towards much greater provision of community-based rather than hospital-based services. The supply of psychiatric nurses and other mental health professionals is important for the effective implementation of this concept.

Although the number of individuals entering psychiatric nurse training have increased from 83 in 1998 to 343 in 2007, according to the strategy report, *A Vision for Change*, this is sufficient only to allow a limited scope for future development in the field of mental health care, treatment and prevention. Moreover, it does not accommodate the identified needs for the development of Primary Care Teams and child and adolescent mental health (CAMH) services (Expert Group on Mental Health Policy, 2006). A total of 90% of psychiatric nurses remain hospital based, and there is an unequal distribution of nursing staff across the country. In some areas, where there are staff shortages and an overreliance on overtime and agency staff, the focus on care tends to be on providing a safe service, rather than on delivering high-quality patient contact and providing therapeutic relationships. The psychiatric nursing staffing needs identified in *A Vision for Change* suggest the potential for a reduction in the number of psychiatric nurses needed in the new mental health service and an increase in a range of multidisciplinary personnel in order to provide a comprehensive mental health service. The report *A Vision for Change* estimated a total staffing requirement of 10 657, that is, a net increase of 1800 posts. This, however, requires the reallocation and remodelling of existing resources, along with extra funding and personnel. An audit of resources is under way in the HSE at the time of writing (Independent Monitoring Group, 2007).

Changes in skill mix and skill utilization, as envisaged, should facilitate increased use of health care assistants to support the delivery of nursing care through the freeing up of psychiatric nurses to focus on therapeutic care interventions. A steering group to oversee the mainstreaming of Health Care Assistant posts in the mental health service has been established (Department of the Taoiseach, 2006). One of the principles underpinning the introduction of health care assistants in mental health services is to facilitate the development of higher level nursing input into patient care by allowing the nurse to divest her/himself of certain duties without impinging on patient care.

The report *A Vision for Change* also identified the requirement for a multi-professional personnel plan to be put in place, linked to projected service plans. This will examine the skill mix of teams, how staff are deployed between teams, and the geographical location of the teams. The personnel plan will be

developed by the National Mental Health Service Directorate, working closely with the HSE, the DoHC and service providers (Independent Monitoring Group, 2007) and should facilitate increased skill mix and teamwork across mental health services in future years.

Supply of general practitioners

According to the ICGP, at the time of writing, job opportunities in general practice – both full- and part-time – are plentiful. GMS scheme lists may become available, and are advertised through open competition; however, there may be less competition for lists serving rural areas. Another route into general practice is to apply for an assistantship at an existing GMS practice, with a view to becoming a partner. Assistants cannot become partners or take patients from a list for at least six months, and entering a practice does not guarantee a practice partnership.

There are some restrictions placed on GPs who participate in the GMS scheme. Since 1995 all GPs in the GMS scheme need to have “Certification of Specific Training” (or Acquired Rights) in general medical practice issued under EU Directive 93/16 by the Medical Council of Ireland, and they also need to pass the entrance examination for membership of the ICGP. Applicants need to have a significant amount of experience in order to enter general practice. A points system is in operation, with points acquired for experience in secondary care or via general practice training schemes, research and publications, membership of professional bodies and other relevant qualifications. In contrast, GPs entering private practice only need to be registered with the Medical Council (see Subsection *Training of health care personnel*, within Section 5.2 *Human resources*).

A substantial number of GPs still work in single-handed practices. Reforms introduced in the mid-1990s put in place GP Support Units in each Health Board to provide advice and incentives to encourage GPs to participate in cooperative practices. Some have developed into Primary Care Units, consistent with the goal within the Primary Care Strategy of integrating GP services into a coordinated and holistic primary care service that has links with acute care services.

Another supply-related issue that has been raised as a concern in the past has been access to out-of-hours GP services. The Health Boards (and now the PCCC Directorate within the HSE), working in partnership with GPs, developed schemes to improve access to out-of-hours Primary Care Services. One such example can be seen in the former North Western Health Board region where the out-of-hours service established in Donegal had more than 32 904 contacts in 2002, with a target of 46 000 contacts in 2003. In 2003 the scheme was expanded into South Donegal, Leitrim and Sligo, while under the CAWT

Initiative the Primary Care Sub-Group have explored options for cross-border out-of-hours arrangements with colleagues in Northern Ireland. By the end of 2004, 62% of all GMS patients had access to similar out-of-hours services provided by GP cooperatives, and in 2006 the Government provided funding to increase this to 70% or 2.75 million people.

General practitioner contract review

The ICGP, as the representative body for GPs, has in recent years called for more flexible working arrangements, claiming that the current GMS contract requires GPs to be available 24 hours per day, 7 days per week. Given the high proportion of female GPs, the Council has argued that these working hours may not be attractive, also claiming that, as a result, as many as 20% of students currently training in primary care will be reluctant to go into general practice. This, in turn, would make it more difficult to recruit the additional GPs needed for the Primary Care Strategy (Shanahan, 2003), especially in light of the ageing of the GP workforce in Ireland (see Chapter 6 *Provision of services*). Indirectly, the introduction of the EWTD may also have an impact. One concern is that GPs who are not subject to the EWTD may have to pick up some of the duties of NCHDs whose working hours are now restricted. However, the impact of the EWTD on general practice, if any, remains to be seen.

The Government has recognized the need for a new contract as part of primary care reform and included this as one of the objectives of the DoHC's 2005–2007 3-year strategy (DoHC, 2005e). In October 2005 a review of the GMS contracts/scheme and all publicly funded primary care services involving GPs commenced under the auspices of the Labour Relations Commission. It was intended that this review would encompass the nature of service provision by GPs in relation to the achievement of defined population health objectives and the best possible person-centred services in line with the strategy "Primary Care: A New Direction". Through this process the DoHC and the HSE are seeking to progress national policy, which is to develop comprehensive, multidisciplinary services in the primary care setting. The aim is also to further extend the nature of services beyond the traditional "diagnosis and treatment" model to encompass health promotion, disease prevention, management of chronic illness and to extend the hours of availability of primary care services.

Training of health care personnel

Physicians

In Ireland students must study medicine for six years²¹ at one of five medical schools: Trinity College Dublin, University College Dublin, University College Cork, National University of Ireland, Galway or the RCSI. From 2007 a new graduate entry stream has provided an additional 240 EU medical school places per annum on the basis of 60 per year over a 4-year period. The University of Limerick has also opened a new school of medicine which will accommodate half of the first cohort of graduate entrants to medicine.

At the time of writing, entry requirements for undergraduate courses are based on school leaving qualifications (the Leaving Certificate). However, from 2009 a new selection process for entry to undergraduate medicine will be introduced, comprising a combination of the Leaving Certificate and a medical schools admission test. This will be open to all students who achieve a threshold level of 480 points in their Leaving Certificate and meet matriculation requirements. Credit for Leaving Certificate performance will be moderated from 550 points onwards, with one point added for each five points scored in the Leaving Certificate results. This will mean the maximum points which can be added to the candidate's overall score is 550. The medical school admission test will measure general and personal skills and abilities that are not directly assessed in academic examinations.

The first two or three years of the course are university based, concentrating on the core sciences of anatomy, biochemistry, physiology and cognitive sciences, while for the last three years students are based in university teaching hospitals where teaching is focused on clinical medicine and related subjects such as pathology, pharmacology and public health medicine.

In 2003, 831 students were admitted, compared with 736 in the year 2000, but the number of non-Irish EU students had decreased from 345 to 315, although this is still in excess of the quota of 305 places for EU students funded by the Higher Education Authority in 2003 (Box 5.2). This quota was introduced in 1978 and in the view of the Medical Council needs urgent revision to take into account current personnel requirements (Medical Council of Ireland, 2004). A government initiative on medical education and training, announced in February 2006, will more than double the medical school places for EU students from 305 to 725 (this will be made up of a new graduate entry stream (240 places)), and will increase the number of EU undergraduate places to 485 on the basis of substituting 180 non-EU places. An additional 110 EU

²¹ Courses at the University of Cork last five years.

Box 5.2 Higher Education Authority-funded medical school places for European Union students, 2003

University College Cork	60 places
National University of Ireland Galway	54 places
Trinity College Dublin	60 places
RCSI	25 places
University College Dublin	106 places
<i>Source:</i> Medical Council of Ireland, 2004	
<i>Note:</i> RCSI: Royal College of Surgeons in Ireland	

undergraduate places were provided between 2006 and 2007, and the first 60 graduate entry places were provided in 2007.

An earlier review of the medical schools conducted by the Medical Council in 2001 reported that from 1995 to 2000 there had been little change in the number of students admitted, the exceptions being University College Dublin and the RCSI, which are linked to Penang Medical College and the International Medical University in Kuala Lumpur. (These Malaysian students undertake the first two years of their medical training at University College Dublin and RCSI). The 2001 review also reported that, with the exception of the students at the RCSI, female EU students outnumbered male EU students by a ratio of two or three to one (Medical Council of Ireland, 2001). In 2003, non-EU students outnumbered EU students at all five medical schools.²²

Students can receive an MB (Bachelor in Medicine), BCh (Bachelor in Surgery) or BAO (Bachelor in the Art of Obstetrics). Graduates are then entitled to work in Irish hospitals and recognized hospitals elsewhere to complete a 12-month internship, usually consisting of six months in medicine and six months in surgery, during which time they are provisionally registered with the Medical Council. Following successful completion of this internship, indicated by a Certificate of Experience issued by the Dean of their medical school, doctors are entitled to proceed to full registration with the Medical Council.

All doctors who wish to practise in the Republic of Ireland should be registered with the Medical Council. The Council maintains two registers, the General Register of Medical Practitioners and the Register of Medical Specialists. There are three types of registration within the Registers which contained over 17 000 names in July 2005. Full registration allows fully independent practice in any setting; internship registration allows a doctor to undertake internship training for one year under consultant supervision; and temporary

²² Historically, because of the limited number of places for home students available at medical schools, many Irish students have opted to study abroad, particularly in the United Kingdom.

registration allows non-EU doctors to be employed and receive further training (Medical Council of Ireland, 2003). Following registration, doctors may continue with further specialist postgraduate training which can last between three and seven years for disciplines such as surgery or general practice, or graduates may seek to work in academic medicine or hospital management.

Undergraduate student fees are covered by the Department of Education and Science under the “Free Fees Initiative”, a scheme that is not means-tested and applies to all EU national students (or those granted refugee status) ordinarily resident in an EU country for three of the previous five years, who are undertaking a first undergraduate degree. Means-tested grant schemes (for living expenses) are also in operation, which include special top-up payments to disadvantaged students. Institutions also receive block grants for courses from the Department of Education and Science and are heavily dependent on generating additional income from non-EU students, who will pay fees of €29 000 per annum in 2008–2009. By contrast, undergraduate fees for medicine were approximately €7500 per annum in 2007–2008. Earlier research indicated that for home and EU students, 58% of income was derived from the free fees scheme, with the remainder coming from block grants (Department of Education and Science, 2003).

A review by the Medical Council criticized the quality of medical education in Ireland, commenting that in a rapidly changing environment, governed by international standards, Irish medical schools were struggling to meet the necessary medical education benchmarks but were still managing to produce competent graduates due to the efforts of medical school staff (Medical Council of Ireland, 2004). In light of these comments, in 2003 the Medical Council formally adopted plans to introduce accreditation for medical education courses, using internationally recognized standards, that is, World Federation of Medical Education benchmarks. Furthermore, following the Medical Council’s review, the DoHC and the Department of Education and Science agreed to set up a working group under the chairmanship of Professor Patrick Fottrell to look at the future of medical education (Working Group on Undergraduate Medical Education and Training, 2006). The Fottrell Report published its conclusions in 2006. Among its recommendations were a call to increase the number of EU places in undergraduate medical education, modernization of the course curriculum in the medical schools, the introduction of graduate entry programmes and an increase in the number of academic clinicians in post. The Government responded to the conclusions of the review rapidly in 2006 (see later).

General practitioners

Medical postgraduates wishing to become GPs needed to undertake one of the ICGP-approved General Practitioner Specialist Training Schemes lasting four years at one of 12 centres across the country. Approximately 150 places are available annually, with courses consisting of two years in hospital training and two years in general practice (part of which may be overseas for certain centres). However, a survey indicated that among the crop of 2003 interns, only 15% of respondents wished to pursue a career in general practice (Finucane, 2004). This would suggest that fewer interns are interested in general practice than the current number of training places available. Many students have undergone postgraduate training in the United Kingdom, but since July 2002 only full 3-year (United Kingdom) general practice programmes are accepted by the ICGP. Self-structured hospital training (which precedes a 1-year general practice training programme) is no longer recognized for GP training purposes in Ireland.

The Primary Care Steering Group, which reviewed the implementation of the 2001 Primary Care Strategy, has called for the establishment of a national group to examine and make recommendations on GP education, training and personnel needs in order to meet future requirements. The Steering Group found a wide variation in postgraduate and undergraduate primary care training, and was not able to identify the current level of investment in education and training by the Health Boards/HSE. These findings are consistent with those of the Medical Council Review of Medical Schools which concluded that “general practice remains a minor part of the curriculum” (Medical Council of Ireland, 2004). The recommendations included having a common module for primary care training and (again, in common with the National Task Force on Medical Staffing) to establish a National Health Service Training and Development Authority to coordinate and target training and development in the health services in general (National Primary Care Steering Group, 2004).

Nurse training

The number of nurses who have trained outside Ireland, particularly non-EU nationals, has become significant in recent years. By 2006 more than two thirds of all new qualification registrations were from individuals who had trained in other EU and non-EU countries (see Table 5.14). The majority of newly registered general nursing qualifications were obtained outside Ireland, while the vast majority of specialist nursing qualifications were obtained in Ireland.

Table 5.14 Newly registered qualifications for year ending December 2006

	Ireland	EU	Others	Total
<i>General</i>	850	703	2 589	4142
<i>Psychiatric</i>	246	70	29	345
<i>Sick children</i>	92	19	0	111
<i>Intellectual disability</i>	135	12	0	147
<i>Midwifery</i>	166	102	13	281
<i>Public health</i>	129	6	0	135
<i>Tutor</i>	13	0	0	13
Total	1 631	912	2 631	5 174

Source: An Bord Altranais, 2007a

At the same time, the number of Irish-trained nurses wishing to work outside the country continues to be high. In 2006, 576 Irish nurses and 301 non-Irish nurses sought one or more verifications (confirmation of nursing credentials) in order to work abroad (see Table 5.15). Australia is the destination of choice for Irish-trained nurses and the majority return to Ireland within a relatively short period. The majority of nurses not trained in Ireland seeking verification are working temporarily in the country, and typically wish to move on to positions in the United Kingdom or the United States. In 2006, 116 nurses from India and 91 from the Philippines sought verification. The number of new students commencing nursing studies has also steadily increased (Table 5.16).

Table 5.15 Verifications sought to work abroad

	<i>Verifications 2000–2006</i>						
	2000	2001	2002	2003	2004	2005	2006
United Kingdom	462	458	735	1 516	846	439	277
Other European	15	21	15	24	16	25	21
Australia	535	701	764	014	560	717	1 024
United States	20	73	240	306	290	151	195
Canada	14	25	50	1	33	30	42
Other	12	28	51	14	39	79	53
Total requests	1 058	1 306	1 855	2 875	1 784	1 441	1 612
Total nurses					1 443	973	877
Total Irish nurses						689	576

Source: An Bord Altranais, 2007a

Note: A nurse can seek more than one verification

Table 5.16 Students commencing nursing studies in Ireland, 2000–2005

	2000	2001	2002	2003	2004	2005
General	1032	1102	964	1137	1076	1137
Midwifery	209	198	184	53	173	169
Psychiatric	313	291	307	374	350	374
Sick children	126	107	117	27	110	111
Intellectual disability	198	153	168	229	242	229
Total	1878	1851	1740	1820	1951	2020

Source: An Bord Altranais, 2006a

Postgraduate medical training

The system of postgraduate training in Ireland has also been the subject of some criticism. It was argued that the time taken to complete training by NCHDs can vary by a number of years, depending on the number of patients that they are expected to treat within their facilities, and that there was also less time available for training and practice because of the increased administration and management demands (Kellet, 1999).

A survey of all interns conducted by the Medical Council in 2003 looked at their attitudes towards postgraduate training and long-term career plans. Of the 300 respondents, 165 (55%) were female, 221 were Irish citizens, 12 were other EU nationals and 65 non-EU nationals. According to the survey, 57% “strongly agreed” and a further 36% “agreed” with the statement: “It is likely that I will leave Ireland at some stage to pursue further training”. These percentages did not change when non-EU nationals were excluded from the analysis. Overall, 24% strongly agreed and a further 39% agreed that “postgraduate training is not as good in Ireland as in other countries”. Again, these percentages were not altered by the exclusion of non-EU nationals from the analysis (Finucane, 2004). The report’s author went on to conclude that:

... it is clear that all of the training bodies have to work to do better in making postgraduate training more attractive to Irish graduates. The stakes appear to be highest for general practice and some of the smaller specialties who may be facing future manpower shortages. A greater exposure to these disciplines is required, particularly at undergraduate level, before career plans are shaped.

The Report by the Forum on Medical Manpower (Forum on Medical Manpower, 2001) also highlighted the need for more fully trained doctors, with enhanced postgraduate training arrangements, and perhaps, most importantly, for more and earlier opportunities for fully trained doctors to take on responsibility in line with their experience. Further, the Report advocated an increase in the number of fully trained doctors and noted that the current balance between fully trained

and partially trained doctors is not beneficial to optimal patient care, and for some doctors can result in heavy workloads.

While doctors in training can play a role in service delivery commensurate with their level of skill and experience, the primary responsibility of trained doctors is providing appropriate patient care. Career structures in Ireland may compound this issue, with the Forum on Medical Manpower noting that:

... the vast majority of consultants (80%) are aged 40 or over, while most NCHDs are in their mid-to-late twenties or early thirties. Consequently, there are relatively few fully trained hospital doctors in Ireland in their thirties – normally a highly productive age cohort. In many cases, this vital cohort is missing and working abroad with little immediate prospect of returning to a consultant post in Ireland. This phenomenon is set to increase as the shorter, more structured continuum of training develops, unless corrective measures are taken.

The Report of the National Task Force on Medical Manpower, chaired by David Hanly, made a number of recommendations with regard to postgraduate medical training. These reflect several limitations, including: the fragmented, overlapping and complex structure of existing training arrangements; the lack of regulation of the number of training posts at senior house officer and registrar grades which has allowed the number of NCHDs to grow; the priority given to service requirements over training needs; and the lack of involvement of any of the medical schools in postgraduate training (Hanly, 2003).

The Task Force recommended the establishment of a central, independent, statutory postgraduate training authority which would have some responsibility over the number of NCHDs by having to give explicit approval for, and stipulate the length of, training posts; have strategic responsibility for the development of medical education; and evaluate and monitor the quality of medical education and training. Other recommendations of the Task Force included stronger mentoring of NCHDs to help facilitate career progression; ensuring that time for training is protected within the terms of the EWTD; and including training in skills such as clinical governance, management, multidisciplinary skills, teamwork, communication skills and ICT in both undergraduate and postgraduate courses. Furthermore, all NCHD posts should become training posts. The Task Force also stated its belief that there is a future role for the medical schools to play in postgraduate training.

The Government commissioned an expert Postgraduate Medical Education and Training Group, under the chairmanship of Dr Jane Buttimer, to look at how to improve postgraduate training for NCHDs within the eventual maximum 48-hour working week. Another key area investigated by the Group was improving graduate retention (Postgraduate Medical Education and Training Group, 2006). Its report was published early in 2006 and among the recommendations set out were the introduction of a robust governance structure to drive forward reforms; independent expert evaluation of the training value of NCHD posts; development of financial/information systems and ICT infrastructure to generate an evidence base to underpin and support implementation of the recommendations; graduate retention measures, including the implementation of the National Flexible Training Strategy; and an increase in consultant numbers. The Training Group also called for systematic annual workforce planning exercises to identify the appropriate numbers required at various levels of training in each specialty and subspecialty, based on the staffing needs of the health service; and for the implementation of training principles to be incorporated into new working arrangements for doctors in training.

Reform of medical training and continuing education in Ireland

Welcoming both the Buttimer and Fottrell reports (Working Group on Undergraduate Medical Education and Training, 2006; Postgraduate Medical Education and Training Group, 2006), in 2006 the Government announced details of a €200 million initiative for major reform of medical education and training from undergraduate level through to postgraduate specialist training (DoHC, 2006d). As well as doubling the number of medical places for Irish and EU students over a 4-year period from 305 to 725, a new graduate entry programme for medicine was introduced in 2007. The curriculum and clinical training are being modernized to strengthen quality and in 2006, eight new academic clinician posts were created, jointly funded by the education and health sectors.

At postgraduate level, measures are to be taken to improve the retention of graduates from Irish medical schools through a range of approaches to enhancing the quality and attractiveness of postgraduate specialist training. NCHD posts with limited training value will be phased out and there will be better workforce planning to align the numbers of doctors in training with projected consultant vacancies. New training principles are to be incorporated into new working arrangements for doctors in training, and research in the health sector will also be enhanced.

The HSE allocation for medical education and training in 2007 was €16.1million (€6.5m revenue and €9.6m capital). The HSE revenue funding includes additional funding totalling €3.3 million in 2007 to support the development of further initiatives, including:

- the appointment of additional academic clinicians;
- subsidized training abroad in specialties for which there is a shortage in Ireland; and
- research scholarships to promote research in medicine.

6 Provision of services

6.1 Public health services

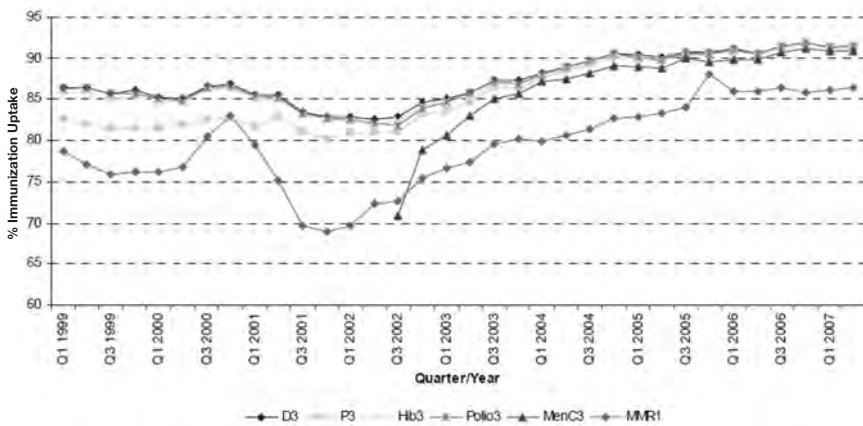
Until the end of 2004 the Health Boards were responsible for delivering a range of health promotion and public health services across the country, taking account of both local needs and National Health Strategy. These functions have been taken over by the HSE's Population Health Directorate under the National Director for Population Health. This division is responsible for promoting and protecting the health of the entire population and certain target groups, with particular emphasis on health inequalities. It is also responsible for immunization programmes, infection control and environmental health, and at local level its functions are organized through the 32 LHOs and Hospital Networks.

The Population Health Directorate is structured into six Assistant Directorates, including Strategic Planning, Health Intelligence, Health Promotion, Emergency Planning, Environmental Health and Health Protection. In addition, the Directorate includes the National Office for Suicide Prevention. The Health Protection Surveillance Centre is part of the Directorate, as are the Public Health Departments and Departments of Health Promotion.

The Population Health Directorate is responsible for the implementation and monitoring of immunization programmes for pertussis, diphtheria, tetanus, Hib (Haemophilus influenza type b, which causes meningitis), polio, meningitis C and measles, mumps and rubella (MMR). Immunization rates have continued to improve (see Fig. 6.1), although by the second quarter of 2007 immunization uptake levels for some conditions were still well below the target level of 95%. For MMR this was only 86%; for Hib (one booster dose of vaccine against Haemophilus influenzae type b after 12 months of

age) coverage was 22% below target; and for all other vaccines at 24 months uptake was 4% below target (Health Protection Surveillance Centre, 2007). Coverage rates for MMR, in particular, fell sharply for a period of time after the high-profile publication of one study – later discredited – linking the MMR vaccine with autism. Regional coverage rates for immunizations can also vary significantly – in the case of MMR in 2007 in the Midland HSE Area, coverage was 94%, whereas in the Eastern Area it was only 83%. As Fig. 6.2 indicates, Ireland continues to have one of the lowest rates of MMR coverage in the EEA.

Fig. 6.1 Uptake rates for immunization at 24 months, 1999–2007



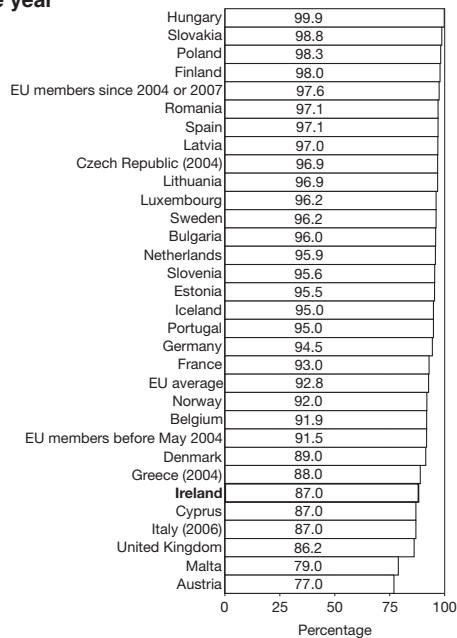
Source: Health Protection Surveillance Centre, 2007

Notes: D3: Diphtheria; P3: Pertussis; Hib3: Haemophilus influenzae type b; Polio3: Polio; MenC3: Meningococcal group C; MMR1: Measles, mumps and rubella

In addition to local approaches to public health and health promotion, there are a number of national strategies to implement, including those for cardiovascular health, cancer and suicide.

Public health and health promotion initiatives include community-based smoking cessation programmes, the establishment of Community Health Action Zones (HAZs) (including Health Promoting Schools Programmes), development of regional Heart Health Promotion Teams, Sports Partnerships, and piloting of GP Physical Activity Referral Schemes. Another area that is under development is mental health promotion; for instance, in the (former) Midland Health Board region, training on suicide prevention was provided to staff and local guidelines on suicide prevention were launched in schools. Other local initiatives have included provision of a Stigma Reduction Worker to develop staff training in mental health promotion and stigma reduction initiatives.

Fig. 6.2 Levels of immunization for measles in the European Economic Area, latest available year



Source: WHO Regional Office for Europe, 2008

Note: EU: European Union

In early 2007, the ICSB was established as part of the DoHC's Cancer Control Strategy. This brings together two screening programmes under one roof – the National Breast Cancer Screening Board and the ICSP. The former, also known as BreastCheck – *An Bord Cíoch Scrudaithe Naisiunta* – was set up in 1998, with a National Breast Cancer Screening Programme launched in 2000. Initially, the programme screened women between the ages of 50 and 64 every two years free of charge.

In its initial phase, the programme covered selected Health Board areas with the intention of expanding the scheme nationally using mobile screening units. In 2005, plans were announced to extend screening to the rest of the country from 2007 (BreastCheck, 2005). The building of two screening units in Victoria Hospital, Cork and University College Hospital Galway took place in 2006, with the units becoming fully operational in December 2007.

Screening services for a range of health problems, including communicable diseases, are also provided for refugees and asylum seekers at Asylum Seeker Centres; for example, at Lissywollen in Athlone, the uptake for health screening has been over 80%.

National Anti-Poverty Strategy and National Action Plan on Poverty and Social Inclusion

A key objective of public health policy is to address deprivation and inequalities in health. The HSE should develop approaches to reduce inequalities in health consistent with the National Report on Strategies for Social Protection and Social Inclusion (Office for Social Inclusion, 2006) and the “*National Anti-Poverty Strategy*”. Actions include the expansion of access to primary health care for Travellers and ethnic minorities; implementing and supporting a number of different parenting programmes, in particular those aimed at parents from disadvantaged backgrounds; targeting health promotion interventions at lower-income groups; and providing the services of Community Welfare Officers.

Community Welfare Officers undertake home visits, deliver public talks and information sessions, carry out interagency work across all sectors and liaise with residential and other care facilities, with a view to reducing some of the adverse impacts of poverty and promoting economic and social inclusion. Other community welfare services may include running scheduled public clinic services, which may target specific groups at risk such as older people, the homeless and immigrants.

Health promotion

Health promotion is managed by an assistant national director with specific responsibility for health promotion within the Population Health Directorate. Responsibilities previously executed by the Health Promotion Unit of the DoHC have been transferred to the HSE. Work has been guided by the “National Health Promotion Strategy 2000–2005”, which built on the previous 5-year strategy published in 1995. Specific strategies also have been developed since the launch of the first Strategy, including a National Alcohol Policy (1996); Plan for Women’s Health (1997); Health Promotion in the Workplace: Healthy Bodies – Healthy Work (1998); Health Promotion Strategy for Older People (1998); the Report of the National Task Force on Suicide (1998); Youth as a Resource: Promoting the Health of Young People at Risk (1999); Building Healthier Hearts (1999); and Reach Out: National Strategy for Action for Suicide Prevention (2005).

Activities include national health promotion campaigns; storage, distribution and printing of health promotion materials; funding of voluntary agencies; and facilitation of partnerships with key national statutory agencies, voluntary agencies and the community sector. Issues covered include promoting mental health, smoking cessation, sexual health, promoting physical activity and nutrition programmes. Work in 2006 included awareness-raising initiatives with regard to alcohol, breastfeeding and diabetes, as well as the development of a national tobacco framework incorporating guidelines and quality standards for smoking

cessation services (HSE, 2007c). The HSE is also responsible for monitoring the level of compliance of local authorities with current fluoride regulations. In Ireland, water has fluoride added to it. The Report of the Forum on Water Fluoridation in 2002 supported the continuation of the fluoridation of water supplies, concluding that fluoridation had made a very significant contribution to dental health and that, at current permitted levels, human health is not adversely affected.

Ban on smoking in the workplace

One of the most significant actions undertaken to promote public health came into force on 29 March 2004 when Ireland became the first EU Member State to introduce an almost total ban on smoking in the workplace, including bars and restaurants. At the time of writing, fines of up to €3000 may be levied on those employers who do not enforce the law. Exemptions from the ban include prisons, nursing homes and psychiatric hospitals, as well as hotel bedrooms. EU directives restricting tobacco advertising and sponsorship also came into force. The ban follows a report prepared on *The health effects of environmental tobacco smoke (passive smoking) in the workplace*, commissioned by the Office of Tobacco Control and the Health and Safety Authority, which concluded that exposure to the hazards of tobacco smoke can best be controlled by legislation in places of work. The measure has been broadly welcomed by the general public, health interest groups and Irish trade unions (Irish Cancer Society News, 2004). The Irish Business and Employers Confederation also said that the ban had caused “little or no difficulty” to its members (Irish Business and Employers Confederation, 2004). A follow-up survey conducted in May 2004 reported 97% compliance with the ban and no negative impact on trade, although in July 2004 some publicans in the west of the country in particular had flouted the ban until threatened with legal action. As yet, it is too early to reach any conclusions about the long-term economic impacts of the ban.

Health Action Zones

Following the publication of the National Health Strategy, with its holistic view of health care and an emphasis on promotion and prevention, the MoHC in 2002 approved a pilot project and provided funding of €200 000 to establish two HAZs in Cork City. These HAZs were intended to be similar to those seen in the United Kingdom, where they have been used to help develop a coordinated approach to tackling both poor health and health inequalities in areas of social and economic deprivation. The project goes beyond developing strategies for health services and examines other issues which impact on health and well-being in the community. The pilots, which won an HSE Special Achievement Award in 2006, were evaluated and mainstreamed into HSE activities in 2005.

6.2 Patient pathways

One possible patient pathway through the health care system can be illustrated using the example of an individual with chronic hip pain. Following the onset of symptoms, initially an individual will go to a local GP for a consultation. The GP may make a diagnosis of hip joint damage, due for instance to osteoarthritis, and refer the patient to a consultant in osteoarthritis. Primary treatments may include advice on diet and lifestyle (to help reduce disease progression), the prescription of pain-relieving medications, access to aids and adaptations, and physiotherapy. A patient may be monitored on an outpatient basis over a number of years. If joint damage becomes severe then different surgical options may be presented to the individual, including partial and total hip replacement. Information on the implications of these different options in terms of pain, mobility and quality of life will be provided. The final decision on whether to receive any surgery rests with the patient.

If agreement between the individual and her/his doctor(s) is reached regarding the need for surgery, the patient is placed on a waiting list for treatment. After a median waiting time of three months, (nationwide hospital waiting times for hip surgery range between 1 and 11 months), an individual will be scheduled to undergo surgery. If an individual has been waiting longer than three months for treatment s/he may be referred to the NTPF by their GP and offered treatment (usually) in a private hospital. The hospital carrying out the treatment will write to the individual, inviting them to a pre-admission clinic (usually about two weeks before surgery). At this clinic they will be examined to make sure that they are fit enough for the anaesthetic and the operation, and then the operation will be confirmed. This also provides another opportunity for the patient to discuss any possible complications and receive further advice about what to do before or after the surgery (for example, post-operative exercise).

Typically, the patient will be admitted to hospital the day before the operation. After surgery s/he will be given medication to help relieve post-operative pain. After 24 – 48 hours the individual will be able to start walking, first with a frame and soon with elbow crutches or sticks. Return to normal activities will depend on many factors, including age, well-being, strength of muscles and condition of other joints. A physiotherapist will help individuals to move freely and will provide advice on exercises to strengthen muscles. An occupational therapist will also advise individuals on how to be independent in daily living and will carry out an assessment of the need for help at home. They might also arrange and/or provide aids and adaptations to help with daily living activities, such as washing or dressing.

After surgery, typically an individual would be discharged from hospital within 6–10 days. At home a district nurse will change bandages and take out any stitches (sutures). An outpatient consultation usually takes place 6–12 weeks after surgery. This is used to monitor progress and may lead to an individual being offered outpatient physiotherapy to help improve recovery. In the long term, although the durability and quality of hip replacements continue to improve, younger individuals may consult again with a specialist regarding a further hip placement many years in the future, in the event that their replacement hip wears out.

6.3 Primary/ambulatory care

Primary care plays a central role in the provision of health care services in Ireland, involving not only access to GPs but also to a broad range of community-based services including nursing, social work, chiropodists, midwives, physiotherapists, occupational therapists, speech and language therapists, child health care, dental care and ophthalmic care services.

Primary care services can be traced back to the Irish Dispensary System set up in 1851. The Poor Relief (Ireland) Act of 1851 placed a duty on Irish Poor Law Commissioners to ensure that local health care dispensaries were set up. Under this system the poor could receive treatment from a state-employed physician at their local dispensary. These physicians could then treat the rest of the community on a private basis. The distinction in service provision between the poor and non-poor was highly visible, but moves towards a United Kingdom-style NHS or Bismarckian comprehensive social insurance system never materialized in Ireland – in part due to the influence of the Catholic Church, which felt that such initiatives were in conflict with the principle of individual responsibility, and might be seen to promote socialism.

Thus, the dispensary system remained in place with only some limited change for a period of over 100 years, until the Health Act of 1970, when the current system of primary care was established, involving the provision of the GMS Card (see Chapter 3 *Financing*). The new GMS system allowed, for the first time, some choice of primary care doctors for the whole population, although this still meant that only around one third of the population (who qualified for Medical Card/Category I status) would have free access to GP services. Other schemes were set up to cover individuals with chronic illness, while a cap was set on the level of out-of-pocket payments in relation to pharmaceutical expenditure through the Drugs Payment Scheme (see Chapter 3 *Financing* and Section 6.6 *Pharmaceutical care*).

At the end of 2006 there were more than 2.91 million people registered as being eligible to benefit from either the GMS scheme or related schemes. A total of 1 221 695 people were eligible for the GMS scheme (that is, holders of Medical Cards), which represents 28.85% of the total population; 1 525 767 people (36.03% of the population) are covered under the Drugs Payment Scheme; and 106 307 (2.51% of the population) are covered by the Long-Term Illness Scheme (HSE, 2007g). More than 95% used either the GP, Pharmaceutical, Dental or Ophthalmic services that were provided by 5811 health professionals under the GMS system.

However, as discussed in Chapter 3 *Financing*, with growing economic prosperity the proportion of individuals qualifying for Category I status has declined in recent years. Recognizing that the charges levied by GPs for a consultation (typically €60–80) might act as an inappropriate deterrent to service use, and mindful of the increasing number of individuals choosing to present at hospital A&E departments (where consultation charges are lower), in 2005 a GP Visit Card was introduced to supplement the Medical Card. This new card allows individuals with modest incomes just above the cut-off point for Medical Cards to qualify for free GP services; 51 760 individuals (1.22% of the population) held GP Visit Cards at the end of 2006 (see Subsection *Compulsory sources of financing*, within Section 3.3 *Revenue collection and complementary sources of funding*).

There has been much debate on the primary health care system in recent years, with some commentators arguing that the primary care system has been somewhat neglected in comparison to the hospital sector. However, the importance of primary care is clear in national health policy. The recognition that primary care services needed to be reformed and strengthened so that they would be capable of dealing with “90–95% of all health and personal service needs” formed a cornerstone of the blueprint of current reforms set out in *Primary care: A new direction* (DoHC, 2001a). Significant reform within the primary care sector is under way and is discussed later in this chapter.

General practitioner services

GPs usually provide the first point of contact for health care, followed by referral to specialist physicians, if necessary, who operate largely in hospital settings. GPs, therefore, are regarded as the “gatekeepers” to secondary care. It is possible to directly access secondary care, but a standard fee (€60) is charged for a non-emergency visit to an A&E department in acute public hospitals. Consultations are free if the individual has a letter of referral from their GP or is a Medical Card holder. The primary purpose of this charge is not to raise

additional funding but rather to discourage inappropriate attendance at A&E departments by those with conditions which could be easily treated within primary care. (In recent years, however, the increase in charges levied by GPs has reduced the impact of this co-payment as a deterrent to the use of A&E services.)

GPs are self-employed, usually working in single-handed practices or in some form of joint practice – or cooperative arrangement – in which, for instance, out-of-hours work might be shared. In 2001 approximately 51% of all GPs worked in single-handed practices, 26% in partnerships comprising two individuals, 15% in partnerships comprising three individuals and 8% in practices of four or more partners (National General Practitioners Information Technology Group, 2001). While there are some GPs who work exclusively either in the public or private sector, the majority treat both private and public patients.

Those providing public sector services enter into a contractual agreement with the National Primary Care Reimbursement Board. Fees are based primarily on weighted capitation, plus additional payments for special services (see Chapter 3 *Financing*). GPs working solely in the private sector may still have a contract with the HSE to provide publicly funded care for their private patients when they reach the age of 70 (and thus qualify for a Medical Card automatically, irrespective of income level) or if they have patients who have been infected with hepatitis C (see Chapter 3 *Financing*). More generally, most GPs provide public maternity, infant and vaccination services on behalf of the local PCCC Directorate office of the HSE. Category I (Medical Card) patients must register with a specific GP of their choice (hence the scheme is sometimes known as the Choice of Doctor scheme), while all others who pay privately for services are free to seek health care services from any GP.

Other primary care services

In the former ERHA area alone, in 2004 it was estimated that nearly 800 GPs and 1000 nurses would provide primary care services, and that over 40 000 contacts would be made with GP out-of-hours cooperatives. A total of 5000 people would also receive orthodontic treatment; 42 000 schoolchildren would receive dental treatment; and 94 000 treatments would be carried out under community ophthalmic schemes (ERHA, 2004a). All the Health Boards were developing primary care services and introducing innovations in line with the National Health Strategy and other documentation.

In each region of the HSE, there are a number of specific strategy projects, including those related to cardiovascular health, such as smoking cessation and Cardio-Pulmonary Resuscitation (CPR) training. Vocational training

schemes may be provided for health care professionals, while increasing use is being made of ICT in primary care at local level – for instance, through the implementation of secure GP e-mail services and the further rollout of Public Health Nurse mobile computing.

Community nursing services

Community nursing services were previously provided by all of the Health Boards, and now by the HSE. These include not only general nurses but also specialists working in public health, geriatrics, mental health and midwifery. Home helps and health care assistants who provide assistance and care for people within their own homes may also be provided. The majority of GP practices have at least one practice nurse.

Ongoing reform: implementation of the Primary Care Strategy

Ongoing reforms aim to better organize and support GP services so that the system may support a wider and more integrated role within the health care system. *Primary care: A new direction* (2001) set out the proposed reforms, together with an implementation timetable and plan. In essence, the plan proposed that an interdisciplinary team approach be adopted for the delivery of primary care services. This would be phased in, building on the existing infrastructure, over a 10-year period. At the time of writing, greater emphasis is being placed on health promotion, prevention, early rehabilitation and personal social services, in addition to the focus on diagnosis and treatment. Another objective is to encourage public–private partnerships, where practical.

The National Health Strategy noted that:

Primary care needs to become the central focus of the health system. The development of a properly integrated primary care service can lead to better outcomes, better health status and better cost–effectiveness. Primary care should therefore be readily available to all people regardless of who they are, where they live, or what health and social problems they may have. Secondary care is then required for complex and special needs which cannot be met solely within primary care (DoHC, 2001a).

While the report recognized the crucial role played by primary care professionals in delivering excellent primary care services and in ensuring public satisfaction, it noted this was achieved despite not having an effective infrastructure; one key limitation was the lack of availability of many professional

groups and limited out-of-hours access to some services, increasing the burden on secondary care. Key challenges identified in the 2001 report included:

- poorly developed primary care infrastructure and capacity;
- current system fragmentation from the users' perspective;
- limited opportunities for user participation in service planning and delivery;
- emphasis on diagnosis and treatment with weak capacity for prevention and rehabilitation;
- no full realization of the potential to reduce pressure on secondary care;
- secondary care is providing many services which are more appropriate to primary care;
- current system is oriented around the needs of providers rather than users;
- underdeveloped out-of-hours services;
- limited availability of many professional groups;
- professional isolation;
- limited teamwork taking place;
- inadequate communication between professionals and sectors;
- lack of quality assurance framework; and
- limited information from primary care for planning, development and evaluation.

The policy response to the weaknesses identified in 2001 was to develop Primary Care Teams. Each one, effectively providing a “one-stop shop”, would serve a population of between 3000 and 7000 people depending on whether it is located in an urban or rural area. Nationally, between 600 and 1000 Primary Care Teams are required. Essential skills within the teams are to include assessment, diagnosis, occupational and physiotherapy, nursing, midwifery, prevention, home help, health education, counselling, administration, management, social services, referral and rehabilitation (see Box 6.1). In addition to these core teams, a network of more specialist professionals would provide services to the new teams. These specialists may include chiropodists, community welfare officers, community pharmacists, dentists, dieticians, psychologists, and speech and language therapists. As well as investment in education and training, electronic health records were to be developed as part of the General Practice Information Technology Project, in order to improve communication and the flow of information.

Box 6.1 Primary care team numbers envisaged (based on a population of 5000)

GP	4.0
Health care assistant	3.0
Home helps	3.0
Nurse/midwife	5.0
Occupational therapist	0.5–1.0*
Physiotherapist	0.5–1.0*
Social worker	0.5–1.0*
Receptionist/clerical officer	4.0
Administrator	1.0

Source: DoHC, 2001a.
Note: GP: General practitioner; * To be assessed.

To implement the strategy, individuals would be actively invited to enrol with a practice and primary care centres would be charged with working with other local population groups and agencies to identify local needs. Additional funding would be provided for screening, immunization, early-intervention services and cross-sectoral interventions, such as those in schools or community education projects. Links with secondary care would also be strengthened, discharge plans would be prepared for those leaving the secondary care sector and individual care plans would be formulated, along with integrated care pathways and shared-care arrangements. A single-point, 24-hour access telephone and internet health information, advice and triage system also would be set up.

Generally, the strategy was welcomed by professional groups, including the ICGP (ICGP, 2004a). A National Primary Care Taskforce was set up to oversee the implementation of the strategy, reporting to a wider National Primary Care Steering Group, chaired by Professor Ivan Perry and containing representatives from the Health Boards, professions and expert groups. Specifically, the Steering Group was charged by the MoHC with (Martin, 2002):

- defining a broad set of primary care services to be delivered by Primary Care Teams;
- developing quality systems, including the development of performance indicators, in primary care service delivery;
- identifying models and locations for the establishment of academic centres of primary care as a source of policy and practice advice to the DoHC, Health Boards and other bodies, as appropriate; and
- developing a national framework for integration within primary care and between primary and secondary care.

The new primary care provision model emerging from the developments outlined above has been subject to consultation, led by the Primary Care Steering Group, and a series of Strengths, Weaknesses, Opportunities and Threats (SWOT) analyses (National Primary Care Steering Group – Services Sub Group, 2004). One key concern has been whether it will be possible to train, recruit and retain all the additional professional staff required. Ensuring the availability of a balanced Primary Care Team will only prove feasible if adequate staff are available in the required disciplines and on an appropriate geographic basis. Another challenge to be faced, in the absence of strong incentives, is to persuade primary care professionals to voluntarily “opt in” to the new Strategy.²³ Considering that about half of the GPs in Ireland operate in single-handed practices at the time of writing, it is to be reasonably expected that it will require more than a government commitment to an interdisciplinary, team-based approach to support and advance this objective. Certainly, the continued support of a range of stakeholders is crucial, including the ICGP, which has consistently argued that primary care has been neglected by successive governments in comparison to hospital care (Wren, 2003).

Different models of working in partnerships have been set up and evaluated, with a view to establishing approaches countrywide. A total of 10 implementation projects, one in each (former) Health Board area, were approved in October 2002 in order to provide an opportunity to test the new model on the ground. Three community-based diagnostic centres were also piloted and evaluated. Additional revenue and capital funding was provided to support the development of these projects. The initial infrastructure costs associated with setting up the pilot Primary Care Teams were €2.5 million per team or a total cost of €1270 million (at 2001 prices). In addition, there would be one-off IT costs of €50 million and annual costs of €10 million at the end of the 10-year period. It is estimated that an additional 500 GPs and 2000 nurses/midwives would be required, together with significant increases in representation of other professional groups. Staffing costs at the end of the 10-year period will be €484 million per annum.

First progress report on implementation of the strategy

The National Primary Care Strategy Steering Group produced its first report on the implementation of the strategy in July 2004. The Steering Group, while recognizing that the current health service reform programme “provided an opportunity to mainstream primary care within the health system as a whole”, noted that the momentum for reform in the sector generated by the Primary Care

²³ Policy documents do mention the benefits to professionals of working in teams and avoiding isolation, but do not appear to provide other more formal incentive mechanisms, although GPs may become budget holders similar to the old Primary Care Groups in England.

Strategy may become dissipated in the wider process. In particular, there was concern among members of the Steering Group that in discussions regarding acute hospital services reform (the Hanly Report) the pivotal role of primary care received insufficient attention. Clearly, it is more difficult to reduce pressure on secondary care services or develop a sustainable “hub and spoke” model of hospital care without an adequately resourced multidisciplinary primary care infrastructure. The group called for “substantial and sustained investment in the years ahead to provide the additional capacity to implement the strategy on a system-wide basis”.

The Steering Group members were of the opinion that eligibility for primary health care services still excluded too many families on modest incomes, aggravating health inequalities, and needed to be clarified further, particularly given the role for public-private partnerships in the provision of capital for primary care projects. In the long term, they felt that there should be an aspiration for universal free access to primary care services in Ireland. Among the report’s other recommendations were that a Primary Care Division be established within the DoHC and a function established within the new HSE to drive forward implementation of the Primary Care Strategy (National Primary Care Steering Group, 2004).

Following the publication of the Steering Group’s report, the DoHC introduced measures in 2005 at a cost of €60 million to increase the number of individuals eligible for Medical Cards, as well as introducing a new GP Visit Card for those on slightly higher incomes (see Chapter 3 *Financing*).

As part of the restructuring of the DoHC, there is now a Primary Care and Social Inclusion Public Health Division and the internal structures of the HSE have also been reformed. The HSE were committed to introducing a major change management programme to better reorientate primary care services to the goals of the Primary Care Strategy and to disseminate and transfer knowledge and learning from the 10 existing multidisciplinary Primary Care Teams. Common standards on out of hours services, better coordination and increased integration between services were emphasized. By the end of 2005, out-of-hours cooperatives were available in at least part of 25 of the 26 counties in the country, and the introduction of more out-of-hours services and expanded palliative care facilities have also been promised (HSE, 2005c).

Speaking in the House of Representatives (*Dáil*) in March 2006, the Minister of Health again reaffirmed the Government’s commitment to the principles contained within the Primary Care Strategy, pledging additional financial support of €16 million, of which €10 million was to support the establishment of 75–100 Primary Care Teams nationally. This, she estimated, would enable the provision of 300 additional front-line personnel to work alongside GPs

to provide integrated and accessible services in the community. A further €4 million was provided for the establishment of additional GP training places and €2 million to enhance GP out-of-hours cooperatives (Dáil Éireann, 2006). By early 2008, 80 teams were in place, with the intention of increasing this to 530 teams in 2010. Each team will serve between 8000 and 10 000 people (larger than originally envisaged in the 2001 Strategy) (HSE, 2008c).

Equity of access to primary care

An equity concern within the Irish health care system has been access to primary care services. Until 2005 these services were available free of charge to patients with Medical Cards, as well as some other (limited) specific population groups, but for more than two thirds of the population charges applied, set independently by GPs. Historically, within the health and political systems there has been much resistance to the introduction of a free, universal primary care system, even for children, although the issue of the extension of medical care coverage has been on the political agenda in the last few years, with the Labour Party proposing universal access; Fine Gael proposing an extension of Medical Card coverage; and the National Primary Care Steering Group also being in favour, in the long term, of free universal coverage to help implement the new Primary Care Strategy. These concerns have been particularly relevant within the context of the declining proportion of the population entitled to Medical Cards in recent years. The two increases in the income threshold for Medical Card entitlement in 2005, as well as the introduction of the new GP Visit Card (see Chapter 3 *Financing*), was the Government's response to these concerns.

The costs to individuals not qualifying for Medical Cards can be significant, especially for those just above the qualifying income threshold. In 2002 it was estimated that one visit to a family doctor cost one third of the weekly income of an individual just above this threshold (Wren, 2003). Another more recent analysis suggests – after controlling for socioeconomic and health status – that Medical Card holders are significantly more likely to visit their GPs, and also visit their GPs more frequently, than those without Medical Cards (Nolan & Nolan, 2003). This may reflect overconsumption of primary care services on the part of Medical Card holders, but also may be evidence of the underconsumption of services for the two thirds of the population faced with financial barriers to access to primary care services. This same study reported that those with private health insurance were also more likely to visit GPs than those without insurance, which may indicate that the population group that may be most affected are those above the Medical Card threshold, but for whom private insurance is either not affordable or not thought to be necessary. This issue of equity of opportunity to access primary care is crucial to the success

of a primary care-driven health system, as envisaged in the Health Strategy, and is one that can have significant resource implications for the utilization of secondary care resources (Tussing, 2001).

Until very recently, voluntary health insurance packages in Ireland provided only very limited coverage for primary care, usually subject to a deductible of several hundred euros (see also Subsection *Health care benefits*, within Section 3.2 *Population coverage and basis for entitlement*). A wider range of packages is now available from all three principal insurers, including those that do not include the payment of a deductible. Future analysis will be required to examine the impact on utilization of primary care services in terms of both enhanced insurance packages and the availability of the GP Visit Card.

A different equity concern is that of the location of primary care practices. At the time of writing the capitation fee schedule pays a rate between three and five times higher for those over 70 years of age who received a Medical Card since 2001, compared with those already in possession of a Medical Card prior to that year. This potentially could have some influence on the location of GP practices, that is, by acting as an incentive for practices to be located in more affluent locations. At the time of writing, however, there is insufficient evidence to determine whether this is the case. One survey conducted by the Centre for Insurance Studies, University College Dublin, reported that one third of 1000 individuals questioned said that their decision to visit an A&E department was influenced by GP availability, while 28% reported that they made their decision because of the lower charges for an A&E visit (without a referral), compared with those for consulting a GP (RTE News, 2004).

6.4 Secondary and tertiary care

Access to the publicly funded acute hospital sector generally requires an initial letter of referral from a GP unless an emergency admission is required. The public hospital sector incorporates both “voluntary” and HSE hospitals which may be further subdivided into regional, county and district hospitals (see Chapter 5 *Physical and human resources* for information on hospital structure). HSE hospitals are funded directly by the State, via the HSE in line with the commitment set out in the NSP. Public voluntary hospitals are primarily financed by the State but may be owned and operated on a non-profit-making basis by religious and lay boards of governors. They remain independent of the HSE. While historically, hospitals were run by both the Roman Catholic and Protestant churches, only one major hospital (the Adelaide and Meath) still maintains a Protestant ethos, while many still have a Catholic perspective. The hospital sector accounts for approximately 50% of health expenditure.

The relationship between primary and secondary care: reform of the acute hospital sector

As noted in Section 6.3 *Primary/ambulatory care*, it is recognized that the Irish health care system has been far too dependent on secondary care services. Reforms in the Primary Care Strategy have been intended to redress this balance and strengthen primary care services so that they can deal with “90–95% of all health and personal service needs”. Lack of access to out-of-hours primary care services and user charges for such services have acted as incentives for individuals to present themselves at A&E departments of acute hospitals. Indeed, between 1995 and 2000 alone, inpatients admitted through A&E increased by 8%. Waiting lists also became a major political issue. The structure, organization and roles of the acute and community/district hospital services in Ireland are the subject of renewed scrutiny at the time of writing. Such scrutiny is not new; as far back as 1968, radical restructuring of the hospital system had been proposed by the Fitzgerald Report, which had recommended that there should be 4 regional and 12 general hospitals, with remaining hospitals becoming new community health centres (Fitzgerald, 1968).

As part of the 2005 reforms, acute hospitals became the responsibility of the HSE NHO. A key function of the Office is to advise on the organization, planning and coordination of acute hospital services, including the location and configuration of particular services or specialties. A total of 10 hospital networks were established, subsequently reduced to eight networks by the end of 2005.

Prior to 2005, at Health Board and ERHA level various initiatives were undertaken to ensure that the setting for treatment was appropriate. For instance, in the ERHA a number of coordinated initiatives in the provision of care between the primary and secondary care settings were carried out. For example, the diabetes shared-care programme involved St James’s Hospital and GPs in the South Inner City Partnership, and Beaumont Hospital and GPs in its catchment area. This shared-care approach has been subsequently embedded into the model of patient care developed by the DoHC and the HSE (DoHC, 2006b). A “Home First” project was instigated in the former Northern Area Health Board from 2001 to facilitate the care of older people in their own homes rather than in hospital; similar schemes can now be found elsewhere, although access to such services remains varied.

While the major focus of the Report of the National Task Force on Medical Staffing (Hanly, 2003) was staff related, redressing the balance between NCHDs and consultants would have significant implications for the way in which acute hospital care services are provided. The implications for the hospital structures were examined in two regions, the East Coast Area Health Board and the Mid-Western Health Board. Multidisciplinary specialist teams would deliver more

effective care, but this would have implications for the size of clinical units, volumes of activity and access to specialist equipment and facilities. A high level of activity is also required to maintain skills. The report noted that “the cost of providing a full spectrum of services throughout the current acute hospital system would be unsustainable in terms of maintaining adequate standards of medical practice and fiscal prudence” (Hanly, 2003).

In consultations the Task Force found that a number of issues needed to be addressed:

- problems with equity of access to public hospital care for public patients, with poor linkages between hospitals, GPs and community health services;
- inadequate data and information systems;
- intra-professional obstacles and a lack of multidisciplinary teamwork;
- claims that some specialties are not adequately equipped to provide the full range of tests and support they are required to;
- while staff working in some settings encounter a wide variety of illnesses among patients, a low volume of patients in some of these areas makes it difficult for them to keep the required range of skills up to date;
- problems in the choice of location for delivery of care to trauma and emergency patients;
- significant, inappropriate or avoidable use of acute hospital beds;
- shortages of service alternatives to acute hospital care;
- lack of integration in the management of hospitals within a region and, in some instances, problems with the capacity of management to plan effectively and deal with current service issues; and
- consistent criticism of local pressure which is focused on “safeguarding” local facilities without regard to the best way forward in terms of providing safe and effective care.

Based on findings in the two pilot regions, the report recommended that acute care should be delivered by a small network of integrated local and major regional hospitals serving populations of approximately 350 000, while a small number of specialist services should continue to be provided on a supra-regional or national basis. Local hospitals would deliver such services as diagnosis, a proportion of elective day surgery and medical procedures, rehabilitation and long-stay care. GPs would be able to access services and diagnostic facilities. Major hospitals would provide all the services found in acute hospitals that were not being delivered in the local hospitals. NCHDs would divide their time between work in local hospitals and the major hospital in the region. The report also concluded that primary care, community care and long-term care should

be an integral part of the network and that a report should be prepared on the organization of acute hospital care outside the pilot area regions.

In welcoming the publication of the report, the then MoHC confirmed that he was committed to the principle of the Hanly recommendations and would work to facilitate their implementation in consultation with stakeholders. He also emphasized that no hospital would be closed, nor was closure recommended by the report (although the report does imply that the functions of many single-specialty hospitals should be mainstreamed). Critics of the report have argued that there is too much focus on producing high volume, without sufficient regard given to issues of quality – a criticism refuted by the Government. The ICGP rejected the proposed “hospital-centred and specialist-driven” realignment of the health care system on the basis that such a move would dramatically increase direct costs (employment of more consultants) and indirect costs (the use of more expensive investigations and treatment, and recruitment of extra specialist nurses and other paramedical staff). Instead the ICGP argued for greater investment in primary care resources, diagnostics and patient education (ICGP, 2004b).

Equity and efficiency within secondary and tertiary care

Perhaps surprisingly, it was only in the 1994 Health Strategy that quality was documented for the first time as a key objective of the health system. Prior to this time, in an almost perpetual era of fiscal constraints, the focus had been more on trying to maintain existing public services in a consultant-driven, mixed public–private system. Subsequent economic growth has led to substantially greater investment in the health care system, but the continuing reliance on the mixed public–private provision of services within public and voluntary hospitals has led to continuing concerns about both the efficiency of, and equity of access to, services. Quality issues, in contrast, have received much less attention.

There is a long-standing perception that private insurance permits faster access to hospital care (Harmon & Nolan, 2001). Access to prompt health care in the public system was to be protected by requiring hospital managers to designate hospital beds as being either public or private, with a recommended ratio of 80:20. Private patients could only be treated in these designated private beds; however, in reality the proportion of beds designated as private has consistently remained above this level. HIPE data from 2000 indicate that, in fact, 30% of all elective patients were treated privately, compared with 21% of emergency patients. Furthermore, this guideline did not cover patients being treated on a day-case basis, and as the Acute Hospital Capacity Review (DoHC, 2002a) indicated, day cases have grown considerably from just 2%

of all non-outpatient care in 1980 to 38% of all hospital activity and 68% of all elective activity in 2002. Between 1995 and 2000 alone the number of day cases increased by 68% or an annual average of 13.5% (DoHC, 2002a). Treatment of elective patients in public hospitals is likely to contribute to increased waiting times for public patients, given the increased rate of day cases and the higher proportion of patients treated privately.

The Acute Hospital Capacity Review only briefly mentioned the issue of bed designation and did not recommend any radical reform in management. Instead, the report recommended that an additional 3000 hospital beds be made available over a 10-year period. The proposed expansion would amount to an overall increase of 25% in the acute hospital bed stock, with additional beds designated solely for public use. To place this initiative in context, it is worth noting that in the latter part of the 1980s, as part of the public expenditure cutbacks, approximately 20% of acute hospital beds were taken out of the system. The need for rationalization of the acute hospital system and the closure of many small and outdated hospitals, in particular, had been proposed since the mid-1960s (Fitzgerald, 1968), and the public expenditure crisis in the late 1980s facilitated the political process to proceed with hospital closures. Some indication of changes in capacity and utilization over the period may be appreciated from the fact that in 1987, just 512 000 patients were treated in 15 200 hospital beds while in 1999, 12 400 hospital beds (inpatient and day care) supported the treatment of over 820 000 patients on an inpatient or day-case basis.

Among the factors cited as warranting a review of acute bed capacity within the Irish health care system was the proposition that “average bed occupancy is one of the highest in the OECD” and “the number of inpatient care beds in Ireland is among the lowest in OECD countries and the lowest among EU countries at 3.7 per 1000” (DoHC, 2002a). Against this background, the report determined that an average bed occupancy of 85% nationally was the standard against which the need for additional capacity would be decided. In addition to the high occupancy levels and persistent waiting lists, the report cited the projected population increase and the ageing of the population as the main factors underlying the need to expand bed capacity in the acute hospital sector. Given these factors, the report estimated that a net increase of 2840 inpatient beds was required, together with an additional 190 day beds (net). This estimate was arrived at on the basis of a range of other proposals to reduce the need for inpatient beds, including measures to decrease delayed hospital discharge, increased occupancy in hospitals where the standard fell below 85%, increased use of day care facilities and improved management of public and private beds for elective patients.

While an increase in hospital bed capacity may be warranted, the adoption of an essentially “unidimensional” approach to the estimation of hospital capacity requirements may prove problematic. In recognizing the limitation of this approach, the report noted that “many of the factors identified ... operate simultaneously and interactively in a complex manner which is difficult to model” (DoHC, 2002a). While acknowledging the difficulties involved, the failure to attempt any such modelling exercise or sensitivity analysis was a serious drawback. Additional deficiencies arose because the implications for staffing, together with the distribution of the proposed additional bed capacity by specialty or geographic region, were not addressed. Ensuring adequate staffing for the acute hospital system at the level of capacity required at the time of writing is proving problematic. While the Health Strategy report (DoHC, 2001b) acknowledged the challenge of ensuring a supply of appropriately skilled human resources within the health care system, the implications for staffing levels are not addressed in the context of the proposals put forward for increased hospital capacity; however, some were later addressed by the National Task Force on Medical Staffing (the Hanly Report) (Hanly, 2003). Unless appropriate staff can be recruited, service levels will not be increased, regardless of the scale of any increase in facilities.

Finally, and of particular concern, is the view in the Strategy report that:

... quantifying the potential for improved efficiency in the throughput of patients in the acute hospital (from admission to completion of acute medical care) is difficult. Furthermore, it has been suggested that current inefficiencies in the hospital system are compounded by capacity problems, and are unlikely to improve until capacity is increased” (DoHC, 2001b).

In fact, there is ample evidence of inefficiency problems within the Irish acute hospital system and any suggestion that such inefficiencies must await an increase in capacity before being addressed is seriously problematic (Wiley MM, 2001; Nolan & Wiley, 2000). An increase in hospital bed numbers, in itself, will not lead to a reduction or abolition of waiting lists, nor will it contribute to an increased level of activity or a reduction in occupancy levels if structural or organizational deficiencies are allowed to persist.

Thus, while increasing the number of acute beds may mitigate some of the problems of access to care if they are kept strictly within the public sector, underlying equity and efficiency issues will persist. This is of particular significance given that, in a positive attempt to reduce public waiting lists, the NTPF (see later) pays for patients to be treated in purely private hospitals at a much higher cost than that paid by private patients treated

in the public/voluntary sector hospitals. Even if the 80:20 split is adhered to, this practice guarantees the (long politically accepted) vision, dating back to the 1940s, of a private–public mix in funding and in delivery of services. The old Consultants’ Contract that remains in effect for those who do not move to a new contract option (see Chapter 5 *Physical and human resources*) guarantees private practice and income while also, on the surface, appearing to generate additional revenue for publicly funded hospitals. To date, the conditions governing employment of hospital consultants by the public health care system have been agreed under the Consultants’ Common Contract. While this contract specifies consultants’ commitment of 33 “notional” hours to the public hospital(s) of appointment, it has never been clear as to what the expectation is regarding the commitment of consultant time to the treatment of public patients. As noted also in the Brennan report (Brennan 2003), clarification of the contractual commitment of hospital consultants to public patient care, whether in terms of time or other appropriate measures, would be an important starting point for the subsequent contract reforms to “level the playing field” for the treatment of public and private patients within the acute hospital system. This would seem to be particularly important given the recommendation of the Medical Manpower Forum for a substantial increase in the number of hospital consultants (see Chapter 5 *Physical and human resources*).

It has been argued that private patients²⁴ who are treated in publicly funded hospitals effectively jump the waiting list to access services provided in public hospitals, regardless of clinical need, because of incentive structures. This raises both efficiency and equity concerns. The 1999 White Paper, *Private health insurance* (DoHC, 1999b), had recommended moving towards full economic costs for private patients by the middle of the next decade. However, private patients treated within public and voluntary hospitals still do not pay the full economic costs of their treatment and are, in effect, subsidized heavily by the public system (in addition to receiving tax relief for insurance contributions). In 2006 it was estimated that charges for private beds in public hospitals only accounted for 80% of their costs, while charges for semi-private beds only covered 63% of costs (Wall, 2006).

This also provides private insurers with a perverse incentive, where possible, to have their patients treated within public or voluntary hospitals rather than purely private hospitals where costs will be higher but the impact on access to public beds much lower.²⁵ To help eliminate these incentives the Government confirmed that from 2005 onwards, charges for private beds in public hospitals would be increased so as to eliminate the public subsidy for private stays in

²⁴ Individuals with insurance coverage are likely to be younger than public patients.

²⁵ Category II consultants may also practise in private hospitals, which may therefore still have some impact on waiting times for treatment in public hospitals.

public hospital beds (DoHC, 2004e). These subsequently increased by 25% in both the Budgets for 2005 and 2007, the latter substantial rise in part being used to fund improvements to the care of older people.

The quality of care delivered to public patients has also been questioned by some commentators, as they are far less likely to receive care directly from hospital consultants, instead receiving care from NCHDs. These doctors tend to have more limited experience, rotating between units every six months; moreover, there has been a perception that some of those trained overseas may be at a disadvantage compared to those more familiar with the Irish population. Consultants are paid on a fee-for-service basis for private work, but are paid a salary for their public work. Hence, they do not have a marginal incentive to spend more time with additional public-sector patients, although of course, this is not to say that consultants are motivated solely on the basis of pecuniary rewards. However, case studies have been cited referring to a number of incidents within the health care system that might perhaps have been avoided if public patients had received more hands-on care provided by consultants (Wren, 2003). Finally, in the context of increasing quality, the Hanly Report recognizes the need to transform the acute hospital system from one that is consultant led to one that is consultant driven, by increasing the number of consultants in the system. The Report of the Forum on Medical Manpower in 2001 also highlighted the need for more fully trained doctors, with enhanced postgraduate training arrangements, as the balance between fully trained and partially trained doctors is not beneficial to optimal patient care and, for some doctors, can result in heavy workloads (Forum on Medical Manpower, 2001).

Waiting lists for treatment

Compounding the problem of access to hospital care for public patients, geographical inequities in access to services across regions and in urban versus rural settings have been widely reported, as well as differences in prescribing patterns (Harkin, 2001; Bennett, Feely & Williams 2002). There have also been challenges in recruiting sufficient human resources for health care, particularly outside the Dublin conurbation (see Chapter 5 *Physical and human resources*). The 2001 National Health Strategy acknowledged these issues and indicated a need to address the “2-tier element” of hospital services so that all individuals have fair access to elective treatments within a reasonable time period, irrespective of their status as public or private patients or where they live (DoHC, 2001b). The responsiveness of the system to patient needs was also acknowledged as an area for further development, with recognition that patients should be empowered to have a much greater say in treatment options, and receive more information on waiting times.

Actions to increase the number of acute hospital beds (see earlier) were augmented by setting a target for waiting times; this aimed to ensure that all public patients would be treated within three months of an outpatient referral by the end of 2004. In 2003, €43.806 million in funding for this waiting list initiative was allocated to the (then) Health Boards to help achieve this goal. Moreover, in 2002, the NTPF was established. With €30 million initially, rising to €91.7 million by 2007, the fund was originally available to adults who had been waiting more than one year and children who had been waiting six months for elective procedures. By 2004 the scheme had been widened to include all those who had been waiting three months or more for treatment. From May 2004, the NTPF became an independent statutory structure. Funds originally earmarked for the then Health Boards were allocated directly by the NTPF (Government of Ireland, 2004c). Since 2005 the NTPF has received its funding directly from the DoHC.

Individuals can either be referred to the NTPF by their treating hospital, consultant or GP, or they can contact the fund directly to see if they are eligible. Examples of procedures undertaken include cataracts, varicose veins, hip and knee replacements, hernias, plastic surgery and cardiac surgery. Patients may be offered treatment within one of a number of private hospitals in Ireland or the United Kingdom. If treatment is provided in the United Kingdom, the NTPF will also cover the travel and accommodation costs of a companion (NTPF, 2006). By December 2007, 98 625 patients had been treated under the NTPF, with a target set for 2008 to treat a further 37 000 patients (NTPF, 2008). Since 2002, 863 patients have been treated in England and a further 2757 at two private hospitals in Northern Ireland. A total of 41 children have also been funded to undergo specialist cardiac surgery at the Johns Hopkins Hospital in Baltimore, United States.

The NTPF also took over responsibility for recording and publishing data on waiting times. Waiting times have fallen markedly since the NTPF began operation. As of October 2007, 18 of the top 20 adult surgical procedures (and 8 of the top 10 for children) had an average waiting time of between two and four months (and 2–5 months for children) (NTPF, 2007b). Prior to the development of the NTPF, waiting times for these procedures had ranged between two and five years in 2002 (NTPF, 2007a).²⁶

Plans for the new PTR were announced in December 2004. This is a single register listing named individuals, together with the specific treatment needed and the length of time they have been waiting (NTPF, 2004). It has been

²⁶ However, one note of caution is that, according to an evaluation by the NTPF, the old waiting list system included widespread variations in the recording and reporting of patient data across Health Boards. This meant that these data sources could not be used to compile meaningful waiting list statistics as they did not have named individuals and were collated according to specialty rather than treatment.

phased in since September 2005, initially with seven hospitals (mainly in the Dublin area) and accounting for approximately 40% of all patients waiting nationally under the former waiting list system included in phase 1. By December 2007, 41 hospitals were participating in the scheme, accounting for 100% of the patient population measured using the former waiting list system. A further three hospitals were to be included in 2008 (NTPF, 2008).

A web site provides detailed information to the entire population on real-time waiting times for both adults and children for more than 7500 procedures. GPs and their patients can make use of data from the PTR in deciding which hospital to refer a patient to. After an outpatient consultation, if a patient decides to go ahead with a procedure, s/he is then added to the hospital's internal waiting list and thus automatically added to the PTR. If still waiting for treatment after three months, the patient may then be contacted by the NTPF and offered treatment in an alternative, private facility. As of October 2007, there were 15 194 adult patients waiting for surgical treatment, of which 43% had been waiting up to six months, 30% had been waiting 6–12 months, and 27% more than 12 months (Table 6.1). A further 2064 children were on the waiting list for surgical treatment, of which 42% had been waiting up to six months, 34% between 6 and 12 months, and 24% more than 12 months (Table 6.2).

6.5 Ambulance services

The Ambulance Service was reviewed in 2001 by the ERHA and the Health Boards, and while major progress had been made in strengthening the service – for example, through the availability of 2-person crewing, the use of pre-hospital standard operating systems and implementation of defibrillation training across all Health Boards – a number of further quality-enhancing initiatives were recommended by the review, echoed by the 2001 National Health Strategy. These recommendations included improved national coordination; 24-hour on duty staffing of all ambulance stations; the potential development of a cross-border air ambulance service (although at the end of 2008 there was still no dedicated air ambulance service in the country); strengthened clinical governance through the audit of pre-hospital clinical protocols and monitoring of pre-hospital standard operating systems; development of continuous quality improvement programmes; and greater monitoring of response times to ensure that those in greatest need receive assistance through priority-based dispatching. As part of the Health Service Reforms the National Ambulance Service was

Table 6.1 Adult patient surgical treatment waiting lists by Health Service Executive Area and hospital, October 2007

HSE Area/Hospital	3–6 months	%	6–12 months	%	Over 12 months	%	Total
Dublin North/North East							
Beaumont Hospital, Dublin	379	41	368	40	187	20	934
Cappagh Orthopaedic Hospital	364	48	245	31	158	21	767
Cavan General	37	59	21	33	5	8	63
Connolly Hospital, Blanchardstown	59	55	29	27	20	19	108
Louth County	145	49	45	15	105	36	295
Our Lady of Lourdes, Drogheda	95	32	143	49	55	19	293
Our Lady's Hospital, Navan	51	46	27	25	32	29	110
The Mater Hospital, Dublin	410	57	224	31	84	12	718
Monaghan General	40	28	31	22	73	51	144
HSE Area Subtotal	1 580	46	1 133	33	719	21	3 432
Dublin East Coast/Dublin South West/Midlands							
Midland Regional, Mullingar	33	58	17	30	7	12	57
Midland Regional, Portlaoise	69	24	84	30	130	46	283
Midland Regional, Tullamore	216	30	211	30	284	40	711
Royal Victoria Eye and Ear	147	57	89	35	23	9	259
St James's Hospital	451	83	93	17	1	0	545
St Vincent's Hospital, Elm Park	291	39	291	39	173	23	755
Tallaght Hospital (AMNCH)	402	28	434	30	622	43	1458
HSE Area Subtotal	1 609	40	1 219	30	1 240	30	4 068
Southern/South East							
Cork University Hospital	271	42	223	34	156	24	650
Lourdes Orthopaedic, Kilcreene	78	61	12	10	37	29	127
Kerry General	167	71	57	24	11	5	235
Mallow General	0	–	0	–	0	–	0
Mercy University Hospital, Cork	114	59	60	31	18	9	192
South Infirmary Royal Victoria Hospital, Cork	90	52	56	32	28	16	174
St Luke's General, Kilkenny	112	70	41	26	6	4	159
South Tipperary General	24	71	10	29	0	0	34
Waterford Regional	170	25	257	38	244	36	671
Wexford General	149	65	66	29	14	6	229
HSE Area Subtotal	1 175	48	782	32	514	21	2 471

North West/West/Mid-West							
Letterkenny General Hospital	357	17	629	31	1 060	52	2 046
Mid-Western Regional, Dooradoyle	341	45	275	36	146	19	762
Mid-Western Regional, Croom	8	40	11	55	1	5	20
Merlin Park Hospital, Galway	117	82	26	18	0	0	143
Mid-Western Regional, Nenagh	0	–	0	–	0	–	0
Portiuncula Hospital	0	–	0	–	0	–	0
Univ College Hospital, Galway	948	79	250	21	7	1	1205
Roscommon County	0	–	0	–	0	–	0
Sligo General	306	32	256	26	407	42	969
St John's Hospital Limerick	70	90	6	8	2	3	78
HSE Area Subtotal	2 147	41	1 453	28	1 623	31	5 223
Total	6511	43	4587	30	4096	27	15 194

Source: NTPF, 2007b

Note: HSE: Health Service Executive

established within the HSE in 2005, replacing the regional structure. The Service operates from 94 stations located throughout the country and is controlled from 14 Command and Control centres.

6.6 Pharmaceutical care

Most pharmaceuticals are dispensed by community pharmacists. The HSE enters into contracts with community pharmacists to provide services to Medical Card holders, those qualifying for support under the Hepatitis C and Long-Term Illness Schemes. For these service users, pharmacists receive a flat dispensing fee (between €2.85 and €3.27), plus reimbursement for the costs of medicine (ex-factory price plus 17.64% markup – reducing to 8% in 2008 – recoverable by the wholesaler), from the HSE Primary Care Reimbursement Service. Pharmacists also negotiate discounts with wholesalers for medicines they provide under these schemes. Pharmacists are contracted by the HSE to cover the remainder of the population under the Drugs Payment Scheme. Under this scheme individuals (or families) pay the full cost of medications (up to a ceiling of €90 per month) to pharmacists, who are entitled to a dispensing fee and a 50% markup on the costs of the medicines prescribed.

In addition to prescription medicines, 103 medications are available over the counter; this process is governed by the Poison Regulations 1982–2003 (IPHA, 2007b). A broad guide for consumers to the types of over-the-

Table 6.2 Child surgical treatment waiting lists by Health Service Executive Area and hospital, June 2007

HSE Area/ Hospital	3-6 months	%	6-12 months	%	Over 12 months	%	Total
Dublin North/North East							
Beaumont Hospital, Dublin	11	79	2	14	1	7	14
Cappagh Orthopaedic	3	75	1	25	0	0	4
Cavan General	1	50	1	50	0	0	2
Our Lady of Lourdes, Drogheda	51	45	40	35	22	20	113
Our Lady's Hospital, Navan	1	100	0	0	0	0	1
Children's University Hospital, Temple Street	100	29	115	34	127	37	342
Monaghan General Hospital	4	80	1	20	0	0	5
HSE Area Subtotal	171	36	160	33	150	31	481
Dublin East Coast/Dublin South West/ Midlands							
Midland Regional, Mullingar	3	75	1	25	0	0	4
Midland Regional, Portlaoise	3	43	1	14	3	43	7
Midland Regional, Tullamore	113	34	129	38	93	28	335
Our Lady's Hospital for Sick Children, Crumlin	158	39	147	36	100	25	405
Royal Victoria Eye and Ear	9	82	1	9	1	1	11
Tallaght Hospital (AMNCH)	81	56	45	32	18	13	144
HSE Area Subtotal	367	41	324	36	215	24	906
Southern/South East							
Cork University Hospital	64	41	63	40	31	20	158
Kerry General	4	50	4	50	0	0	8
Mercy University Hospital, Cork	5	50	4	40	1	10	10
South Infirmary Royal Victoria Hospital, Cork	12	80	1	7	2	13	15
St Luke's General, Kilkenny	5	100	0	0	0	0	5
Waterford Regional	54	54	20	20	26	26	100
Wexford General	1	100	0	0	0	0	1
HSE Area Subtotal	145	49	92	31	60	20	297
North West/West/Mid-West							
Letterkenny General Hospital	13	23	15	27	28	50	56
Mid-Western Regional, Dooradoyle	26	37	30	43	14	20	70
Univ College Hospital, Galway	64	71	23	26	3	3	90
Sligo General	87	53	49	30	28	17	164
HSE Area Subtotal	190	50	117	31	73	19	380
Total	873	42	693	34	498	24	2 064

Source: NTPF, 2007b

Note: HSE: Health Service Executive

counter medication available, together with advice on use, has been jointly produced by the pharmaceutical industry and the DoHC's Health Promotion Unit (IPHA, 2006b).

Regulations prohibit the sale by mail order or the Internet of prescription-only medicinal products as well as any medicinal product that is not authorized for supply in Ireland, regardless of where else it may be authorized for supply. There is a prohibition also on the owner-occupier of any premises from using or permitting others to use such premises for the receipt, collection or transmission of orders or any correspondence in connection with a mail order service for medicinal products in contravention of this regulation. Individuals may only obtain by mail order non-prescription medicinal products where such products are authorized for supply in Ireland; products authorized in another EU Member State may not be authorized in Ireland.

Two new 4-year agreements on pharmaceutical pricing were made between the IPHA (prescription medicines), the APMI (generics) and the HSE in July and October 2006, respectively (HSE, 2006b; HSE, 2006c). They apply to all medicines licensed by the IMB or the European Medicines Agency (EMA). These agreements replaced a previous agreement on the price regulation of all licensed pharmaceuticals in place between the DoHC and the pharmaceutical industry since 1997.

Under the terms of the previous agreement, the price to the wholesaler of a pharmaceutical could not exceed the lowest wholesale price of the product in the United Kingdom or the average of the wholesale prices in Denmark, France, Germany, the Netherlands and the United Kingdom (Barry, Tilson & Ryan, 2004). Under the terms of the new IPHA/HSE agreement there will be a price reduction of 35% where there are substitutable off-patent medicines and the HSE can price medicines using an expanded list of nine European countries, including the lower-priced countries of Austria, Belgium, Finland and Spain. At the time of writing, the same price now applies to both hospital and community pharmacist-dispensed pharmaceuticals and all prices for new medications will be subject to review after two and four years. The HSE estimates that this will reduce annual pharmaceutical price increases to approximately 6% and save more than €300 million over four years.

Following receipt of market authorization, a new product will be reimbursed within 60 days of the reimbursement application. The HSE may also require the assessment of new and existing technologies that may be high cost or have a significant budget impact. In the case of new medicines, assessment may be conducted prior to reimbursement but must be completed within 90 days of the reimbursement application (HSE, 2006c). Products will be reimbursed within 40 days of a positive decision.

The agreement also permits the HSE to increase patient awareness of the whole range of prescription options available. Prescribers may, in consultation with their patients, prescribe medicines of their choice from the list of medicines available, as appropriate, although the HSE reserves the right to influence the prescribing habits of prescribers. Pharmacists are now required to dispense these medicines as prescribed (HSE, 2006d).

In 2007 the HSE announced that it would reduce the wholesale markup it pays on medicines from 17.66% to 8% from January 2008, reducing further – to 7% – in January 2009. Their analysis indicated that the wholesale markup in Ireland is more than double the EU average. A wholesale markup of between 3% and 5% will be used for medicines supplied to public hospitals. If this goes ahead, the HSE expects the change to avoid costs of €100 million in 2008 (HSE, 2007b).

Under the terms of the APMI/HSE agreement, the price of generic pharmaceuticals in Ireland will be tied to the price of a new “basket” of EU countries, including, for the first time, countries such as Spain, Austria and Belgium, in which the prices for such pharmaceuticals have been consistently among the lowest in Europe. The agreement applies to all generic medicines available in the HSE’s various schemes (including Medical Card and pharmaceutical reimbursement schemes) and is expected to generate a 35% reduction in prices over four years. This included a 20% reduction from 1 March 2007 with a further 15% reduction due 22 months later. The manufacturer rebate which the HSE receives has also increased from 3% to 3.53%. The agreement contains provisions to guarantee the continuity of the supply of medicines and an agreed price freeze on all items covered under it.

Pharmaceutical expenditure and consumption

More than 40.5 million items were dispensed under the GMS scheme to Medical Card holders alone in 2006 – with an average of 2.91 items per prescription. Under the scheme, aspirin was the most commonly prescribed pharmaceutical, being prescribed more than 2.1 million times at a cost of €4.6 million. A cholesterol-lowering medication was the second most prescribed pharmaceutical (1.2 million prescriptions) at a cost of €47.5 million (HSE, 2007g). The annual public pharmaceutical bill is in the region of €2 billion. The majority of expenditure takes place in the community, where total pharmaceutical expenditure under the Community Drugs Schemes has increased by 370% in nominal terms from €332 million in 1997 to €1572 million in 2006. This is 2.5 times greater than the rate of medical inflation (HSE, 2007b).

Contribution of the pharmaceutical industry to the economy

The pharmaceutical sector is a major contributor to economic output in Ireland. According to the IPHA, 120 overseas companies have plants in Ireland, including 14 of the 15 largest pharmaceutical companies in the world. In 2007 it employed 24 500 people and in 2004 had net pharmaceutical exports of €15 billion, making Ireland the largest net exporter of pharmaceuticals in the world. Over €4.3 billion has been invested since 2000 in a period when job growth in the sector has averaged 1400 jobs annually. Tax receipts from the pharmaceutical industry are also estimated to be in excess of €3 billion (IPHA, 2007a).

6.7 Long-term care

Long-term institutional care is available in a number of settings in both the public and private sectors, although places in the public system – through community nursing units, community hospitals and specialized dementia units – are limited. As indicated in Chapter 5 *Physical and human resources*, at the end of 2006 there were 24 253 beds available for long-term care; most of these are for older people, although 7.5% of all long stay beds were occupied by people under the age of 65 (DoHC, 2008b).

In addition to directly providing places, the HSE has contracts with private homes (to provide “boarding out” care) and private nursing homes. More than 50% of all long-term care places were provided by the voluntary or private sectors at the time of writing. The HSE may cover a portion or all of an individual’s costs, as they can apply for a means-tested subvention towards the cost of care in a private nursing home. A new system for funding long-term care is being introduced, which draws on an individual’s assets after their death (see Chapter 3 *Financing*). All nursing homes must be registered with the HSE, who may inspect the premises occasionally.

Services for people with learning disabilities

The HSE provides a range of services for people with learning disabilities, with a core aim of trying to promote independent living as much as possible. In the 2006 psychiatric census, people with learning disabilities made up more than 11% of the psychiatric inpatient population in Ireland (MHC, 2007). Placement in such institutions is inappropriate for a large number of these individuals as they have no psychiatric health problem. Consequently, across Ireland there is an ongoing urgent programme to take people with these disabilities out of institutional

care, and place them in more appropriate community-orientated settings. Community-based services vary between HSE areas but typically include home support, respite and day care, residential services, rehabilitation and sheltered workshops, counselling and carer support. These services are funded by the HSE and delivered in partnership with non-statutory service providers.

Services for people with physical or sensory disabilities

Similar community-based services are available for people with physical and/or sensory disabilities. Access to services is determined following assessment of needs. Rehabilitation is a key objective and day resource centres aim to facilitate choice and independence. Training and sheltered workshops are provided in partnership with the charitable organization Aontacht Phobail Teoranta, which works for the social inclusion of people with disabilities. Services are funded by the Board and delivered in partnership with non-statutory service providers. In 2002 it was estimated that 7900 people with physical disabilities were working in 215 sheltered workshops, and 2587 rehabilitative training places were available, providing services for 2539 trainees (DoHC, 2003b).

6.8 Palliative care

Palliative care in Ireland can be traced back to the late 1800s and the establishment of Our Lady's Hospice in Dublin and St Patrick's Hospital in Cork by the Sisters of Charity to provide care for the dying. The Sisters of Charity also set up the first specialist palliative care multidisciplinary team to work in the community from Our Lady's in 1985, funded largely through charitable donations and fund-raising activities. The 1994 Palliative Care Strategy committed the Government to further developing services, and Ireland became only the second country in Europe to recognize palliative care as a distinct medical specialty in 1995. The 1996 National Cancer Strategy also has served as a spur for service development as a key element was the development (by the Health Boards) of regional palliative care services for cancer patients.

The Health Strategy 2001 recommended that a nationwide comprehensive palliative care service be developed. A detailed strategy and implementation plan were set out in the Report of the National Advisory Committee on Palliative Care, published in late 2001 (O'Brien, 2001). The recommendations of the report were approved by the Government, which stated that they would be implemented over a time frame of 5–7 years within the context of the Health Strategy.

The central recommendation was that three types of service provision should be available in all care settings (specialist, acute and community), and that all acute general hospitals should have a consultant-led specialist palliative care service, offering advice and support to health care professionals in the hospital. The report also estimated the number of resources that would be required for a comprehensive national service, including 8–10 specialist palliative care beds available per 100 000 population and at least one WTE consultant in palliative medicine per 160 000 population, with a minimum of two consultants in each Health Board area. Other recommendations were made on the provision of specialist palliative care nurses, community physiotherapists, occupational therapists and social workers. In total, the Advisory Group estimated that the total costs of providing an adequately resourced system in 2001 would have been €81.57 million, requiring additional funding of €56.18 million on top of the then current expenditure on palliative care services.

Current service provision

The National Advisory Committee report commented that there was little information available on the state of palliative care nationally, partly because of the lack of a standard information data set. At the time of writing, it remains the case that care is provided in a number of hospices, specialist units in hospitals and within the home, but there remains considerable variation in the availability of services around the country, with a fragmented model of provision. Approximately 95% of patients receiving services have cancer, but services for other end-stage diseases are increasing; it is anticipated that these could increase demand for services by as much as 80% in future.

There are several specialist inpatient palliative care units – one each in Limerick, Galway and Cork, with two in Dublin, and another in Sligo. There is a consultant-led specialist palliative care service in the HSE (South Eastern) Area, which is based in St Luke's Hospital, Kilkenny. The Foyle Hospice in Londonderry, Northern Ireland, provides home care services in parts of Donegal. Each of the specialist palliative care inpatient units has specialist palliative care teams working in the community. The specialist units include a day care service and some also provide specialist palliative care service to acute general hospitals in their areas (Citizens Information Board, 2007d). There are seven consultant physicians in palliative medicine in Ireland: three in the HSE (Eastern) Area and one each in the HSE (Southern) Area, the HSE (Mid-Western) Area, the HSE (South Eastern) Area and the HSE (Western) Area. Seven consultant posts in palliative medicine are in the process of being filled: three in the HSE (Eastern) Area and one each in the HSE (Southern) Area, HSE (North Western) Area, HSE (North Eastern) Area and HSE (Midland) Areas.

The voluntary sector also has an important role to play in palliative care. The Irish Hospice Foundation was established in 1986 as a voluntary support organization for the development and improvement of hospice services. It supports hospital-based palliative care services and acts as a support for the Voluntary Hospice Movement, which is an affiliation of voluntary hospice support groups in Ireland. The Hospice Foundation receives some funding from the DoHC. The Irish Cancer Society also provides some home-based palliative care through the provision of so-called “twilight nurses” to provide support at night. All services are used by both public and private patients, with patients being referred by their GP or upon admission to hospital. Hospice care may be funded by the voluntary sector or by the public sector; however, the level of funding varies between areas. The National Strategy recommended the phased implementation of statutory funding to fund core services, with ring-fenced protection of funds for palliative care services.

In 2004, 105 beds were available in consultant-led specialist units. This compared with 118 beds available in 1999 (DoHC, 2005d). Work is ongoing to further develop services. The former ERHA had announced investment in the development of specialist palliative care units, acute hospital palliative care and home care teams, including a new hospice in Blackrock in the suburbs of Dublin (ERHA, 2004b). In the meantime, in December 2005 the DoHC, in order to improve palliative care services in line with the recommendations of the National Advisory Committee Report, announced funding allocations for specialist palliative care, including home care and community initiatives. A total of €9 million was provided for these health services in 2006, with a further €4 million allocated in 2007. An allocation of €2 million was assigned to the development of specialist palliative care services for children in 2006. The Irish Hospice Foundation has also contributed major funding to the development of palliative care services, and continues to support hospital-based palliative care services in particular, as well as bereavement support. The Hospice Foundation also provides housing grants to help with home adaptations.

6.9 Mental health care

A sum of €1.04 billion was allocated to the HSE for mental health services in 2007 (Government of Ireland, 2008). Mental health policy and service delivery are continuing to undergo major transformation, with 2007 being the first year in which all the provisions of the Mental Health Act of 2001 (the most important piece of legislation in this field since the 1945 Mental Health Treatment Act) were fully applied. This Act has the stated aim of providing modern, comprehensive,

community-orientated services, available to all regardless of location or ability to pay. It also finally brought Ireland's mental health regulations regarding the involuntary detention of individuals into line with the European Convention on the Protection of Human Rights and Fundamental Freedoms.

Prior to 2001 the 1984 document, *Planning for the future*, had been the mainstay of mental health policy in Ireland and was instrumental in driving the pace of deinstitutionalization, and thus reducing the number of long-stay psychiatric beds. This was consistent with a general trend in mental health policy across many countries in western Europe. However, it was not until the publication of the 2001 Health Strategy (DoHC, 2001b) that there was a stated intention to develop a new mental health policy framework. New mechanisms to further safeguard rights and monitor practice have been put in place. One development was the establishment in 2002 of the MHC, a national independent body charged with promoting, encouraging and fostering the establishment and maintenance of high standards and good practices in the delivery of mental health services in Ireland. It also protects the interests of those who are involuntarily detained (see Chapter 4 *Regulation and planning*). The MHC published a strategic plan, initially noting that Ireland had a significantly higher rate of involuntary admissions compared with other western European countries.

Under the Mental Health Treatment Act of 1945 all psychiatric hospitals, both public and private, had been inspected at least once a year, on both announced and unannounced visits by the Inspectorate of Mental Health Services. The 1945 Act was substantially repealed by the Mental Health Act of 2001 and a new office of the Inspector of Mental Health Services was created. The Inspector conducts inspections in accordance with the 2001 Act, which have a much broader remit and include taking an active role in examining community-based services, assessing the quality and extent of service provision in six areas: community mental health and day hospital activity; day centre activity; rehabilitation, residential community placement and recovery services, along with acute inpatient services; primary care liaison activity; home care programmes; and specialist psychiatric services. The Inspectorate also acts in an advisory capacity to the MoHC and the DoHC on mental health policy and the implementation of the Mental Health Act of 2001. A national strategy on actions to prevent suicide was also launched in 2005.

In August 2003 an 18-member Expert Group on Mental Health Policy, chaired by Professor Joyce O'Connor (President of the National College of Ireland), was charged with preparing a new national policy framework for mental health services, to replace *Planning for the future*. The Expert Group was assigned the task of looking at different models of care, the balance between medication and other forms of care, ways of tackling stigma and the provision

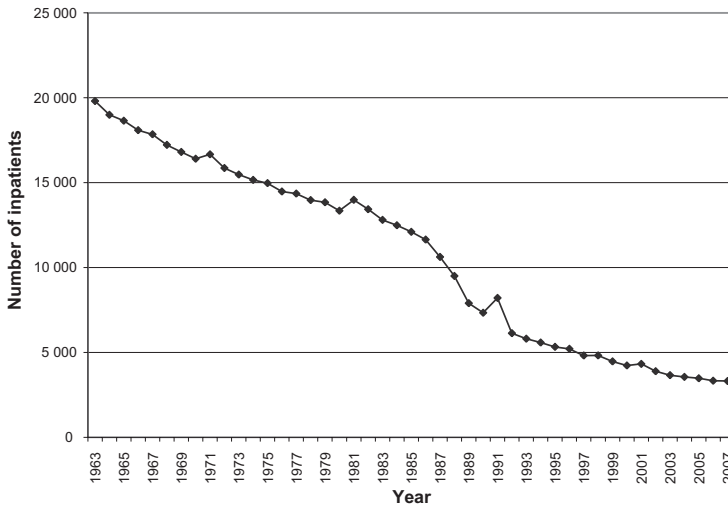
of psychiatric services for specialized groups, such as the homeless, prisoners and children/adolescents. After a wide consultation process and 141 written submissions, the group published its report, *A Vision for Change*, in January 2006 (Expert Group on Mental Health Policy, 2006). The report, positively received by the Government, made a series of recommendations for adopting a holistic approach to tackling mental health problems in the country. These wide-ranging recommendations cover issues on the focus and orientation of services, as well as organization and management. The suggestions included greater involvement of service users and carers in all aspects of service development and delivery; increased access to positive mental health promotion for all age groups; and access to well-trained, multidisciplinary community mental health teams that can provide a range of services, including assertive outreach, across the lifespan. The Expert Group also called for a plan to be developed to close all psychiatric hospitals, and to ensure funds are transferred to community-based services, whilst also putting in place substantial extra capital and non-capital investment. An independent group was established to monitor progress on the implementation of the Mental Health Strategy report, *A vision for change*, in March 2006 (DoHC, 2006g).

The MHC has also developed a Quality Framework with 24 standards that are the subject of ongoing monitoring (see Chapter 4 *Regulation and planning*) (MHC, 2006). Moreover, the Government announced that €25 million in additional funds was to be made available each year to support implementation from 2007.

Current service provision

Mental health services range from the prevention of illness and promotion of mental health, to assessment, treatment and rehabilitation for people with mental health problems or illness. Services are provided in schools, home, community and inpatient settings. Specialist services provide care to children and adolescents, asylum seekers, the Irish Traveller community, the general adult population, older people, those with substance misuse-related problems, people abused in institutional care settings in childhood and people bereaved through suicide. Support and counselling may also be available for carers and families. Recent years have seen an emphasis placed on the development of community-based multidisciplinary mental health teams to help support individuals to live in the community.

There were 20 288 admissions to psychiatric hospitals or wards in 2006, a figure that has been declining since a peak of 29 932 in 1986 (Daly, Walsh & Moran, 2007). The average length of stay was 27.5 days and overall, inpatient numbers have decreased by more than 80% since 1963 (see Fig. 6.3).

Fig. 6.3 Trends in the number of individuals in (inpatient) psychiatric care, 1963–2007

Source: MHC, 2008

At the end of 2007, the annual census of inpatients indicated that there were 3314 residents in all psychiatric hospitals and psychiatric units (MHC, 2008). A total of 34.9% of these inpatients had a diagnosis of schizophrenia, with a further 18.4% suffering from depressive disorders; 30.3% of these were long-stay patients who had been resident for more than five years, of whom 66% were between 18 and 64 years old. A total of 10.1% had been involuntarily admitted to these hospitals.

International guidelines recommend the integration of psychiatric units into general hospitals where possible. Between 1984 and 2003, the number of psychiatric units available in general hospitals increased from 8 to 21 and by 2003 the majority of new admissions have been to general rather than psychiatric hospitals (Walsh, 2004). However, obstacles remain to transferring personnel from psychiatric hospitals to general hospitals, such as the need to provide “movement money” for staff. Funding provided under the NDP 2000–2006 allowed for the development of further additional acute psychiatric units linked to general hospitals.

The Central Mental Hospital at Dundrum, Dublin, is the only secure forensic institution in the country and receives patients both from the Prison Service and from the health services. Dating back to 1845, the hospital has been described as “totally unsuitable on both accommodation and humanitarian grounds” (Walsh, 2004), a view reinforced by the Council of Europe Committee on the Prevention of Torture. The hospital is to be closed and replaced by a new

facility (see Chapter 5 *Physical and human resources*); however, virtually no forensic psychiatry services are available outside of the Central Mental Hospital. The Inspector of Mental Health Services has called for:

... a fully staffed community forensic mental health team for every population of 300 000 to 350 000. A network of low-secure units is required, with a total bed complement in the region of 120–140 beds so that people with a mental illness who pose a risk to others but who do not need high levels of security can receive specialist care in an appropriate environment (Carey, 2005).

The links between the criminal justice and mental health systems are important and in 2003 the police service (*An Garda Siochana*) introduced a mental health module into *Garda* training, to help improve understanding of mental health and to develop contacts and awareness of availability of services.

Challenges in mental health services provision

While it is clear that deinstitutionalization has continued to proceed apace, there remains a need to improve the quality and availability of alternative community-based services. Annual reports of the Inspector of Mental Health Services, while acknowledging this progress, have identified several factors that have hampered the development of community-orientated mental health services in Ireland. These challenges are not unique to Ireland and can be found in many countries. They revolve around the balance between different institutional (such as units in general hospitals, rehabilitation facilities and forensic units) and community-based care settings. One key problem is the lack of accommodation provided by local housing authorities for people with mental health needs, coupled with the difficulty of obtaining affordable private sector accommodation (Walsh, 2004). Successive reports of the Inspector have highlighted the shortage of professionals – including psychologists, social workers and occupational therapists – necessary to deliver community-based services (Walsh, 2003). These reports also have drawn attention to the slow progress in the development of community mental health teams in many areas of Ireland, in part due to recent restrictions on recruitment during the transition of services to the HSE. Nationally, at the end of 2007 there were 23.0 psychology vacancies, 26.75 social work vacancies, 27.6 occupational therapy vacancies and 12 consultant psychiatrist vacancies, all of which had been approved and funded.

Rehabilitation mental health services, as well as services for adults and children with learning difficulties, are also in need of further development. In 2007 there were 18 rehabilitation consultant psychiatrists in post, an increase from 12 in 2006. However, some consultants had been appointed without

rehabilitation teams. This remains insufficient to provide basic rehabilitation services nationwide. In 2003 the Inspector had estimated a need for 35 such teams to be available across the country. The 2007 report also noted that more than 1100 people are still resident in long-stay wards in old psychiatric hospitals which often have a poor structural fabric. This means that many residents continue to live in “inappropriate and unacceptable conditions” (MHC, 2008).

The importance of improving the links between mental health and primary care services has also been stressed. A joint report of the ICGP and the (old) South Western Area Health Board, launched in February 2004, looked at the current status of mental health service delivery in primary care settings in the South Western Area Health Board’s catchment area (Dublin South City, South County Dublin, Kildare and West Wicklow). The report’s recommendations included the need for: increased mental health skills training among GPs; agreed clinical protocols for detection, assessment, treatment, referral, follow-up and discharge of patients; and improved communication and better exchange of information between mental health providers and GPs.

The majority of psychiatrists indicated that at least 80% of their patients were referred to them by GPs. Over one third of psychiatrists felt that between 40% and 60% of their patients could be treated within primary care if given adequate support. In terms of areas for improvement, psychiatrists ranked shared care, communication with general practice and GP training as most important.

Child and adolescent mental health services

The annual reports of the Inspector of Mental Health Services have consistently highlighted the need for further development of CAMH services. In 2001 the Health Strategy had identified two areas requiring immediate attention: the organization of services for the treatment and management of Attention Deficit Hyperactivity Disorder/Hyperkinetic Disorder (ADHD/HKD), and the provision of child and adolescent psychiatric inpatient units. Under the Mental Health Act of 2001, child and adolescent psychiatric services were extended to cover those aged between 16 and 18 years. However, a report in June 2003 by a subgroup of the Working Group on Child and Adolescent Psychiatric Services highlighted the continuing limited provision of services for adolescents in Ireland (DoHC, 2003c).

The Working Group set out a number of service principles for adolescents between 16 and 18 years, which included the use of specialist multidisciplinary teams, along with access to day hospital services that include an educational focus; assertive outreach; acute same-day inpatient adolescent admissions, as appropriate; access to liaison adolescent psychiatric services within

general hospitals; and the provision of rehabilitation services (DoHC, 2003c). However, at the end of 2007 there had been no significant increase in the provision of inpatient CAMH services. Children continue to be treated in facilities intended only for adults and CAMH services that are in place are inadequately staffed. High-support and special care places for children with conduct disorders and other behavioural problems also remain very limited: as of 2006 only two inpatient units for children were available with the HSE (MHC, 2007).

Services for adult survivors of child abuse

The physical and emotional abuse of some children within educational and religious establishments, often dating back over 60 years, lay hidden in Ireland until very recently. Irish society simply refused to accept that such activities could take place, nor could they believe that any members of the clergy, who made up much of the country's teaching workforce, could be involved. Attitudes have now changed and the bravery of some victims in going public with their stories has led to a number of inquiries into possible cases of abuse in different dioceses across the country. These inquiries (and some are ongoing) have acknowledged the large number of individuals that were subject to abuse from a small number of clergy and others. These inquiries, in turn, have helped encourage many more victims to come forward. This has had important implications for the State's health services. Specialist counselling services and, where appropriate, referrals to psychiatric care are provided by the HSE at the time of writing via its regional offices for these adult survivors of child abuse. National targets have been set for these services.

6.10 Community care services

A wide range of community-based care services are funded and/or provided by the HSE for older people, as well as for people with mental health problems, and those with intellectual or physical disabilities. The emphasis is on helping individuals to maintain their independence and reside in the community for as long as possible. Medical Card holders are entitled to services free of charge; other individuals are subject to means-testing to determine whether or not they should pay for these services. Special rules govern residential care. While the provision of some services is mandatory, others historically have been provided at the discretion of the Health Boards. The range of community care services provided in different HSE regions is diverse and can include home

help services, physiotherapy, occupational therapy, sheltered workshops, respite care, chiropody services and day care.

For older people the HSE may fund voluntary sector groups, such as the Alzheimer's Society of Ireland, to provide specialist day/home care centres and other services in accordance with local service level agreements. Community Rehabilitation Unit Teams have been established in some areas to help improve the linkages between community, acute and long-term care. These units also conduct needs assessments and develop care delivery plans. Other support services may include chiropody, dental care, audiology, ophthalmology, pharmacy, community welfare, community development, environmental health, continence advisory service and old-age psychiatry. Access to meals services, for instance, is not available everywhere and out-of-pocket payments per week range between €1.27 and €6.35 (Citizens Information Board, 2007a). The introduction of a modest allowance for carers since 1997 has also helped to maintain more people in their homes with more than 18 700 people in receipt of this allowance in 2002 (Callely, 2004).

The 2001 Health Strategy set as one of its targets the relocation to the community of all inappropriately placed people with mental, physical and learning disabilities. For instance, it identified that older individuals were being cared for in acute hospitals due to the unavailability of extended care or community care support and a target was set of maintaining 90% of people over 75 in their own homes. The strategy also provided additional funding for the development of domiciliary, day care and respite services. Problems of inadequate coordination of services for older people were also identified, both within services for older people and in terms of the interface between those services and acute hospital and other specialized services, such as mental health.

In response to the Strategy, the former Health Boards began developing their own local strategies to meet targets. For instance, the Midland Health Board developed a Transfer Programme which provided community-based support to people transferred back into the community (Midland Health Board, 2003). In total, approximately €287 million was made available between 1997 and 2004 by the DoHC to improve services for older people, including the development of more community-based services. Between 2004 and 2008, as part of the Capital Investment Framework Programme, a further €293 million has been provided. Home care grants are also available to assist older people to remain living at home.

6.11 Dental care

In addition to those entitled to free care under the GMS scheme, some help with the costs of dental care under the Dental Treatment Services Scheme is provided to those paying health contributions as part of PRSI. Specialist private dental insurance can be purchased by the rest of the population (see Chapter 3 *Financing*).

Dentists are either employed by the HSE to deliver services to public sector patients, or may work in the private sector but enter into contracts with the HSE to provide public services. The significant financial costs of going into independent practice mean that many dental graduates join the public dental service initially. Increasingly, there are also possibilities to become an “industrial dentist”, working in dental practices funded by large companies for their employees. A total of 1414 dentists at the end of 2006 had public contracts with the HSE to provide services (HSE, 2007g).

6.12 Optical and ophthalmic services

Optical or ophthalmic services are provided by opticians employed by the HSE as well as by the private sector. Medical Card holders, together with people with hepatitis C and children referred by child health services, qualify for some free services. Others can benefit via the Optical Treatment Benefit Scheme depending on PRSI contributions, but otherwise services have to be paid for out of pocket. A total of 552 optometrists participated in the public scheme at the end of 2006 (HSE, 2007g). Since the introduction of the Opticians (Amendment) Act in 2003 all contact lenses can now only be sold/dispensed by registered professionals. Reading glasses can be sold by anyone, whereas prior to the Act, they could only be sold by optometrists and ophthalmologists.

6.13 Complementary and alternative medicine

At the time of writing, no statistics were available on the extent to which CAM is available in Ireland. In fact, a key recommendation of one report into the state of CAM in Ireland was to begin collecting statistics on complementary therapies and the education of CAM professionals, as well as to establish/maintain registers of qualified members of professional bodies (O’Sullivan, 2002).

6.14 Services for the Traveller community

The Traveller community in Ireland suffers from markedly worse health and problems related to social exclusion compared with the general population. The problems of trying to promote good health are compounded by an illiteracy rate of 80%, making it difficult to fill out forms to register for health benefits, prescriptions, and so on. Historically, utilization of services has been low; for instance, with low immunization rates, and poor use of prenatal and antenatal services, along with women's health services.

During 2002 the policy, *Traveller health – A national strategy 2002–2005* (DoHC, 2002b), was launched, containing 122 actions aimed at improving the health status of Travellers. Each Health Board was required to complete a Regional Implementation Plan with regard to these actions and to set up a Traveller Health Unit. Interventions are provided to help improve the uptake of health promotion information, as well as health and social care services by Travellers (for instance, by providing cultural training for health care professionals), and professionals are working with the Traveller community to improve awareness of health-promoting information. Other measures include the appointment of dedicated Public Health Nurses to work with Travellers; primary health care projects for Travellers (with two coordinators, one being employed by a Travellers' organization); and special dental clinics with an emphasis on reaching families (in addition to encouraging greater use of mainstream dental services). In 2007 the MoHC also launched the All-Ireland Traveller Health Study. To be carried out by University College Dublin, the study will include a census of the Traveller population and an examination of their health status, taking between 2.5 and 3 years to complete (DoHC, 2007a).

7 Principal health system reforms

7.1 Analysis of recent reforms

Since the turn of the millennium the Irish health care system has undergone a constant process of review and implementation of staged initiatives, culminating in major structural changes to the organization of the health care system and its orientation.

These reforms aim to make the system more primary care driven. The reforms, in part, were made possible by the continued strong economic growth in the Irish economy during the late 1990s and early 2000s, which allowed significant increases in funding to be injected into the health care system and contributed to increased public expectations about the health care service. One of the key objectives of the 2001 Health Strategy – to increase investment within the health service – has certainly been vigorously pursued.

The National Health Strategy also committed Ireland to general taxation as the mechanism through which public health services will continue to be funded. In discussions on alternative health funding models, the relative advantages and disadvantages of social insurance, private health insurance and general taxation were assessed. The strengths noted for the general taxation model included the fact that it had been demonstrated to be the most progressive of the various methods of funding; that it has the lowest administrative costs; and that it is a more focused approach to cost-containment. The Strategy concluded that “there is no compelling evidence that any alternative approach to the tax-based system would deliver significant improvements while each [alternative] would undermine the ability of the system to deliver the integrated expansion of capacity required both immediately and across the next decade” (DoHC, 2001b).

Despite the increase in funding and a long-term commitment to a tax-based system, a key public perception has continued to be that there are inequities in access to treatment both in secondary care and within the primary care sector because of funding and entitlement structures. Surveys have shown that the primary reason for obtaining private health insurance VHI is to reduce the amount of time spent waiting for care. There is a perception that private patients are treated more rapidly than public patients because of different incentive structures.

In the primary care sector, attention has focused on the level of utilization and access by those individuals who have neither a Medical Card nor private health insurance, and who, therefore, may reduce inappropriately their use of primary health care services. A survey conducted by the Centre for Insurance Studies, at University College Dublin, reported that one third of those questioned said their decision to visit a hospital A&E department was influenced by GP availability, while 28% reported that lower cost was the reason for visiting the A&E department rather than a GP (RTE News, 2004). Recognition of this problem led the Government to significantly raise income guidelines for Medical Card entitlement in 2005, as well as to introduce a new GP Visit Card to provide free access to GPs for an estimated further 230 000 individuals whose incomes were previously slightly above the maximum limit to qualify for a Medical Card.

The Government also noted that:

... primary care infrastructure is poorly developed and the services are fragmented with little teamwork and little availability of many professional groups. Liaison between primary and secondary care is often poor and many services provided in hospitals could be provided more appropriately in primary care. Out-of-hours primary care services are underdeveloped at present” (DoHC, 2001a).

Recognition of these problems led to the development of a Primary Care Strategy, aiming to more fully integrate primary, secondary and continuing care. Central to this Strategy is the development of 550 multidisciplinary Primary Care Teams across the country and greater access to GP Cooperative Out-of-Hours Services.

Inefficiencies in the organization and delivery of health care services were also identified in a number of review documents commissioned by the Government since the turn of the millennium and an increased emphasis has been placed on providing value for money. A number of reviews recommended radical changes in organizational structures in order to improve strategic direction, management, delivery and accountability of the health care system (Brennan, 2003; Deloitte & Touche Organization, 2001; Prospectus, 2003). One key problem had been the fragmentation of the health care system, although

this was first partly addressed through the creation of the ERHA in 2000. Another factor was the perception that local political influence over the delivery of health care services has been unhelpful in achieving strategic change. The Government's response was to introduce the most radical restructuring of the health care system since 1970, abolishing the former Health Boards and establishing one central HSE. This new body, it was hoped, would improve performance, efficiency and value for money within the system. Moreover, the abolition of the Health Boards was intended to help reduce the level of local political involvement in the health service.

Inequities in access to hospital care between private and public patients have been addressed largely through a commitment to increase the number of acute care beds within the health care system. However, less attention has been focused on addressing inefficiencies in the designation of existing public and private beds within the system. Perverse incentives in the existing Consultants' Common Contract have allowed significant fee-based income from private patients, potentially to the detriment of public sector patients.

These issues often have been identified as key barriers to improved system performance, as indicated in the Brennan Commission report (2003), which also recommended that new consultants work for a period of time exclusively in the public sector. The recently concluded negotiations over a new Consultants' Contract do provide an opportunity for change, but uptake of the new public sector-only contracts is not mandatory. The fact that private insurers do not pay the full economic costs of treatment within public hospitals also lends itself further to the persistence of inefficiencies and perverse incentives. Again, this has been recognized by the Government, which is committed to implementing full economic costing over time, and it has also increased charges for private beds in public hospitals substantially. In the private sector, greater competition between insurers will be promoted through measures to promote consumer understanding of the voluntary insurance market, as well as new regulatory measures, including placing the VHI health care under the same rules as other health insurance providers. Moreover, risk-equalization payments between the insurers were triggered in 2006, which led to the transfer of BUPA Ireland's business to QUINN-healthcare.

A key facet of the Government's strategy to tackle inequities in access to treatment has been to establish the NTPF, allowing treatment of those waiting for more than three months in the private sector in Ireland, or the United Kingdom as necessary. This initiative has had considerable success in reducing waiting times, but it may not be the most efficient way of improving delivery and performance if patients are treated in private hospitals at much higher cost to the public purse and private patients continue to be, in effect, subsidized by the State within public and voluntary hospitals. Human resource issues are also a key matter for

the future of the health care service, with a commitment to increasing both staff numbers and the mix of skills provided; first, through increasing the number of consultants; and second, by developing multidisciplinary Primary Care Teams. Reforms of the medical education system to help deliver this new workforce will require a significant period of time and investment in order to realize results.

Section 7.2 *Chronology of major health care reforms and policy measures* provides a chronological account of some of the main policy measures, legislation and other events affecting the Irish health care system since 1994. Each issue is described only briefly, having already been discussed more fully elsewhere in this health system profile.

7.2 Chronology of major health care reforms and policy measures

1994

Shaping a healthier future: A strategy for effective health care in the 1990s was published. This was the first strategy to set out a 4-year implementation time frame with targets and objectives, underpinned by key principles: equity, quality of service and accountability. The Strategy advocated a broader agenda of health and social gain than previous documents and argued for extensive devolution of executive responsibility to the Health Boards and others.

Following an EU Directive requiring Ireland to open up its health insurance market to competition, the Health Insurance Act put in place legislation for the eventual creation of the HIA, and enshrined a commitment to community-rated open enrolment with lifetime cover for private health insurance. It also provided for the creation of a risk-equalization scheme, if required.

1996

The Health Amendment Act provided a range of free health care services for people who had contracted hepatitis C through infected blood products.

Health Amendment (No. 3) Act imposed stricter financial controls on the Health Boards. It had a secondary aim of reinforcing the need for cooperation and coordination amongst the Health Boards.

Cancer services in Ireland: A national strategy was published, followed by an Action Plan in 1997, to reorganize cancer services in Ireland.

1997

A new Fianna Fáil/Progressive Democrats Coalition Government came to power.

The Department of Health was renamed the DoHC and Brian Cowen was appointed MoHC.

The first private insurer, BUPA Ireland, entered the market.

The Freedom of Information Act was passed, giving right of access, subject to some exceptions, to information such as medical records or the decision-making process used to determine eligibility for Medical Cards.

The Hepatitis C Compensation Tribunal Act was passed to provide compensation for people infected through contaminated blood products.

1998

The British–Irish (Good Friday or Belfast) agreement on Northern Ireland was signed. A cross-border body on public health was set up under the auspices of the North/South Ministerial Council.

1999

The Health (ERHA) Act was passed, which also made provision for the establishment of the Health Boards Executive (HeBE), allowing formal joint activities between the Health Boards.

2000

Michéal Martin took over from Brian Cowen as MoHC.

Major restructuring of the health care system took place, following the implementation of recommendations in a number of earlier reviews to replace the Eastern Health Board with the ERHA. The number of agencies reporting directly to the DoHC was also reduced with the devolution of executive work to other agencies and the transfer of the funding of voluntary agencies to the Health Boards.

National Health Promotion Strategy 2000–2005 was published, recognizing the need to improve the health and social gain of those who are disadvantaged or from lower socioeconomic groups by developing sensitive and appropriate health promotion programmes to meet their needs. Key priorities were to focus on the link between health promotion and the determinants of health; provide information and data on socioeconomic and environmental factors, lifestyle behaviours and health; and emphasize the role for intersectoral and

multidisciplinary approaches to planning, implementation and evaluation of health promotion initiatives.

2001

Quality and fairness: A health system for you was published, as the National Health Strategy intended to guide development and reform within the Irish health services over a period of 7–10 years. This Strategy continues to develop the commitment to pursuing the principles of equity, quality and accountability, which have underpinned previous Health Strategy statements, but with the additional focus on placing the patient at the centre of future reform.

Primary care: A new direction was published, which set out a comprehensive strategy for the primary care system. Key elements included the development of between 400 and 600 multidisciplinary Primary Care Teams, backed up by specialist support over a 10-year period. Moreover, GP Cooperatives to provide Out-of-Hours Services were to be created.

The HIA was established to facilitate the further development of the private health insurance market in Ireland, and to promote competition while ensuring that schemes use community rating, have open enrolment and provide lifetime cover. The body would be responsible for the determination of any procedures for risk equalization in the market.

Category I (Medical Card) coverage is extended to all people aged over 70 years, irrespective of income, but at a higher capitation fee rate for physicians than for existing Medical Card holders.

The NDP 2001–2006 was published, setting out proposed capital expenditure projects for health and social care.

Making knowledge work for health – a national health research strategy – was published.

The Mental Health Act provided for the establishment of the MHC to review procedures around the involuntary detention of individuals. The post of Inspector of Mental Health Services was created.

2002

The National Primary Care Taskforce was established in April, and is responsible for driving forward the Primary Care Strategy.

Acute hospital bed capacity – A national review was published. The review proposed an expansion in hospital bed capacity to almost 3000 beds over a 10-year period.

The NTPF was established. Proposed under the National Health Strategy, its purpose is to purchase treatment for public patients who have waited more than three months. The Fund may enter into contracts with public or private hospitals in Ireland, as well as with private hospitals in Great Britain and Northern Ireland. By March 2006, 39 000 patients were under the scheme.

Traveller health – A national strategy 2002–2005 (DoHC, 2002b) was launched, containing 122 actions aimed at improving the health status of Travellers. Each Health Board was required to complete a Regional Implementation Plan with regard to these actions and to set up a Traveller Health Unit.

The Public Health (Tobacco) Act established the Office of Tobacco Control to register those selling tobacco and to control advertising, sponsorship, marketing and sales promotion restrictions. The body was to eventually become responsible for overseeing the introduction of restrictions on smoking in public places in 2004.

2003

Prospectus report on audit and structures in the health care system was published. Among its many recommendations, it put forward proposals for the abolition of the Health Boards, along with their replacement by the HSE, and many statutory agencies.

The Brennan (Commission on Financial and Control Systems in the Health Service) Report was published. The report found that no single organization was responsible for the management of the health service as a unified system; current structures did not promote cost-effectiveness or value for money; the system was poorly evaluated; and there was a lack of investment in effective information and management systems. The Commission recommended the establishment of the HSE; making GPs and consultants budget holders; greater use of cost-effectiveness in selecting treatments; and exclusive public sector consultant contracts.

The Expert Group on Mental Health Policy was established to prepare a new national policy framework for mental health services.

The Health Insurance (Amendment) Act set out regulations for the introduction of a risk-equalization scheme, which came into force in June. Health Insurance providers were required to make 6-monthly data reports to

the HIA. Risk-equalization payments might then be triggered under certain conditions.

The report of the National Taskforce on Medical Staffing was published. The report recommended that acute care should be delivered by a small network of integrated local and major regional hospitals serving populations of approximately 350 000, while a small number of specialist services should continue to be provided on a supra-regional or national basis. Local hospitals would deliver such services as diagnosis, proportion of elective day surgery and medical procedures, rehabilitation and long-stay care. GPs would be able to access services and diagnostic facilities. Major hospitals would provide all the services found in acute hospitals that were not being delivered in the local hospitals. The report estimated that the number of consultant posts should be increased to 3600 (up from the figure of 1731 posts in the year 2000), with a parallel reduction in the number of NCHD posts.

The *Health service reform programme* was published. Without doubt, this was the most radical structural change of the Irish Health Care System since 1970. Among the changes announced and subsequently enacted were a reorganization of the DoHC and the abolition of all the Health Boards and the ERHA. The HSE was to be responsible for managing services as a single national entity, with three divisions: the NHO responsible for the management of the acute hospital sector; the PCCC Directorate responsible for the delivery of local and regional services through four regional offices; and the National Shared Services Centre to promote wider economies of scale. The HIQA was also proposed along with the merger of many other executive agencies.

2004

The Public Health (Tobacco) (Amendment) Act came into force, banning smoking in most public places, including pubs and restaurants. Exemptions to the ban include nursing homes, psychiatric institutions, prisons and hospices for the terminally ill. EU Directives restricting tobacco advertising and sponsorship came into force.

The NTPF took over responsibility for the management of waiting lists and announced the establishment of a national PTR which was to be fully operational nationwide by the end of 2006.

Health information: A national strategy was published.

The Health Act was passed, establishing the HSE (*Feidhmeannacht na Seirbhíse Slainte*) as a statutory body to come into existence in 2005. The Health Boards,

Area Health Boards and ERHA were to be dissolved and their personnel and assets transferred to the HSE. Mechanisms were set up for public involvement in the HSE. Some other statutory bodies were dissolved, merged or subsumed within the HSE.

The *Tánaiste* (Deputy Prime Minister), Mary Harney, succeeded Michéal Martin as Minister of Health.

A second private insurer, Vivas, entered the market.

The Health (Amendment) Bill 2004 was referred by the President to the Supreme Court to test the grounds of constitutionality.

2005

The HSE came into operation on 1 January. The Health Boards, the ERHA and many statutory agencies were abolished but continued to operate in a shadow capacity until mid-2005.

The Interim Health Information and Quality Authority (IHQA) was established. One function of the HIQA when fully operational is to increase the use of cost-effectiveness and HTA criteria in decision-making within the health care system.

It was announced that Medical Card entitlement was to be expanded by 30 000 as income guidelines were raised. In addition, a new GP Visit Card was also introduced for those whose income was up to 25% above the income guidelines for a Medical Card. The income guidelines for Medical Cards and GP Visit Card were raised further in October. The GP Visit Card, available to approximately 230 000 people, covers GP consultation costs but not medicines or hospital treatment.

The Health (Amendment) Bill of 2004 was ruled to be unconstitutional, with the Supreme Court stating that it is not possible to change the law to introduce retrospectively applied charges towards the costs of long-term care. The Government announced that immediate compensation of approximately €50 million was to be paid to individuals (or their descendants) who were incorrectly charged for long-term care within the health service. The Government subsequently announced that substantial repayments of approximately €1 billion were to be paid to individuals or their estates.

In July 2005 the functions of the Health Boards were fully transferred to the HSE and one unitary structure is put in place. A national integrated Ambulance Service is to be developed.

Professor Brendan Drumm took up his post as CEO of the HSE in August, with some senior posts still to be filled. Later in the year a reorganization of the structures of the HSE would be announced.

Reach out. National strategy for action on suicide prevention 2005–2014 was published in September.

The HSE entered into negotiations with consultants over a new contract.

The HSE and the DoHC Strategies for 2005–2007 were published.

In December the *Tánaiste* accepted the recommendation from the HIA that risk equalization should commence from 1 January 2006.

2006

The Minister of Health, speaking in the Dáil in March, reaffirmed the Government's commitment to the principles contained within the Primary Care Strategy, pledging an additional €16 million in funds, of which €10 million was to support the establishment of 75–100 Primary Care Teams nationally.

The Minister of Health established an A&E Taskforce to examine ways in which to reduce blockages in access to acute care hospital beds.

The DoHC announced plans for a bill to alter the rules governing VHI Healthcare, and eventually to change its corporate status to that of a public company.

A Vision for Change was published by the Expert Group on Mental Health Policy. The report recommends the introduction of a holistic, recovery-driven approach to mental health and that all remaining mental hospitals should be closed. The importance of mental health promotion was also recognized. The Government welcomed the report and set up an independent group to monitor progress on implementation.

The Fottrell and Buttimer Reports on Medical Education and Postgraduate Medical Training were published. The Government welcomed the reports and immediately took action to implement their respective recommendations. These include the expansion of places in medical schools, modernization of the curriculum, new academic posts, improved workforce planning and greater opportunities for health sector research.

The Lourdes Inquiry report was published. The report contains recommendations and safeguards to prevent clinical malpractice and highlights the lack of awareness of best practice within the system. The Government confirmed that

the Medical Practitioners Bill was to include measures to strengthen clinical governance and also made public the fact that negotiations with consultants over a new contract included talks on how to ensure consultants work in teams.

The Government announced that from January 2008 a new way of accessing and charging for long-term care in Ireland would come into effect. Under the new system older people would contribute no more than 80% of their disposable income towards the costs of care. There would be no need for family members to voluntarily contribute towards the costs of care; instead, a charge would be made against the older person's home to a maximum of 15% of its value. If a spouse lives in the house this would be reduced to 7.5%; in all cases the charge would be deferred until an individual's and their spouse's estate is settled.

The risk-equalization mechanism for health insurance was introduced but was still the subject of legal challenges domestically and at European level. BUPA Ireland subsequently announced its staged withdrawal from the market in December 2006.

2007

QUINN-healthcare entered the insurance market, taking over the policies of BUPA Ireland.

The A&E Taskforce recommended patients should be discharged or admitted to hospital within six hours of arrival; it also called for the further development of primary care and community care services. Additional long-stay care beds, particularly in the Dublin area, were also required.

The ICSB was established as part of the DoHC's Cancer Control Strategy. This brought together two previous screening programmes under one roof – the National Breast Cancer Screening Board and the ICSP. Breast cancer screening was extended to the south and west of the country and at the time of writing has been expanded nationwide.

The HIQA gained full statutory status.

The NDP 2007–2013 was published. This includes €4.9 billion for health projects, of which €4.5 billion comes directly from Exchequer funds and €415 from public–private partnerships. The plan includes €2.1 billion in funding to help provide the infrastructure for 500 Primary Care Teams by 2011, as well as the extension of community care services to help older people remain independent for as long as possible. A total of €2.4 billion is to be invested in hospital infrastructure, including A&E units; acute hospital bed capacity; infection control standards of care and efficiency; and the location

of private hospital facilities on public hospital sites to free up 1000 additional public hospital beds and to maximize the potential use of public hospital sites. Major projects will also include a new National Children's Hospital in Dublin. The Pharmacy Act removed the derogation that restricts pharmacists educated in other EU or EEA countries from owning, managing or supervising a pharmacy that is less than 3 years old. The Act also introduced fitness-to-practise provisions, to ensure the highest standards from pharmacists and to safeguard the safe and effective delivery of pharmaceutical services to all citizens of the State. These provisions fall under the auspices of a new independent Pharmaceutical Society of Ireland

A new Medical Practitioners Act made most continuing professional development and education compulsory under the auspices of the Medical Council. It also ensured that competence assurance would be given a statutory basis, as well as allowing suitably qualified nurses to prescribe medications.

2008

In May the two professional bodies representing hospital consultants recommended acceptance of the new Consultants' Contract options.

In December it was announced that the implementation of the "Fair Deal" on charges for nursing home care is to be delayed until 2009.

7.3 Implementation of reforms

As can be seen from the chronology outlined in the previous section, the publication of the National Health Strategy and various subsequent review documents, especially the Prospectus and Brennan reports, appear to have driven significant and ongoing structural changes in the health care system as part of the Health Service Reform Programme. At the time of writing, work is under way on approximately 91% of the 121 actions set out in the Action Plan underpinning the 2001 National Health Strategy, *Quality and fairness: A health system for you* (DoHC, 2007e). This work will continue in line with the ongoing rollout of the Health Service Reform Programme. The focus of the reform programme is on consolidating the new structures and implementing the provisions of the Health Act of 2004.

It is still far too early to be able to determine how successful the HSE – with its constituent branches and still changing new structures – will be in dealing

with some of the inefficiencies and inequities that have long been recognized within the system. The DoHC, Health Boards, HSE and others have concentrated on working collaboratively to deal with issues relevant to the handover of functions and the transition to a unitary system. Change has proceeded, albeit not without some delays that might be expected in any system undergoing such sweeping changes.

Opposition politicians have criticized the Government for introducing the enabling legislation far too close to 1 January 2005 (McManus, 2004). However, as the Interim CEO of the HSE, Kevin Kelly, stated at the time, health service reforms were not going to be introduced en masse overnight, but would be phased in over time. At the end of 2005, for instance, legislation was still in preparation to provide for the establishment of the much heralded HIQA, which was eventually implemented fully in 2007.

Perhaps unsurprisingly, much of the early impetus for reform has focused on the secondary care sector and dealing with bed availability issues, the A&E crisis and management of waiting lists. Clearly, the number of people treated on a day-case basis has risen dramatically in the last few years; moreover, there has been some increase in bed numbers. By the end of 2007, the NTPF had treated almost 100 000 people who had been waiting over three months for treatment. In contrast, although the importance of the primary sector has been emphasized and a clear strategy set out, implementation of change has proceeded more slowly. There have been important steps taken, most notably the expansion of out-of-hours GP service provision and the extension of access to free primary care via the introduction of the GP Visit Card. The Primary Care Strategy had envisaged that 50–60 multidisciplinary Primary Care Teams would be in place by the end of 2005, but only 10 pilot projects were up and running by that time.

Of course, this may be surprising given the speed and extent of reforms introduced into the health care system. In the Government's announcement of further funds to implement the Primary Care Strategy in March 2006, additional revenue of €16 million has been provided, of which €10 million is to support the establishment of 75–100 Primary Care Teams nationally. The Minister of Health also previously indicated that the Government may be amenable to tax relief as an incentive for developers to set up more primary care centres. This move was welcomed by the IMO GP-section chair, Martin Daly, who said that "it is the only way the primary care infrastructure envisaged in the Primary Care Strategy can be delivered rapidly" (Ring, 2005). Again, it will be some time before a judgement can be reached on the success of implementing the vision of multidisciplinary Primary Care Teams at the centre of a primary care-driven health care system. A critical role was played by the HSE's PCCC

Directorate. The Directorate set up 32 LHOs in September 2005 to help manage and drive change at local level.

It should also be recognized that attention was deflected from the reform process by a number of high-profile media stories, most notably the A&E department crisis, in which hospitals, particularly in Dublin, found it difficult to cope with the public demand for treatment. Another important issue had been securing appropriate medical indemnity arrangements within the new Consultants' Contract, as United Kingdom-based insurer, the Medical Defence Union, withdrew cover for some consultants. The Supreme Court's ruling on the Health (Amendment) Act of 2004 also meant that the Government had to spend time putting in place arrangements to compensate those incorrectly charged for long-term care.

As is often the case with health system reform, health sector professionals understandably were concerned about the long-term security of their jobs. This did impede the pace of implementation. For instance, the IMPACT union, representing 25 000 managers and administrators in the health system, stated back in December 2004 that its members would refuse to work on new administrative structures necessary for the introduction of the HSE without having their concerns over job security and working conditions addressed.

7.4 Future challenges

Many of these challenges were to be expected during the implementation of wide-scale change. Perhaps what is most interesting about the health service programme and strategy statements for future development are the changes that have not been proposed. Without taking anything away from the importance of the overriding principles and objectives and many of the proposals, it is important to recognize that *Quality and fairness* did not propose fundamental changes to the funding of the health care system, that is, it remains tax funded and regionally administered (at the time of writing through four HSE offices), with those on low income having universal coverage, GPs being paid through a mix of capitation and private fees, and hospital consultants paid on a salaried basis, retaining the opportunity to earn supplementary income from private practice.

This system is unlikely to change substantially by the time the next strategy dawns, towards the end of the 2000s. Nevertheless, there are signs that some of the long-standing, perverse economic incentives that exist within the system are being addressed; but careful evaluation of these steps will be required. Other serious challenges to the progress of reforms are likely to arise. The unprecedented rate of growth in health expenditure levels in recent years may

be difficult to sustain if there is a period of economic slowdown. Rapid inward migration and increasing population diversity also present new challenges. The OECD has indicated that the Irish economy, being heavily dependent on foreign inward investment, is greatly exposed to external world economic events. The Organization has also indicated that significant structural reform of all public services is required in order to keep pace with the rapid economic growth the country has been experiencing.

As living standards rise and funding for the health system increases, so does the need to ensure accountability for the effective deployment of public funds on behalf of the public health system. Resource issues become particularly problematic in the context of an adequate supply of medical, nursing and related personnel to support the increase in acute hospital bed capacity as well as the changes to the organization of the primary care system. This may prove to be very difficult given the problems being experienced at the time of writing in terms of attempts to sustain existing capacity. The role of HIQA in assessing the effectiveness and cost-effectiveness of interventions and organizational structures may be vital in promoting efficiency.

The issue of resource allocation across the system also needs to be addressed. The methodology used at the time of writing is still largely based on historical precedent – with some adjustments for the demographic characteristics of the population – rather than on an assessment of population needs. Nor does it reflect actual costs within the health care system. The move towards a greater use of DRG case-mix funding, coupled with further investment in information systems such as the HIPE, may go some way towards improving system efficiency.

The challenges of promoting equity in the system are likely to remain critical to public confidence in the performance of the health service. The persistence of inefficiencies within the health system is the focus of reform but will need to go further still. Given the continuing commitment of successive Irish governments to support a “mixed” health care system, whereby the same personnel may deliver public and private services within the same facilities, a clarification of the “boundaries” of each sector must be addressed if the rights and entitlements of public patients, in particular, are to be protected. More generally, this may yet prove to be a particularly challenging undertaking in an environment where half the population has private health insurance and the capacity of the private – as well as public – systems to deliver against rising consumer expectations may be open to question.

8 Assessment of the health system

This chapter attempts to provide a brief assessment of the Irish health care system against its principal objectives and a range of additional criteria. However, it should be stressed that the intention here is not to refer to all of the developments and detail discussed in previous chapters, but simply to provide a broad overview of some aspects of performance. In doing so, the chapter draws on information and assessment of different aspects of the health care system that have already been the subject of attention, perhaps most notably issues concerning equity of access to both primary and secondary care facilities.

8.1 Stated objectives of the health system

The Irish health care system is in a period of significant structural reform at the time of writing (see Chapter 7 *Principal health system reforms*). The 2001 National Health Strategy set out 121 specific objectives intended to guide development and reform within the Irish health services over a period of 7–10 years. The reforms centred on six main areas: strengthening primary care provision, development of the acute hospital system, improved funding, better planning and training for the health care workforce, review of current health care structures and improvement of health information systems (see Subsection *Developments in planning functions*, within Section 4.2 *Planning and health information management*).

The review of health care structures identified key weaknesses, such as the lack of a single institution or person responsible for the day-to-day management of the service as an integrated national entity, and the absence of clear accountability relating clinical and other budgets to output (Brennan, 2003).

The creation of a single HSE, coupled with a revision of the structures and activities of the DoHC, were intended to improve both strategic planning and service delivery. Another aim was to reduce the potential conflict of interest between local political considerations and the National Health Strategy, an issue that had been identified as problematic in the past.

The DoHC has also revised its objectives, taking account of its new position within the health care system. These include the strengthening of regulation and governance, extending eligibility for Medical Cards, reducing waiting lists, a greater emphasis on evaluation and performance, reform of key contractual relationships, improving population health and the implementation of health-related actions within all aspects of public policy. The need to tackle health inequalities has also been reflected in health policy documents and the national anti-poverty strategy (see Section 6.1 *Public health services*).

It is still too early to come to any definitive judgement on the impact and effectiveness of the large-scale restructuring within the system, but it is clear much progress has been made. By 2006, actions had been taken with regard to 91 of the 121 objectives set out in the National Health Strategy (DoHC, 2007e). These included the major public health initiative on 29 March 2004, when Ireland became the first country in the EU to introduce an almost total ban on smoking in the workplace, including bars and restaurants (see Section 6.1 *Public health services*). Health spending per capita has also grown in real terms, by an average of 8.8% a year, between 2000 and 2006, the second fastest growth of all OECD countries during this period, and significantly higher than the OECD average of 5% per year (OECD, 2008a).

The Health Strategy called for expansion of acute care bed capacity in the public sector by 3000 over a 10-year period. Acute care bed numbers in the public health system have increased by 13.1% between 1997 and 2006, after years of decline; however, there has been little change in bed numbers since 2006. The Department of Health/HSE Five Year Capital Investment Plan 2005–2009 included plans for 450 more acute care beds, but by the end of 2007 there was little difference in overall capacity compared with 2005. However, expansion of capacity can also be achieved by ensuring that more of the existing acute sector beds in public and voluntary hospitals are used by public patients. In theory, 80% of beds have been earmarked for public patients, but in practice up to 30% of beds have been occupied by private patients (see Section 6.4 *Secondary and tertiary care*). In 2005 a plan was announced to co-locate private hospitals within the grounds of public hospitals. It was hoped this would free up 1000 beds within the public hospital system. At the end of 2007, six winning bids to build 914 private sector beds were confirmed. However, it will take about three years for these beds to actually become available.

The NTPF, set up to speed up the treatment of those waiting for more than three months, had treated almost 100 000 patients by the end of 2007 and helped considerably to reduce waiting times (see Chapter 6 *Provision of services*). Prior to the development of the NTPF, waiting times for these procedures had ranged between two and five years in 2002 (NTPF, 2007a). The initial government target was that no patient should be waiting more than three months for treatment by the end of 2004, and as of October 2007 waiting times were broadly moving towards this target. A total of 18 of the top 20 adult surgical procedures (and 8 of the top 10 for children) had an average waiting time of between 2 and 4 months (and 2–5 months for children) (NTPF, 2007b).

Less progress has been made in terms of the implementation of the Primary Care Strategy (see Section 6.3 *Primary/ambulatory care*). By March 2006 only 10 Primary Care Teams were in place, although the Government did make a further commitment of new funding to help support implementation, including explicit funding to support the establishment of 75–100 teams. At the time of writing, 80 teams have been rolled out, with the intention to have 530 teams covering the country by 2010 (HSE, 2008c). Implementation of the national Mental Health Strategy “A Vision for Change” is also behind schedule (see Section 6.9 *Mental health care*). Planned changes to the financing of long-term care through the “Fair Deal” scheme have also been put on hold (see Subsection *Out-of-pocket payments*, within Section 3.3 *Revenue collection and complementary sources of funding*).

Some other key objectives have also been achieved. A new Consultants’ Contract has been agreed, intended to incentivize more consultants to spend time working for publicly funded patients. However, as the new contract options are not mandatory, it will be some time before it will be possible to assess uptake rates of the new public-only consultants’ contract (see Subsection *Hospital consultants*, within Section 3.6 *Payment mechanisms for health system personnel*).

The Government has taken steps to increase access to primary care services free of charge by increasing the income ceiling at which individuals qualify for a Medical Card and through the introduction in 2005 of the more limited GP Visit Card for those with incomes up to 50% higher than the Medical Card qualifying level. A further 75 000 people had access to free GP consultations through the GP Visit Card by the end of 2007 (see Section 3.2 *Population coverage and basis for entitlement*).

A number of regulatory reform objectives have been fulfilled. HIQA, established in 2007, is responsible for developing health information; setting and monitoring standards; promoting and implementing quality assurance programmes nationally; and overseeing HTA, including the consideration of

cost–effectiveness as well as clinical effectiveness. It is also responsible for most accreditation mechanisms for publicly funded health care services in Ireland (see Subsection *Quality assurance and accreditation*, within Section 4.1 *Regulation*). Reform measures are also being introduced into the voluntary private health insurance market, most notably to place the VHI Healthcare on the same operating platform as its competitor private health insurance providers (see Subsection *Health care benefits*, within Section 3.2 *Population coverage and basis for entitlement* and Section 10.3 *Competition, risk equalization and the Irish insurance market*).

There have been some setbacks in the development of electronic information systems. The 2007 report of the C&AG was critical of spending on the PPARS project, a framework designed to produce one integrated Personnel Administration, Payroll, Attendance monitoring/control, Rostering, Recruitment and Superannuation system across the health service and other agencies, as appropriate. Work on the system began in 1997 but after many technical problems it was abandoned 10 years later.

Despite these developments, debate has continued over the appropriateness of some structural arrangements, in particular the internal organization within the HSE. An independent review of events that had led to the misdiagnosis of breast cancer in a number of women identified problems in coordination and management within the system. Changes intended to improve accountability and coordination subsequently were due to come into effect in late 2008, merging the NHO and the PCCC Directorates within the HSE. Understanding of the new structures and arrangements also has not always been clear. Amendments to the Health Act of 2007 were introduced to clarify that the MoHC continued to retain responsibility for negotiating the annual health budget, along with the Minister of Finance. The HSE also had to undertake cost savings measures in 2007 to deal with budget overspend.

8.2 Distribution of the health system's costs and benefits across the population

The Irish health care system remains predominantly tax funded (see Chapter 3 *Financing*). Although there can be significant (but limited) out-of-pocket costs for some services, the structure of the system means that no individual will be subject to catastrophic health care costs. In terms of vertical equity, overall funding of the Irish care system can be classified as being marginally progressive. Ongoing work using data from the 1999 Household Budget Survey suggests that this signifies little change has taken place since the 1980s (Smith,

2007). Income tax, PRSI and the Health Contribution are all progressive, as they take account of ability to pay, while indirect taxes such as VAT and out-of-pocket payments for services are regressive. Charges for public health services accounted for almost 15% of total public sector current expenditure in 2007.

Horizontal equity in the system has been assessed using data from the 2000 wave of the European Community Household Panel Survey (van Doorslaer, Masseria & Koolman, 2006). When it came to specialist care, however, Ireland was found to be particularly pro-rich, since, given equal need, higher income people were more likely to seek specialist care than those from lower-income groups. This is consistent with the situation seen in other European countries, such as Portugal, Finland and Italy, where private insurance and out-of-pocket payments can influence access to specialist care services.

Utilization of primary care

The study by van Doorslaer, Masseria and Koolman (2006) also reported that access to primary care appears to be significantly pro-poor. There has been much analysis of the utilization of primary care services. The different incentive structures facing Medical Card and GP Visit Card patients – who incur no costs for using GP services – and the rest of the population – who must pay substantial consultation fees – may thus present a barrier to access. Another recent study looked at satisfaction with primary care services in the Republic of Ireland, contrasting this with the situation in Northern Ireland, where there are no charges for GP consultations (Galway et al., 2007). High levels of satisfaction were reported in both countries, although rates of satisfaction were higher in the Republic of Ireland. A total of 68% of respondents in the south obtained same-day GP access, compared with only 31% in the north.

One potential reason for this higher rate of satisfaction with GP services is the consultation fee that GPs receive. This can encourage GPs to offer a more accessible service. It might also be the case that demand amongst the 70% of the population who are treated privately by GPs may be reduced because of these fees, thus freeing up space for those who do pay, as well as those patients with Medical Cards or GP Visit Cards. This is consistent with another comparative analysis of the Republic of Ireland and Northern Ireland. Over a 1-year period, one in four people in Ireland who experienced medical problems, but did not qualify for a Medical Card, reported that they did not visit their GP because of financial concerns. This compared with less than 2% of patients in Northern Ireland. The effects of the GP consultation charge were most pronounced in the middle of the income distribution, with these individuals being four times more likely not to access GP services compared to those with the highest levels of income (O'Reilly et al., 2007a). However, other analyses suggest that the

differences in utilization between Medical Card holders and the rest of the population treated as private patients by GPs are of much more significance than differences between private patients, regardless of income (Nolan & Nolan, 2008; Nolan, 2008). Analysis of data from the Living in Ireland Survey of 2001, undertaken by the ESRI, identified that patients with a Medical Card had an average of six GP visits per annum compared to just 2.3 visits for non-Medical Card holders (Layte, Nolan & Nolan, 2007).

The need for people with low incomes to apply for a Medical Card and have their eligibility reviewed regularly necessarily means that some will lose or not claim the benefit because they have not filled in the appropriate forms. One study reported that 90% of those individuals who lose their Medical Cards do so not because their entitlement status changes, but simply because they do not return the review forms (O'Carroll & O'Reilly, 2008). In contrast to utilization of GP services, there is some evidence to suggest that frequency of visits to dentists increases with income and education. A total of 33% of those in the bottom income decile visited their dentist at least once per year compared with 63% of those in the highest income group (Layte, Nolan & Nolan, 2007).

It is perhaps also worth noting that some commentators have argued that there is a lack of suitable data in Ireland to examine socioeconomic inequalities in utilization of health care services. They point out that the EU-SILC, the EU Survey on Income and Living Conditions – only asks for information on free GP visits. Another problem is that national administrative databases cannot be linked because of the lack of use of a personal identifier (Layte, Nolan & Nolan, 2007).

Availability and utilization of acute sector hospital beds

One issue that has continued to be the subject of discussion in the Irish health care system is the availability and utilization of acute sector hospital beds. By international standards, despite some investment in new beds, overall capacity remains low by OECD standards. The number of patients who, at various times, have had to make use of trolleys in hospital A&E departments, particularly in winter, because all beds have been fully occupied, has been the subject of much public and media attention. However, the problem is not due to a lack of beds in the system; a number of other factors have contributed to the situation. These include the use of more beds by private patients than intended and incentives in the old Consultants' Contract which encouraged them to spend more time with private patients. New analysis of data from the HIPE also suggests that almost a quarter of hospitals have been treating more private patients than their estimated private capacity. As the authors note, given fixed capacity constraints in the short term, in most circumstances

public sector patients are likely to be crowded out by their private sector compatriots (O'Reilly et al., 2007b).

There have been challenges in obtaining long-stay care places and home care packages, as well as gaps in the primary care system. Another factor is inappropriate admissions. A review of the appropriateness of the use of acute care beds commissioned by the HSE was conducted across 37 hospitals between November 2006 and February 2007. Looking at the files of more than 3000 patients, it found that 13% did not meet internationally validated criteria for admission and could potentially have been treated outside of the acute care sector. Moreover, when looking at elective surgery patients, 75% were admitted too early and 31% might have had the surgery undertaken in an ambulatory setting. The study concluded that the results provided evidence that "it is the way local health systems are configured to treat and care for that patient that results in inappropriate occupancy of an acute bed" (Balance of Care Group & P A Consulting Group, 2007).

In March 2006, at a time when 380 people were waiting on trolleys for beds, the MoHC established an A&E Taskforce to examine the issue. In January 2007 the Taskforce recommended that patients should be discharged or admitted to hospital within six hours of arrival; it also called for the further development of primary care services, including diagnostic services and clinics for chronic illnesses, such as cardiovascular and respiratory diseases and to help reduce the likelihood of admission to hospital. Further long-term care beds were also needed, particularly in the Dublin area, so that patients might be transferred out of the acute care system.

In response, substantial funding has been allocated to the creation of home care packages and the provision of more long-stay beds. The Winter Initiative was also set up within the HSE to help deal with the natural seasonal increase in demand for services and the HSE was also able to effectively implement the earlier discharge of patients. These measures have helped to improve the situation markedly. The first national survey of patient experiences in the 35 A&E departments in publicly funded acute hospitals was undertaken in 2006 (ISQSH, 2007). A total of 93% reported that they were treated with dignity and respect; 76% said they were satisfied with the overall service provided; and 86% said they would return to the same A&E department if they needed future treatment. Most patients (79%) said they were clinically assessed within an hour of their arrival at the emergency department and 75% of patients who needed to be examined by a doctor said they were examined within three hours. However, it should be noted that at the end of 2007, when short-term financial restrictions impacted on funding for long-stay beds and home care packages, the availability of acute care beds again decreased. Expectations that the Fair Deal on funding of long-stay care was to be implemented from 1 January 2008

also meant that no new contracts with nursing homes for additional beds had been made during this period (O'Meara, 2008).

The NTPF has been successful in helping to reduce waiting times for services across the country, although there remain several areas of the country in which much progress still needs to be achieved: in 2007 more than 50% of all patients on the waiting list at Letterkenny and Monaghan General Hospitals had been waiting for more than 12 months. Capacity in the provision of some services, such as palliative care or access to community mental health teams is still lacking in some parts of the country. However, breast cancer screening was due to have been fully rolled out across the country by 2008. Eight centres of excellence for cancer treatment have also been proposed as part of a new national cancer control plan.

8.3 Efficiency of resource allocation in health care

A key challenge in the Irish health care system continues to be the balance between investment and provision of hospital- and institution-based care, relative to primary care and other community-based services. Expenditure on hospital services has been steadily declining as a share of total HSE expenditure, accounting for 38% of expenditure in 2006 compared with almost 50% of the budget held entirely by the DoHC in 1998. The Government has acknowledged the need for greater development of the primary care system through the Primary Care Strategy. In 2007 primary care accounted for only 23% of the HSE budget. Section 8.1 *Stated objectives of the health system* indicates the relatively slow progress in the implementation of the Strategy. Most attention appears to have focused on reform of the hospital sector, but multidisciplinary Primary Care Teams need to be in place in order to ensure that more people can be treated outside the secondary care sector.

Other areas where it is acknowledged that there needs to be a shift in the balance of care include mental health. Although there appears to have been a substantial increase in the level of funds allocated to mental health, with a 45% nominal increase in funding since 2004, serious reservations remain about the availability of resources to help implement mental health service reforms set out in the new Mental Health Strategy report, *A Vision for Change* (MHC, 2008). Equally, community-based services for people with disabilities have been targeted for greater investment. There has already been significant investment in additional long-stay care and home care packages. The eventual introduction of a new system for financing long term will also help to end the

inequality between those receiving care within HSE long-stay care facilities and those living in private nursing homes. This, in turn, should also help redress the balance of care.

Substantial capital investment has been allocated to health-related activities and will impact on the balance of care. Capital expenditure is guided by the NDP 2007–2013 at the time of writing (see Section 3.5 *Purchasing and purchaser–provider relationships*). This includes €2.1 billion in funding to help provide the infrastructure for 500 Primary Care Teams by 2011, as well as the extension of community care services to help older people remain independent for as long as possible. A total of €2.4 billion will be invested in hospital infrastructure, including a new National Children’s Hospital in Dublin. A further €9.7 billion will be invested in the development of living-at-home programmes (€4.7 billion) and improvements in residential care (€5 billion) for older people. The previous 2000–2006 NDP allocated €3.3 billion for health-related capital investment, including an additional 1300 inpatient and day treatment places and investment in acute mental health wards in general hospitals as part of the reduction in the number of individuals residing in long-stay psychiatric hospitals.

The balance of care is not just dependent on capital infrastructure; the health and social care workforce mix is also crucial. The Government is committed to increasing both staff numbers and the mix of skills provided, including the number of hospital consultants and specialist staff required for primary care and community mental health teams. Ireland has the lowest rate of GPs per 1000 population in any of the OECD countries at the time of writing. The FÁS is undertaking a more detailed analysis of a smaller number of professions (due for completion in 2008) and health sector analysis has now been included in the work programme of the Expert Group on Future Skill Needs, reflecting its importance in the national economy. Work has also commenced on a national workforce planning strategy in conjunction with the HSE.

At the time of writing, the majority of the budget for the HSE is not determined using any resource allocation formula, but instead seeks to estimate future expenditure, taking account of the previous year’s actual expenditure pattern, national agreements on salaries, demographic changes, value-for-money targets and other factors, such as inflation and anticipated revenue from charges levied to public and private patients. Thus, the substantive basis of the budget remains historical, with fixed allocations made to public and voluntary hospitals. An increasing proportion of the budgets of some acute care hospitals is adjusted on the basis of case mix and volume of activity, using DRGs. In 2007 the 37 biggest acute care hospitals – responsible for 95% of acute hospital admissions nationally – had 50% of their budgets allocated on the basis of “peer group-related performance”, in relation to 2006 costs.

Hospitals whose costs are lower than the national mean gain funding, while those whose costs are higher than the mean lose funding.

There is also limited scope for flexibility in funding within the system at the time of writing. The HSE is bound by the annual global budget it receives. This has led to temporary stays of funding for some services towards the financial year end if actual expenditure turns out to be higher than that projected in the budget. There is also limited scope for the retention of funds by the HSE to use in subsequent financial years.

8.4 Technical efficiency in the production of health care

Judging the value for money of the Irish public health system is no easy task. As is common to many countries, obtaining information can be challenging. In its recent review of public services in Ireland the OECD noted a need for the “development of performance indicators that are measurable, can incentivize local management and staff to improve the patient experience, and that do not create unnecessary administrative burdens at the local level that can detract front-line staff from patient care” (OECD, 2008b). Investment in ICTs such as the sharing of information is also critical to this process.

In terms of length of stay, Ireland’s performance is very similar to the average for acute care hospitals in the EU15 (see Chapter 5 *Physical and human resources*, Fig. 5.2). There has been little change since the late 1990s; it remains substantially lower than that seen in Germany, but much higher than rates observed in Denmark or Finland. While length of stay can be a proxy for the productivity of the inpatient system, as noted earlier, discharge from hospital in Ireland has often been complicated by a shortage of long-stay beds for those individuals requiring further non-acute care. Again, there is a need to further develop the primary and community care systems to ensure that only individuals meeting all appropriate clinical criteria receive treatment in the hospital system.

It is unclear whether the new Consultants’ Contract, with its substantial increase in basic salaries and increase in contracted time from 33 to 37 hours per week, will improve productivity within the public health system. If this reduces time spent with private patients then gains may be made. Experience from the United Kingdom, if repeated in Ireland, suggests that consultants might already be putting in more hours than required in their contracts. If this were to be the case it would imply a substantial increase in personnel costs without the commensurate levels of improvement in productivity. However, the

new contracts will also ensure that consultants undertake evening and weekend shifts, something that has not always been readily available.

Another issue concerns the use of the NTPF. This has had considerable success in reducing waiting times, and thus helping to improve system output. However, this may not be the most efficient way of improving delivery and performance if patients are treated in private hospitals at much higher cost to the public purse, while some private patients continue to be, in effect, subsidized by the State and receive care within public and voluntary hospitals.

Moreover, one of the key reasons for holding private insurance (as more than 50% of the population do) is to avoid waiting lists for treatment; this might suggest that there are inefficiencies in the secondary care system (Insight Statistical Consulting, 2008). Again, the situation is complex: private insurance, in itself, can cause inefficiencies, as it does not follow that those who jump ahead on the waiting lists by being treated privately in public facilities are necessarily those in most need of care.

Several recent measures may help to improve value for money within the system. HIQA will now assess the clinical effectiveness and cost-effectiveness of the medicines, devices, diagnostics and health promotion used within the health system. The outcomes of assessments will be used to help the MoHC make informed decisions on the desirability and effectiveness of investing in new therapies, pharmaceuticals, equipment or health promotion activities. It will also be used to advise on the rationale for continuing with existing practices to ensure that people are not being treated with outdated therapies, pharmaceuticals or procedures (see Subsection *Health technology assessment*, within Section 4.2 *Planning and health information management*).

The HSE has established a National Corporate Pharmaceutical Unit to negotiate with industry regarding pharmaceutical prices. Prices for pharmaceuticals are governed by agreements between the HSE, the APMI and the IPHA, with the latest agreement coming into effect in September 2006 (see Section 6.6 *Pharmaceutical care*). Under the terms of the agreements there will be a price reduction of 35% for substitutable off-patent medicines and the HSE can price medicines using an expanded list of nine European countries, including the lower-priced countries of Austria, Belgium, Finland and Spain. At the time of writing, the same price applies to pharmaceuticals dispensed by both hospital and community pharmacists and all prices for new medications will be subject to review after two and four years. The HSE estimates that this deal will reduce annual pharmaceutical price increases to approximately 6% and save more than €300 million over four years.

Generic prescribing has declined in recent years. For more than a decade, the Indicative Drug Target Savings Scheme had been in operation. This was intended to help contain the costs of GP prescribing. GPs were issued

with an annual prescribing target determined on the basis of national practice patterns, modified to take account of demographic characteristics prevailing within each GP's practice. However, the Scheme was subsequently suspended, given that just 2.75% of the 2200 GPs who look after patients with Medical Cards came in under target on their prescribing budget. The savings for the year fell to €670 462, well below those achieved when the Scheme first commenced. A decrease in the use of generic prescribing was noted as a major contributory factor (Barry, 2007).

At the individual hospital level, steps have been taken to improve financial management. For example, the Adelaide and Meath Hospital (incorporating the National Children's Hospital) introduced a financial management system to provide complete user-specific information on financial, budgetary, costing and statistical systems, while allowing for both clinical and non clinical performance measurement.

8.5 Quality of care

While recognizing that there were many quality initiatives within the health system, the 2001 Health Strategy identified a number of areas for improvement, including the need for an overriding national structure responsible for developing, evaluating and monitoring quality protocols and standards, as well as the need for better integrated information systems (see Subsection *Quality assurance and accreditation*, within Section 4.1 Regulation).

There have been several major structural developments since 2001, which strengthen quality assurance. Most notably, since 2007 HIQA has been responsible for developing health information, setting and monitoring standards and promoting and implementing quality assurance programmes nationally. To this end, HIQA expert working groups build minimum standards for quality and safety for a given service, as well as setting developmental standards to support movement towards excellence. Some of the first standards have included those for the independent assessment of needs for people with physical and intellectual disabilities; symptomatic breast disease; residential care settings for older people; infection prevention and control; and hygiene.

Multidisciplinary teams of professional and lay reviewers monitor use of standards by undertaking site visits and working with health care organizations to identify areas for improvement and recognize good practice. There is a high degree of transparency, with reports and recommendations published on HIQA's web site. Most accreditation mechanisms for health and social services also have been brought under HIQA's wing.

Mental health is the only area of the health care system that does not fall under the auspices of the HIQA. Instead, responsibility rests with the MHC, which has a similar role to the HIQA. In addition, it runs mental health tribunals which review all health-related decisions regarding the involuntary detention of individuals. In assessing mental health services, the MHC makes use of a quality framework that it has developed in consultation with stakeholders.

Another move to promote high quality of care was the passing of the Medical Practitioners Act in May 2007. This made continuing professional development and education compulsory, within the remit of the Medical Council. This new legislation was partly a response to isolated, but gravely serious adverse events which have been firmly in the public eye, most notably the inappropriate rate of hysterectomies performed by one physician at a hospital in Drogheda. The year 2007 also saw a substantial amount of public and political focus on procedures and lines of communication with regard to breast cancer screening. This, in turn, has led to an independent review of practice in this area.

In addition to developments in quality assurance, steps have been taken to promote patient empowerment (see Section 2.5 *Patient empowerment*). More than 85% of patients report being involved in decisions about their treatment and care as much as they would have liked (ISQSH, 2005). The NTPF, for example, provides public patients who have been waiting an excessively long time for treatment with the choice to obtain – at public expense – treatment in the private sector, if appropriate. Patients also have a number of formal complaint procedures open to them, which were most recently updated and harmonized across all health and social care providers as part of the Health Act of 2004.

Patients and service users also have an opportunity to be involved at a high level in the organization and planning processes of the HSE, through the recently launched HSE Expert Advisory Groups (initially covering older people, children, mental health and diabetes). One of the objectives of these groups is to provide patients and consumers with a voice to influence decision-making processes; however, the composition of these first four groups is heavily dominated by professionals. It is also too early to judge how effective these groups will be in giving patients and service users a voice in policy-making. In 2007 the HSE launched a new NSUE for mental health services.

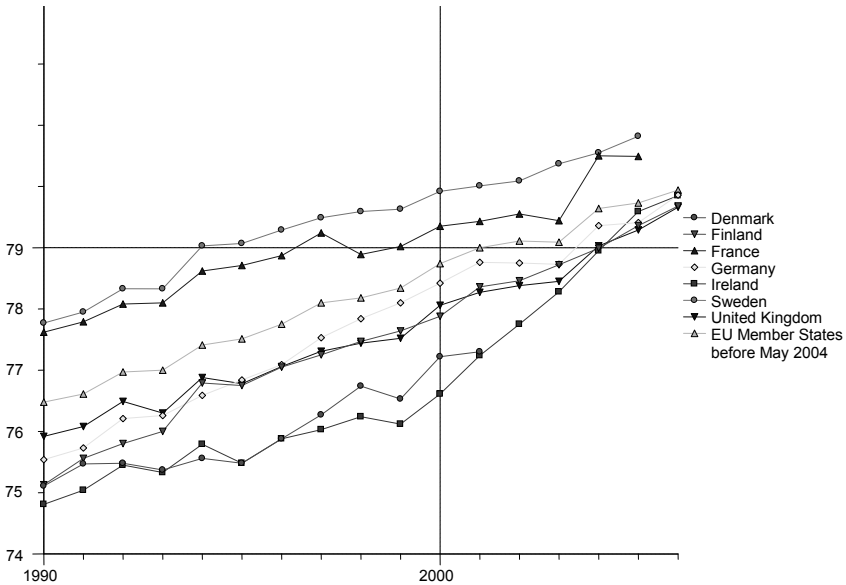
The National Health Strategy also promised a national standardized approach to the measurement of patient satisfaction. HIQA is now responsible for the development of such surveys. A number of surveys of both public and patient satisfaction with the health care system have been conducted in recent years. One independent survey conducted by University College Dublin and Lansdowne Market Research obtained experiences relating to health and social care services from more than 2700 people who had used services in the previous 12 months

(Boilson et al., 2007). Ratings of quality of care were generally positive. As many as 64% of inpatients, 58% of outpatients, 84% of GP patients and 76% of people using other community services rated their experience as being “excellent” or “very good”. A majority (78%) of inpatients, 67% of outpatients, 86% of GP patients and 78% of other community services patients, expressed “definite or complete trust” in the health professional they encountered. A total of 80% of inpatients, 79% of outpatients and 86% of GP patients felt the information they were given was “about the right amount”.

8.6 The contribution of the health system to health improvement

The health status of the Irish population has improved rapidly, although – of course – identifying the specific contribution of the health care system to this rate of improvement is challenging. Many health system and non-health system factors will contribute to population health. Nonetheless, life expectancy at birth has increased substantially by more than five years over the period from 1990 to 2006 (see Fig. 8.1).

Fig. 8.1 Trends in life expectancy in Ireland and selected EU countries, 1990–2006



Source: WHO Regional Office for Europe, 2008

In 2006 average life expectancy for men was 77.46 years; this rate is higher at the time of writing than the EU25 average (75.62 years) and is only surpassed by Greece (77.48 years) and Sweden (78.57 years) in the EU15. In 2006 average life expectancy for women was 82.22 years, still slightly lower than the EU15 average (82.7 years).

Mortality rates have fallen substantially since the late 1970s in most disease areas. For instance, infant mortality rates have fallen from 19.49 per 1000 live births in 1970 to 3.71 in 2006, the seventh lowest rate in the EU15. However, one key health challenge is female breast cancer. The age-standardized death rate from breast cancer for women in 2006 was one of the highest rates in the EU at 29.8 deaths per 100 000 females. Although deaths from all respiratory diseases have fallen from 129.15 per 100 000 in 1995 to 83.19 per 100 000 in 2006, this rate remains the highest in the EU27 countries. Other challenges include the low rate of child immunization against measles. Coverage rates ideally should be above 90% but only 86.2% of children were vaccinated in 2006. In the EU, only Austria and the United Kingdom had a lower rate of immunization.

By 2006 only 24.7% of both men and women over the age of 15 reported being regular or occasional smokers, compared with rates of 32% and 31%, respectively, in 1998. Public support for the ban on smoking in the workplace might suggest that this downward trend will continue. However, alcohol consumption per head of population remains high. In 2005 this was 10.61 litres; only Austria, the Czech Republic, Germany and Luxembourg had higher rates within the EU.

9 Conclusions

Ireland has undergone major economic and social transition since the turn of the millennium. It has been a “star performer” in terms of economic progress in the industrialized world and has reversed decades of net outward migration, while retaining one of the youngest and most highly educated populations in Europe. There have also been positive changes for the health of the population: average life expectancy has increased by more than 5 years within just 15 years, while Ireland led the way in Europe on the introduction of legislation to ban smoking in the workplace.

In many ways, developments within the health care system have mirrored these rapid and significant transitions. The health care system can be characterized by a constant process of review and implementation of staged initiatives since the turn of the millennium. This process has culminated in major structural changes – made possible due to the economic growth that Ireland has enjoyed in recent years – impacting on both the organization and orientation of the health care system. The aim is to make the system more primary care driven and supported by improved access to specialist, acute and long-stay services.

The reforms have revolved around the abolition of the former Health Boards and the creation of a single national body, the HSE. With a budget of more than €13 billion, it is the largest employer in the State, with more than 65 000 staff in direct employment and a further 35 000 employed by voluntary hospitals and bodies funded by the HSE. The HSE has not only taken on the functions of the former Health Boards but also those of many of the statutory and non-statutory agencies and organizations that had developed under the former system. The DoHC has changed its role, while other major changes include the establishment of the HIQA.

Such major transformation of the system was never likely to be implemented smoothly and it is still too early to reach any definitive judgement on the

success of the reforms. While action has been undertaken in terms of most of the key actions set out in the 2001 Health Strategy, the pace of reform has varied. Perhaps unsurprisingly, given public concerns, much of the early impetus for reform has focused on the secondary care sector, with attempts to reduce both waiting times for elective treatment and blockages in admission to acute care hospitals. There have also been concerns about the effectiveness of administrative structures and accountability within the new system, which, again, may lead to more significant structural change.

Promoting equity within the health system is likely to remain a critical concern. The “mixed” health care system has allowed incentives to exist which favour private patients within the secondary care system. At the same time, access to the primary care system tends to be pro-poor, in that services are free for this group, while the remaining 70% of the population who do not qualify for free primary care must pay the substantial cost of GP fees out of pocket. Their disadvantage is compounded further by the failure of the private health insurance schemes to provide anything other than token support for the costs of primary care services.

Much work remains to be done to try and overcome these inequities and many questions remained unanswered. Primary Care Teams will not be fully operational nationwide until 2010, and it is unclear as yet how effective the new public-only Consultants’ Contracts will be. Will the public sector be better able to safeguard beds for public patients once the promised additional private sector beds in co-location hospitals are operational, or will this encourage more individuals to invest in private health insurance? Will investment in hospital reconfiguration be able to improve the quality of services without making them remote from local populations? Will the country be able to obtain the necessary additional medical personnel to deliver all of these changes?

Ultimately, the challenges that are faced within this mixed system may merit reconsideration of the way the health system is financed. One option that might bear serious consideration in future, given the long history and high penetration of private insurance in the country, is to move towards a comprehensive social insurance system for all. However, careful evaluation is required, and this may be of even more importance at the time of writing, given the uncertainties over whether a risk-equalization scheme can be applied to private health insurance within the country.

In summary, much has been done to change the Irish health system for the better since the turn of the millennium. Significant challenges remain; none more so than primary care reform. Implementation of promised reforms is the key challenge, particularly now that the country, like most of the developed world, is likely to experience an economic downturn which will give the Government less room for manoeuvre in the near future.

10 Appendices

10.1 References

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10.2 Health Boards and associated structures, 1970–2005

Under the 1970 Health Act, eight Regional Health Boards were established, primarily on a population/geographical basis. A range of factors, including fragmentation of management and inefficiencies resulting from the fact that historically the majority of teaching hospitals had been maintained on an independent basis outside of the Health Board structure, led to the replacement of one of the boards (the Eastern Health Board) with three new “Area Health Boards” under the direction of the Eastern Regional Health Authority (ERHA) in March 2000. The population of the ERHA area was estimated at approximately 1.4 million, more than one third of the entire population. The Health Boards elsewhere in the country served between 200 000 and 580 000 people.

Until January 2005 the seven Health Boards had a statutory responsibility for either providing or ensuring the delivery of health, social and child care services in their geographical areas. However, they were not accountable to the Department of Health and Children (DoHC) for the evaluation of service provision, apart from (in recent years) being required to provide quarterly performance indicator data. While the Health Boards were the principal providers of general hospital services, many of the services provided to older people, those with disabilities and other community-based services are delivered by the voluntary sector. Prior to the restructuring that occurred in 2000, there was no direct funding relationship between voluntary service providers and the Health Boards. However, the ERHA did have responsibility for funding all voluntary agencies, including hospitals within its geographical catchment area. Most voluntary hospitals outside the ERHA were funded directly by the DOHC, with one notable exception in the Southern Health Board region, in which some voluntary hospitals in Cork were directly funded by the Southern Health Board.

Members of the Health Boards, under the board chairperson, were responsible for policy decisions and for monitoring the implementation of plans by board staff. Boards consisted of approximately 30 members, depending on population size. Around half the members were elected representatives nominated by each county in the region, and in addition, there were three nominees from the Minister for Health and Children (MoHC). This system meant that the majority of members of Health Boards were local or national political representatives. The remaining board members consisted of health care professionals elected by professional bodies. These consisted of a number of medical practitioners (consultants, public health, general practice), plus one dentist, one pharmacist, a general nurse and a psychiatric nurse.

Responsibility for management of each of the Health Boards rested with a chief executive officer (CEO), supported by a management team whose organizational structure varied across the Health Boards. Under the terms of the 1996 Health (Amendment) (No. 3) Act the boards were responsible for policy, major financial decisions and approval of annual service plans, while the CEO was responsible for executive matters and accountable to the Health Board. Historically, the operation of the Health Boards was structured around three core programmes: general hospitals, special hospitals and community care programmes. However, these structures were already changing prior to reform with an increasing move towards care management approaches for specific groups, such as children, older people, the mentally ill and those with learning disabilities (MHC, 2003). Annual service plans were produced setting out performance targets and activity levels. Plans took account of Board and national policy, and needed to be delivered within budget. Although management structures changed, the core group of services delivered directly (or by the voluntary sector) did not change. These services included the following:

- AIDS/HIV/drug abuse services
- child care and family support services
- community health services
- counselling services
- dental services
- environmental health services
- general hospital services
- medical services
- mental health services
- public health services
- services for the elderly
- services for people with physical and sensory disabilities
- services for the homeless
- some intellectual disability services.

The Eastern Regional Health Authority, 2000–2005

Unlike the Health Boards, the ERHA did not provide services itself. Primarily, it was concerned with strategic planning, commissioning, overseeing and coordinating services in the Eastern region. It was also charged with evaluating and monitoring the performance of services – again, unlike the Health Boards. With a budget of €3.175 billion in 2003, the ERHA negotiated contracts with

each of the three Area Health Boards under its remit (Northern Area Health Board, Eastern Coast Health Board and South West Area Board) to provide services. Furthermore, the ERHA directly contracted with 34 voluntary agencies, including hospitals, for the provision of services. In 2003, €1.70 billion (54% of the total budget) was allocated by the ERHA to these voluntary bodies (ERHA, 2004a).

The ERHA board was similar to that of the other Health Boards, with 55 members, mostly appointed by city and county councils in Dublin, Kildare and Wicklow, plus elected representatives of the medical professions and three ministerial appointees. Members were also members of their respective Area Health Boards. The ERHA Board included representatives from voluntary service providers, voluntary hospitals and voluntary intellectual disability agencies. In its short lifespan the ERHA was also concerned with a reorientation of services in the Eastern region. Its principal aims, in line with the 2001 Health Service Strategy, were to ensure that:

- all services are primarily oriented towards the patient/client and their family;
- services are integrated around the patient/client and are to be seamless from the user's point of view;
- there is a high level of consumer consultation in the development of new services;
- appropriate multiethnic service responses are provided;
- close inter-professional liaison occurs at the point of service delivery;
- close inter-service liaison occurs at all levels, particularly at local level;
- quality and performance measures and targets are agreed and set for each service: these targets should include arrangements for inter-service liaison, referral, discharge, patient/client support and inter-professional collaboration;
- services demonstrate that their operation adheres to international best practice; and
- a standard of excellence by national and international norms is the goal for all service units, with the aim of obtaining ISO (International Organization for Standardization) awards or other recognized quality marks from professional bodies.

Area Health Boards and shared services

The three Area Health Boards – the Northern Area Health Board, the East Coast Health Board and the South West Area Health Board – were responsible

for the delivery of a range of services. They were similar in structure to the Health Boards, except that they were accountable directly to the ERHA. There was, however, some overlap in the functions of the ERHA and the Area Health Boards, as they were also responsible for planning within their own areas. For the direct provision of services, the Northern Area Health Board received €574 million, the Eastern Coast Health Board €365 million and the South West Area Board €493 million in 2003.

A separate organization, Eastern Health Shared Services (EHSS), provided a wide range of professional, technical and information support services to the ERHA and the three Area Health Boards. This avoided duplication locally and was consistent with the principle of providing value for money that was a key component of the 2001 Health Strategy. The EHSS, for instance, was responsible for all aspects of employee services, including recruitment, payroll, staff development/training and counselling. It also played a role in central procurement of goods and services for the whole region. In addition, the EHSS provided financial services, employee services (including payroll and recruitment), materials management, information and communications technology, and architectural and property services. This model was replicated within The National Shared Services Centre of the new Health Service Executive (HSE).

The Health Boards Executive

Both the 2001 Health Strategy and the Value for Money Audit (Deloitte & Touche Organization, 2001) recognized the need to improve the coordination of services across Ireland, improve efficiency and value for money, adopt more people-centred approaches and reduce disparities in access to services. In 2002 the Health Boards Executive (HeBE) was set up as a statutory agency, with a budget of €2.4 million (€1.7 million from the Health Boards and €0.7 million from the DoHC) to facilitate joint working between the Health Boards and the ERHA, in particular in promoting the core principles of the national health strategy “*Quality and Fairness*”, as well as other strategy documents, such as the *National Primary Care Strategy* and the *National Health Information Strategy*. Formally, the HeBE was a legal entity allowing formal and extensive conjoint activities to be undertaken by the Health Boards. Its board comprised the 11 CEOs of the Health Boards, Area Health Boards and the ERHA.

Decisions could only be made by consensus between the Health Boards and did not apply to Health Boards which did not engage in a particular project. Key strategic themes pursued included: child health and welfare; information and communication technology (ICT); health gain; service improvement and modernization; health strategy implementation projects; value for money; and knowledge management. The structure of the HeBE meant that a number of

different projects were undertaken during its first year of operation. For instance, under the theme of Best Health For Children, a workshop on a national universal screening programme for neonatal hearing was discussed; a national steering group for adolescent health was set up; research was conducted on the national infant metabolic screening programme and neonatal screening programme for cystic fibrosis; the “investing in parenthood strategy” was developed in conjunction with the National Children’s Office and the Department of Social, Community and Family Affairs; a database of research and activity in child welfare was developed within the Health Boards; and the pilot phase of a European project to develop standardized Quality of Life Instruments for children and adolescents was coordinated.

Other activities included developing and managing the Irish Cervical Screening Programme (ICSP) and a Medical Card project to make it easier for eligible individuals to obtain a Medical Card. The HeBE also worked on a project to identify the best way to implement the recommendations put forward in the 2001 Strategic Ambulance Review. The Irish Clearing House that identifies and maintains a database of evidence-based practice also became part of the HeBE. On 1 January 2005 the functions of the HeBE were transferred to the HSE. Activities delivered by HeBE after the end of 2004 continued within the HSE as part of the remit of the Project Management Unit.

10.3 Competition, risk equalization and the Irish insurance market

The 1994 Health Insurance Act legislation, which opened up the insurance market to competition, required that products offered by any new insurance provider had to be consistent with the existing conditions of community rating, open enrolment and lifetime cover. Thus, competition would be based on the differences in the package of benefits offered (over and above Minimum Benefit Requirements) and thus differences in premium rate.

The Act also provided for the introduction of a risk-equalization mechanism, if the Government determined this to be necessary. This is a mechanism for dealing with differences in health insurance companies’ costs due to differences in the risk profiles of their subscribers. Essentially, companies who have healthier-than-average subscriber profiles would be required to make a cash transfer to those companies whose subscribers have worse-than-average health risk profiles.

The potential and actual use of risk equalization has proved to be highly contentious, particularly as the VHI Healthcare (VHI) has by far the oldest

subscriber profile, and thus will benefit financially from any risk-equalization scheme. There have been a number of reviews looking at how a risk-equalization system might operate, in practice, in Ireland. An Advisory Group to the Minister of Health and Children (MoHC) concluded in 1998 that a system of some sort was needed. A White Paper on the topic was also published (DoHC, 1999b). When the Health Insurance Authority (HIA) was established in 2001, one of its objectives was to oversee the introduction of risk equalization, and in 2003 the Government formally informed the European Commission (EC) of its plans to implement the scheme. The proposal stated that if the difference in risk profiles between insurers was between 2% and 10% then the scheme could be enacted by the MoHC if it were recommended by the HIA. Where differences were more than 10% the scheme would be enacted by the Minister after consultation with the HIA, unless there were compelling factors for not doing so. A formula for transfers developed by the HIA would take account of age, gender and health status.

This approach to the risk-equalization scheme has been the subject of a number of legal challenges at the European Union (EU) level by the then principal competitor to VHI, British United Providential Association (BUPA) Ireland. BUPA argued that any transfers of funds to the semi-state organization – the VHI – would constitute a form of state aid. However, in 2003 the EC concluded that the operation of such a risk-equalization scheme would not constitute a form of state aid (EC, 2003).

In its defence the VHI has consistently argued that the absence of a risk-equalization mechanism has allowed new entrants to the market to “cherry pick” those younger and healthier consumers by undercutting the premiums offered by the VHI. The organization argued that the level of surplus generated from this healthier population group is much greater than that achieved by VHI.²⁷ In addition, the VHI contended that the prices of its premiums had to rise as a result of this cherry picking by competitors. Writing in their 2004 Annual Report, Chairman Bernard Collins issued a warning that without risk equalization, the very future of the VHI, as well as the community rating system as a whole, would be at stake (VHI Healthcare, 2004).

If new entrants into the market were able to consistently undercut the VHI by focusing on low-risk consumers, one consequence would be to increase the overall cost of premiums set by the VHI, which in itself may act as a further incentive for some consumers to switch to other providers. The other insurers argued that, in fact, this would help to stimulate competition. Research from the HIA indicates that only 10% of Irish consumers switched insurance

²⁷ The financial records of BUPA Ireland are not public and are amalgamated into annual reports prepared for its parent company, BUPA UK, making it difficult to test the veracity of this claim.

companies, suggesting that the growth in coverage is mainly new business (Insight Statistical Consulting, 2005).²⁸ Certainly, VHI premiums have risen significantly in recent years; data from 2001 indicate that, over a 10-year period, premiums increased by 72%. Moreover, older data from the late 1990s also reported that BUPA Ireland's premiums were indeed 10% lower for subscribers under 19 years of age; 4% lower for those aged between 19 and 49 years; and 20% higher for those aged over 54 (Mossialos & Thomson, 2004). Information from BUPA Ireland also indicates that they offered lower premiums for plans of comparable benefit compared with both the VHI and the new entrant, Vivas (BUPA Ireland, 2005).²⁹ One academic study also indicated that the annual rate of growth of VHI premiums after the introduction of competition in 1997 to 2003 was 10.0% compared with an annual rate of 5.9% for the period 1990–1996. In the meantime, average premiums for BUPA Ireland increased at a slightly lower annual mean rate of 9.6% between 1997 and 2003 (York Health Economics Consortium, 2003). The mean cost of any policy, regardless of provider, reported in a survey in 2005 was €1108, representing a 44% or €340 increase since the previous survey in 2002–2003 (Insight Statistical Consulting, 2005).

BUPA Ireland continued to contend that the VHI's profitability had actually grown following the introduction of competition in the market. It maintained that not only had the number of consumers covered by VHI increased (although its market share had fallen), but that VHI Healthcare had also succeeded in increasing the proportion of younger people that it covered. However, BUPA did concede that VHI consumers were likely to be older than those covered by BUPA Ireland, noting that many of the former may have been with the VHI for a very long time, including some dating back to 1957. One independent, HIA-commissioned survey also suggested that while the age profile of BUPA consumers was younger than that of VHI, the difference in age profiles had been decreasing since the previous 2002–2003 survey (Insight Statistical Consulting, 2005). BUPA also argued that international experience showed that the risk-equalization mechanism would end competition. Moreover, since so-called "cherry picking" was an illegal practice, it was not something that any insurance company in Ireland would engage in, thus reducing the case for risk equalization (BUPA Ireland, 2000).

The HIA had commissioned a wide-ranging, independent review to look at the extent of competition for health insurance, the range of products and services provided, and the level of innovation. This review, undertaken by York

²⁸ However, one possible reason for the low level of switching may be due to the difficulties consumers may experience in distinguishing between the many different products available on the market.

²⁹ Premiums for a family of two adults and two children would be €1296.66 under BUPA's Essential Plus (no excess) policy, compared with €1440.86 for VHI's Plan B and €1537.20 for Vivas' "WE level 2 plus Day 2 Day Level A" plan.

Health Economics Consortium, also assessed the impact of introducing a risk-equalization system on competition and services, and the impact of changing the commercial status of the VHI, from its position at the time of writing as a semi-state organization to full independence, as previously put forward in the White Paper mentioned earlier (DoHC, 1999b). Finally, the review analysed the possible impact of the exit of a market player, and investigated why, to date, there had been few new entrants into the market (York Health Economics Consortium, 2003). Although the report was submitted to the HIA in 2003, its findings were not made public until late 2004. The review concluded that competition had increased since the opening up of the market in 1994, but – contrary to some expectations – there was little evidence of fierce price competition, with the changes in the premiums of the new entrant (BUPA) being similar to those of the VHI. The review referred to this phenomenon as “price following”, arguing that it was less competitive and generated fewer new members for the entrant, but at more favourable prices (York Health Economics Consortium, 2003). It also concluded that the uncertainty over the introduction of, and mechanisms for, risk equalization would act as a deterrent to market entry, but that “competition from new entrants, in the absence of risk equalization, would not necessarily be beneficial for the market”, as new entrants would necessarily attract younger consumers (in part, due to the brand loyalty to the VHI on the part of older consumers), effectively allowing new insurers to generate windfall profits. Finally, the review took the view that if new entrants to the market could not continue to generate surpluses under a risk-equalization system, then they may be introducing inefficiencies into the market.

In the midst of this debate, the risk-equalization scheme was (partly) introduced on 1 July 2003, when insurers were required to make data returns. The first reports were received from three insurers (VHI Healthcare, BUPA Ireland and the Electricity Supply Board Staff Medical Provident Fund) for the six-month period to 31 December 2003. Although the market equalization percentage was determined to be between 2% and 10% (3.7%) during this period, and 3.5% in the next 6-month period in 2004, on both occasions the HIA recommended that risk-equalization payments should not come into effect, partly due to concerns over the “uncertain competitive consequences that could arise” (HIA, 2004). The HIA first recommended that risk-equalization payments be triggered in April 2005 but the MoHC decided against this, believing at the time that “the introduction of risk equalization would be premature in advance of a government decision regarding the commercial status of VHI and that deferring a decision would allow time for further corroboration of trends both in risk profile and competition in the market” (DoHC, 2005f).

The status of the VHI has been one of the principal arguments put forward against risk equalization. The VHI had enjoyed an exemption under Article 4(c)

of the 1973 EU First Non-Life Insurance Directive. Without this exemption, VHI Healthcare would have been regulated by the Financial Regulator, as well as legally required to have reserves far greater than its levels at the time of writing and to establish subsidiary or sister companies to sell its non-health insurance products (such as travel insurance). Thus, VHI Healthcare has benefited from a regulatory advantage allowing it to compete in ways not available to other health insurers (Competition Authority, 2007). Legislation to change some aspects of the status of VHI was brought forward in the summer of 2006. This was to give commercial freedom to the VHI on products and pricing, but would oblige it to achieve the level of reserves needed to obtain authorization as an insurer within six years (subsequently reduced to two years). In the longer term one option might be for the VHI to become a fully independent company.

In December 2005, in light of this proposed change in the VHI's status and the increased divergence in the market risk profiles, the Government announced that risk equalization would finally be introduced from 1 January 2006. Advice given to the MoHC by the HIA, backed up by the DoHC and its actuarial advisors, concluded that risk equalization was both necessary and fair to any potential contributors. The advice also pointed out that BUPA Ireland entered the market in the knowledge that risk equalization was a (potential) key feature of the Irish regulatory framework and, moreover, that BUPA operated in other markets, such as Australia, where risk equalization takes place (DoHC, 2005a; Mercer, 2005).

BUPA Ireland contested the introduction of the scheme, claiming that it would make competition unworkable (BUPA Ireland, 2006). Following legal proceedings, in late December 2005 the High Court in Dublin disallowed an injunction which had sought to prevent the implementation of risk equalization. In November 2006, the High Court in Dublin upheld its previous ruling with regard to risk equalization, noting that BUPA had been fully aware of the regulatory framework when it had entered the market. Furthermore, in January 2007 the High Court also ordered BUPA to pay the legal costs of the State, the VHI and the HIA. Another legal action was launched by BUPA Ireland in February 2006 and – as of November 2007 – this case was in the process of being heard before the Supreme Court. A case was also lodged with the European Court of First Instance.

In December 2006, following the High Court judgement, BUPA Ireland announced its staged withdrawal from the Irish health insurance market, stating that the payments it was required to make under the risk-equalization scheme were already costing more than €1 million a week, and that the €161 million it would be required to pay to the VHI over the next three years would far exceed its estimated surplus of €64 million (BUPA Ireland, 2006). Its business was bought by the Quinn Group in April 2007. Initially, Quinn had been under the

assumption that they would be classed as a new entrant (even though they were buying an existing insurance business), and thus exempt from risk-equalization payments for three years. Emergency legislation passed in February 2007 closed this loophole. In July 2007, Quinn instituted High Court proceedings against the Attorney General over the decision to introduce this emergency risk-equalization legislation, claiming that it should be exempt from the risk-equalization requirements for its first three years of operation, on the grounds that it was a new entrant to the sector.

Ongoing review and reform, 2006–2008

In introducing risk equalization, the MoHC also requested that the HIA take further steps to promote competition in the insurance market and “to ensure that consumers are aware of their rights to move between insurers without having to incur penalties” (DoHC, 2005f). In response, the HIA, in conjunction with the Competition Authority, launched a public consultation on the private insurance market in March 2006 (HIA, 2006), which led to publication of two reports on competition in the private health insurance market the following year (HIA, 2007a; Competition Authority, 2007).

The HIA’s own report recommended allowing the VHI to have the flexibility to sell insurance products not related to health through associated companies or subsidiaries, as well as stating that it also should have to pass the “solvency test” in terms of its financial reserves (at the time of writing, to have financial reserves equivalent to 40% of annual premiums) in exactly the same way as private insurers, over a shorter time frame than the previously proposed six years; that the need for approval by the MoHC for any increase in VHI premiums should be abolished; that unfunded lifetime community rating should be introduced; and that the time period over which new entrants to the market would be exempt from full risk-exemption payments (at the time of writing, three years, with 50% in year four and full obligations from year five) should be extended.

The report noted that, while there were no financial barriers to consumers switching between products, in practice the level of uptake for switching was very low, and more needed to be done to promote consumer awareness on how to switch. Insurers, it recommended, should have to provide more information to consumers on their rights, including in terms of consumer switching and the fact that waiting periods to obtain insurance coverage only apply to first-time consumers. Moreover, renewal notices would have to be sent out to consumers at least one month before the renewal date. These should set out in a common format, detailing the cost of current cover and the cost of renewal of cover. A switching code should also be drawn up by the private health insurers. The system of minimum

benefits that must be provided within insurance plans could also be simplified, removing fixed monetary values, specifying instead benefits in non-monetary terms where possible, and removing some restrictions on the types of procedure and specific hospitals that should be included.

The Competition Authority report made 16 recommendations to promote competition in the private health insurance market in Ireland, within the limits of intergenerational solidarity. Again, key recommendations revolved around the future status of VHI and the solvency requirement; providing consumers with useful and timely information and increasing awareness of switching; modernizing Minimum Benefits Regulations; increasing the powers of the HIA to enforce the Health Insurance Acts; and promoting the interests of consumers. It also called for the VHI to discontinue its practice of cancelling its MultiTrip Travel Insurance when its members switch health insurer (Competition Authority, 2007).

A rapid appraisal from a business perspective of the private health insurance market, chaired by Colm Barrington, was also commissioned by the MoHC in January 2007. It had the aim of examining

... whether, having regard to all aspects of the current health insurance market in Ireland (structure, size, regulatory framework, etc.) and the need to maintain community rating, it is possible for current and prospective participants in the health insurance market to earn a rate of return on capital employed which would be regarded as adequate for the insurance industry” (Barrington, Creedon & Dowling, 2007).

The group of three business leaders concluded that the market did not operate in a way such that existing or new insurers could expect to earn a reasonable rate of return on their investment. In addition to highlighting the need to change the status of the VHI and the provision of better information to consumers on their rights with regard to health insurance, they recommended that community rating only be applied to those benefits deemed sufficient to provide adequate private health insurance, and that risk equalization become more limited, transparent and possibly prospective.

In the meantime, the EC announced in January 2007 that it had decided to “send Ireland a formal request to submit its observations on the continued legality of the exemption of the Irish VHI from certain EU rules on non-life insurance.” It will subsequently decide whether to issue a “reasoned opinion” formally calling on Ireland to amend relevant legislation (Commission of the European Communities, 2007). A report commissioned by Vivas and undertaken by Goodbody Economic Consultants also highlighted limited competition and recommended that risk-equalization payments be suspended until the VHI

operates under the same rules as other market entrants; any risk-equalization payments made should also be scaled back because of the limited number of participants in the insurance market (Finegan, 2007).

In response to the Competition Authority, HIA and the Barrington Group reports, the Government approved a number of reform measures in April 2007. In announcing the measures, Minister Harney stated that

... the fundamental issue of creating a level playing field in the market is being brought forward to the earliest possible date. There are also a number of important new pro-consumer measures being taken to make it easier for people to understand and select insurance plans and to switch between insurers... [adding that] ...it is not in the interests of VHI staff or customers or the wider health insurance market that it should continue to occupy its current anomalous status as an unauthorized insurance undertaking (Harney, 2007b).

The VHI is to become a conventional insurer, authorized by the Financial Regulator by the end of 2008; at this time, it will also have to fulfil the solvency requirements for insurers. Legislation is being introduced to ensure that the VHI establishes subsidiaries to operate its ancillary activities, including travel insurance and health care clinics. This legislation will also remove the reserve powers of the MoHC with reference to product development and pricing.

The Government also agreed to implement immediately the various pro-consumer measures outlined in the Barrington Group report that did not require legislation. These included providing health insurance customers with clear statements of consumers' rights and standardized renewal notices; requesting companies with payroll deduction schemes to offer at least two companies' products to employees; and having group schemes put out to tender on a regular basis. The waiting periods imposed on older people now should also be reviewed to ensure that they comply with equality legislation.

In response to the Barrington Group and in order to encourage competition, the Health Insurance Amendment Act 2007 will allow risk-equalization payments to be discounted by 20%. There will also be consultation on draft regulations for Lifetime Community Ratings to encourage individuals to enter the market at a younger age. Consultation will also consider defining what level of health insurance should be subject to community rating. As noted by the MoHC,

... the question posed here is whether people with low or modest health insurance cover should subsidize the additional benefits purchased by wealthier people who have very high levels of coverage. Should

all policies, even if they offer the most generous benefits in the most expensive hospitals here and internationally, be subsidized by the vast bulk of people who have normal benefits in their health insurance policy? (Harney, 2007b)

The HIA will explore the feasibility of introducing a prospective risk-equalization scheme and the Government continues to have an open mind over the future ownership status of the VHI.

10.4 HiT methodology and production process

The Health Systems in Transition (HiT) profiles are produced by country experts in collaboration with the Observatory's research directors and staff. The profiles are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources, and examples needed to compile HiTs. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: http://www.euro.who.int/observatory/Hits/20020525_1.

Authors draw on multiple data sources for the compilation of HiT profiles, ranging from national statistics, national and regional policy documents, and published literature. Furthermore, international data sources may be incorporated, such as those of the Organisation for Economic Co-operation and Development (OECD) and the World Bank. OECD Health Data contain over 1200 indicators for the 30 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All (HFA) database. The HFA database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health for All policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard HFA data have been officially approved by national governments. With its January 2007 edition, the HFA database started to take account of the enlarged European Union (EU) of 27 Member States.

HiT authors are encouraged to discuss the data in the text in detail, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT profile consists of ten chapters:

1. **Introduction:** outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
2. **Organizational structure:** provides an overview of how the health system in a country is organized and outlines the main actors and their decision-making powers; discusses the historical background for the system; and describes the level of patient empowerment in the areas of information, rights, choice, complaints procedures, safety and involvement.
3. **Financing:** provides information on the level of expenditure, who is covered, what benefits are covered, the sources of health care finance, how resources are pooled and allocated, the main areas of expenditure, and how providers are paid.
4. **Regulation and planning:** addresses the process of policy development, establishing goals and priorities; deals with questions about relationships between institutional actors, with specific emphasis on their role in regulation and what aspects are subject to regulation; and describes the process of health technology assessment (HTA) and research and development.
5. **Physical and human resources:** deals with the planning and distribution of infrastructure and capital stock; the context in which information technology (IT) systems operate; and human resource input into the health system, including information on registration, training, trends and career paths.
6. **Provision of services:** concentrates on patient flows, organization and delivery of services, addressing public health, primary and secondary health care, emergency and day care, rehabilitation, pharmaceutical care, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health care for specific populations.
7. **Principal health care reforms:** reviews reforms, policies and organizational changes that have had a substantial impact on health care.
8. **Assessment of the health system:** provides an assessment based on the stated objectives of the health system, the distribution of costs and

benefits across the population, efficiency of resource allocation, technical efficiency in health care production, quality of care, and contribution of health care to health improvement.

9. **Conclusions:** highlights the lessons learned from health system changes; summarizes remaining challenges and future prospects.
10. **Appendices:** includes references, useful web sites and legislation.

The quality of HiTs is of real importance since they inform policy making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to:

- A rigorous review process (see the following section).
- There are further efforts to ensure quality while the profile is finalized that focus on copy editing and proof reading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.
- One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely to ensure that all stages of the process are as effective as possible and that the HiTs meet the series standard and can support both national decision making and comparisons across countries.

10.5 The review process

This consists of three stages. Initially the text of the HiT is checked, reviewed and approved by the research directors of the European Observatory. The HiT is then sent for review to two independent academic experts and their comments and amendments are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant ministry of health, or appropriate authority, and policy-makers within those bodies are restricted to checking for factual errors within the HiT.

10.6 About the authors

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The Health Systems in Transition profiles

A series of the European Observatory on Health Systems and Policies

The Health Systems in Transition (HiT) country profiles provide an analytical description of each health care system and of reform initiatives in progress or under development. They aim to provide relevant comparative information to support policy-makers and analysts in the development of health systems and reforms in the countries of the European Region and beyond. The HiT profiles are building blocks that can be used:

- to learn in detail about different approaches to the financing, organization and delivery of health care services;
- to describe accurately the process, content and implementation of health care reform programmes;
- to highlight common challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in countries of the WHO European Region.

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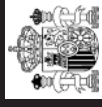
HiT country profiles published to date:

Albania (1999, 2002^{a,g})
Andorra (2004)
Armenia (2001^g, 2006)
Australia (2002, 2006)
Austria (2001^e, 2006^e)
Azerbaijan (2004^g)
Belarus (2008)
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Russian Federation (2003^g)
Slovakia (2000, 2004)
Slovenia (2002)
Spain (2000^h)
Sweden (2001, 2005)
Switzerland (2000)
Tajikistan (2000)
The former Yugoslav Republic of Macedonia (2000)
Turkey (2002^{g,i})
Turkmenistan (2000)
Ukraine (2004^g)
United Kingdom of Great Britain and Northern Ireland (1999^g)
Uzbekistan (2001^g, 2007)

Key

All HiTs are available in English.
When noted, they are also available
in other languages:

- ^a Albanian
- ^b Bulgarian
- ^c French
- ^d Georgian
- ^e German
- ^f Romanian
- ^g Russian
- ^h Spanish
- ⁱ Turkish
- ^j Estonian
- ^k Polish



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HITs are in-depth profiles of health systems and policies, produced using a standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.