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Tenth anniversary of the HSE

The year 2015 proved demanding for the health services. As a result of the economic recovery, additional funds were available for healthcare but major challenges remained, the most visible being the problem of patients on trolleys in hospital emergency departments and wards.

The year also marked the tenth anniversary of the establishment of the Health Service Executive (HSE), which replaced the health board regional structures set up in the 1970s by Minister Erskine Childers, TD. The health board system had been criticised for regional differences in standards, inefficiencies, excessive influence by politicians at regional level and slowness in reform. Its strengths, on the other hand, arguably included local political accountability and transparency and a marked sense of the local ‘ownership’ of services.

Prior to 2005, arguments for change were strongly influenced by the UK National Health Service model and envisaged a single national service in Ireland, free of significant regional variation. Proponents of a new national structure also considered that it would facilitate service rationalisation, particularly in acute hospital care, which had been difficult to achieve within the previous regional boundaries; and much reform in this direction has taken place in the intervening decade, with some of it being described in 2011 by a former HSE CEO (Drumm, 2011).

With the establishment of a single national structure, however, policymaking has had a ‘top-down’ rather than ‘bottom-up’ emphasis,

while criticism of healthcare has focused on one body, the HSE, which has experienced a very challenging decade. Ten years on, its days, or at least years, appear numbered. The 2012 strategy document *Future Health* provided for the dissolution of the HSE in stages and for the establishment of a purchaser-provider service-delivery arrangement in the health sector. While Minister James Reilly, TD, had committed to the abolition of the HSE, Minister Leo Varadkar, TD, who assumed office in 2014, opted for a period of reassessment of the ambitious reform process undertaken by his predecessor and the postponement of the abolition of the HSE, which is still expected in the coming years. In a speech at the MacGill Summer School in Glenties in July, the current minister also suggested that there had been inadequate discussion in the Oireachtas prior to the original establishment of the HSE (Varadkar, 2015b).

In a newspaper interview in December (Mitchell, 2015), the current HSE director general, Tony O'Brien, argued that the organisation had lacked the funding necessary to deliver major change and that the current budgetary process militated against medium- to long-term decisions, and he made a case for a national vision for healthcare.

Universal health insurance

The 2011 programme for government (Department of the Taoiseach, 2011) made a commitment to the introduction of a single-tier, multi-payer model of universal health insurance (UHI) covering both hospital and primary care, and was followed by a White Paper, *The Path to Universal Healthcare* (Department of Health, 2014c), which was covered in last year's review (Curry, 2015).

In September an Economic and Social Research Institute (ESRI) report, *An Examination of the Potential Costs of Universal Health Insurance in Ireland*, estimated that the model of UHI set out in the White Paper would increase overall Irish healthcare spending by up to 11 per cent (Wren et al., 2015). In November, following Cabinet discussion, the minister announced that a comprehensive programme of health reform would continue but that more research into UHI, to be overseen by the Department of Health and the ESRI, would be required before a final model was chosen. The decision on such a funding model, the minister suggested, could be taken towards the end of the term of the next government.

Before making such a decision, the minister argued, several foundations needed to be put in place over the next few years:

sufficient capacity to satisfy unmet demand; enhanced primary and social care; reformed structures to replace the HSE with hospital groups and trusts; community healthcare organisations and other new structures; financial reforms, including activity-based funding ('Money Follows the Patient'); and the 'Healthy Ireland' public health and patient safety agendas.

Expansion of eligibility for GP care

The GP continues to play a pivotal role in the Irish health services and developments in eligibility for GP care are therefore of considerable importance. While delays in the introduction of universal healthcare, incorporating free GP as well as hospital care, have sparked criticism, free GP services for those aged under six and those aged seventy and over were introduced in 2015, and are seen by the government as stepping-stones to universal healthcare.

The government's *Statement of Government Priorities 2014–2016* (Department of the Taoiseach, 2014) reiterated a previous commitment to the introduction of a universal GP service for the entire population, in line with the 2011 programme for government, and indicated that the government had prioritised children aged under six and people aged over seventy for the first two phases of the roll-out of universal GP care.

In April an agreement was announced between the Department of Health, the HSE and the Irish Medical Organisation (IMO) on the terms for the delivery of free GP care for all children aged under six, at an estimated annual cost of €90 million; the service became operational in June. According to the department, an additional 270,000 children aged under six would benefit from this service. The services provided include age-based preventive checks and a specific 'cycle of care' for children diagnosed with asthma.

During the summer the extension of GP care free at the point of service to everyone aged seventy or over, and who did not currently qualify for this benefit, also took effect. This service, the department estimated, would benefit about 36,000 new patients.

Policy and budgetary priorities

In an address to the Oireachtas Joint Committee on Health and Children in May, Minister Varadkar (2015a) identified his major policy priorities as 'Healthy Ireland', the government-led programme

to improve personal and public health; patient outcomes and patient safety; universal health; greater investment in IT; and investment in modern infrastructure and facilities, including the planned new Children's Hospital – an oral hearing about this hospital's planning application began at An Bord Pleanála in late November.

In his speech in Glenties in July the minister placed particular emphasis on 'Healthy Ireland', as well as on the need to build up primary and social care in the community (Varadkar, 2015b).

He highlighted the progress made on smoking and argued that a similar focus was required for alcohol misuse, obesity and physical inactivity. In December the minister published a Public Health (Alcohol) Bill, which included various measures intended to combat alcohol abuse, including minimum pricing.

In the same month the Minister of State with Special Responsibility for the National Drugs Strategy, Aodhán Ó Ríordáin, TD, addressed the first meeting of the National Drugs Strategy Steering Committee. The committee has been established to advise the minister on the development of a new National Drugs Strategy, which will commence in January 2017.

In October Minister Varadkar published Ireland's first *National Sexual Health Strategy*, which incorporated a fifteen-month action plan (Department of Health, 2015d). It aims to raise awareness of sexual health and stem the rising incidence of sexually transmitted infections, and incorporates a commitment to Dublin's first free and rapid HIV-testing service.

The current budget for the health services in 2015 was €13.079 billion while the total capital budget for 2015 was €382 million (Department of Health, 2014b).

Priorities for 2015 included the extension of BreastCheck to women up to the age of sixty-nine, the expansion of mental health teams, further investment in suicide prevention, as well as the introduction of free GP care to those aged under six and those aged seventy and over.

Specific savings and efficiencies of €130 million were identified in the areas of procurement, drug costs, agency costs, clinical audit and special investigation. These savings were to be used for the development and delivery of services for patients. Funding of €25 million was set aside to respond to the issue of delayed discharges.

Minister of State Kathleen Lynch, TD, noted that the €35 million ring-fenced for mental health services in Budget 2015 was in line with the commitment in the programme for government to accelerate the pace of change to develop a modern, patient-centred and recovery-

oriented mental health service. She added that the department was implementing a significant restructuring in disability services to a new model of person-centred, community-based services. These were intended to provide greater choice for people with disabilities and increased access to the supports and resources they require.

The Health Budget for 2016, which was announced in autumn 2015 by Ministers Varadkar and Lynch, indicated that the Department of Health will have funding of €13.175 billion for current expenditure and €414 million for capital expenditure (Department of Health, 2015b).

This Budget included funding to cover the full annual cost of measures, such as free GP care for the under-sixes and over-seventies. It also provided for the annual rise in demand on health services as a result of demographic pressures, and for the Lansdowne Road Agreement on pay provisions for health sector staff. The 2016 Budget also comprised saving and efficiencies measures of €125 million in procurement, prescribing and drug costs.

While the actual scope for new programmes was described by the minister as ‘modest’, they will include a further extension of free GP care (subject to negotiations with the IMO), speech and language therapies for children, further investment in mental health services, measures recommended under the maternity strategy and extra ambulance staff.

As noted in the 2014 review (Curry, 2014), deficits have characterised HSE budgets in recent years, and have necessitated, since 2008, a supplementary estimate on top of the original voted Exchequer contribution. In December the minister sought a net supplementary estimate of €600 million (Dáil Éireann, 2015a). However, at the launch of the HSE’s 2016 *National Service Plan* (HSE, 2015b), its director general warned that supplementary estimates would not be available for 2016 as a result of new EU fiscal rules. He also highlighted the importance of integrated care and the contribution to such integration of the integrated care programmes and of the developing hospital groups and community health organisations.

The three-year agreement for 2012–15 between the health service and the pharmaceutical companies came to an end in 2015, and discussions were ongoing at year end about a successor agreement. In October an Oireachtas report on the cost of prescription drugs recommended that the minister should consider expanding to fifteen the number of comparator countries used to calculate average drugs

costs, in order to ensure that lower-cost countries are included in such calculations (Houses of the Oireachtas Joint Committee on Health and Children, 2015).

Service challenges and priorities

Overcrowding in hospital emergency departments continued to be a major challenge for the health services in 2015. In late September the HSE reported that 368 patients were recorded as being on trolleys on a specific recent night. Shortly afterwards, the HSE's director general, Tony O'Brien, assumed the role of chairman of the Emergency Department Task Force, and announced that he planned to work with hospital groups and community health organisations in order to reduce overcrowding across the country. In December a ministerial review of the year reported that some progress had come at year end from the implementation of the recommendations of the Emergency Department Task Force report in April, and specifically from changes to process and patient flow, additional funding for the Fair Deal Scheme, community hospitals and beds, home care packages, the expansion of community intervention teams and the provision of additional hospital beds (Department of Health, 2015c; 2015f).

The Emergency Department Task Force is co-chaired by Liam Doran, general secretary of the Irish Nurses and Midwives Organisation, which estimated in November that numbers on trolleys had increased from just over 4,000 in 2006 to almost 8,000 in October 2015 (see www.inmo.ie/Trolley_Ward_Watch).

Waiting times for inpatient and outpatient treatment also remained a considerable challenge for the healthcare system in 2015. Data on such waiting times continue to be gathered and published by the National Treatment Purchase Fund (NTPF, 2015).

Minister Varadkar told the Oireachtas Joint Committee on Health and Children in May that he had mandated the HSE to ensure that no one was waiting more than eighteen months for a surgical procedure or outpatient appointment by July, and no more than fifteen months by the end of 2015 (Varadkar, 2015a).

NTPF figures published relating to October 2015 indicated that over 13,000 patients were waiting over eighteen months at that time for an outpatient appointment, and that almost 2,200 patients were waiting for the same length of time for inpatient or day-case treatment. A Department of Health statement in December welcomed a certain reduction in these figures – to under 10,000 and

just over 1,500, respectively – that was revealed by the NTPF data for November (Department of Health, 2015g).

The minister told the Oireachtas in April that hospital groups, which were set up in 2013, had been established on an administrative basis, that his priority for 2015 was to get all the hospital groups up and running as single cohesive entities, and that primary legislation would be required in due course to give full effect to the introduction of hospital trusts (Dáil Éireann, 2015b). It is planned that the groups will eventually evolve into such trusts.

Since the 2012 *Future Health* strategy document (Department of Health, 2012), the achievement of integrated care has been a key aim of Irish health policy and this aim has been reflected in the development of community health organisations, as well as in other initiatives.

The HSE's *National Service Plan 2015* (HSE, 2014b) included a commitment to implement the recommendations of the 2014 report on community health organisations (HSE, 2014a), the new governance and organisational structures that are designed to improve service delivery outside the acute hospitals in areas such as primary care, social care (services for older people and for persons with a disability), mental health, and health and wellbeing, and to develop integrated care with a patient focus.

In the autumn, the HSE's Clinical Strategy and Programmes Division reported on progress towards the development of integrated care in Ireland and stressed that such integration has 'the patient perspective as an organising principle of service delivery' (HSE, 2015a).

The HSE also reported that five integrated care programmes were being established – Patient Flow, Older Persons, Prevention and Management of Chronic Disease, Children and Maternity – and that these programmes would liaise with the existing national clinical programmes. The first Integrated Care Conference was organised by the HSE in October in Dublin Castle.

Private health insurance

In late 2014 Minister Varadkar announced various measures that were intended to reduce the costs of private health insurance premiums, including, among others, a reduction in the Health Insurance Authority (HIA) levy, a halt to the diminution of tax relief and the introduction of Lifetime Community Rating (LCR). As a result, the

minister indicated to the Oireachtas Health Committee in May that the number of people with private health insurance was rising again in mid 2015 (Varadkar, 2015a). The HIA's annual report for 2014 indicated that just under 44 per cent of the population had health insurance at the end of 2014, as compared with a peak of just under 51 per cent in 2008.

LCR was introduced to the private health insurance market in Ireland in 2015. Community rating means that, in broad terms, holders of private insurance do not pay premiums on the basis of the risk they carry; for example, because of increased age. Under LCR, which is intended to encourage individuals to enter the health insurance market at an early age, community rating has been adapted to reflect the age at which a person takes out private health insurance. Late-entry loadings are now being applied to those who subscribe at age thirty-five or over. Thus, a person who takes out private health insurance earlier in life, and who retains it, will pay lower premiums than someone who joins at an older age.

Reports and discussion on abortion legislation

The first annual report on the 2013 abortion legislation, the Protection of Life During Pregnancy Act, was laid before the Houses of the Oireachtas in June, as required under Section 20 of the Act (Department of Health, 2015a). The report covered the period from 1 January to 31 December 2014.

The report stated that twenty-six 'terminations of pregnancy' were carried out under the Act in 2014. Fourteen of these arose from a risk to the life of the mother arising from physical illness, three arose from a risk to the life of the mother from suicide, and nine arose from a risk to the life of the mother from emergencies arising from physical illness.

In an accompanying press release Minister Varadkar maintained that, on the basis of the notifications received by the department, 'the evidence indicates that the Act is working and that the hospitals are compliant with the notifications requirement under the Act' (Department of Health, 2015e).

In 2014 a *Guidance Document for Health Professionals* relating to the 2013 legislation stated that the procedures set out under the legislation are intended to ensure that, 'where lawful termination of pregnancy is under consideration, the right to life of the unborn is respected where practicable, and... that a woman can ascertain by means of a clear

process whether she requires this medical procedure or not' (Department of Health, 2014a, p. 5).

Following the June report to the Oireachtas, written questions were submitted in the Dáil, by Deputies Éamon Ó Cuív, Caoimhghín Ó Caoláin and other TDs, on issues such as the number of terminations that resulted in a live birth, the gestation period at which the terminations reported were carried out, the number of pregnancies that were delivered by caesarean section and the medical condition of the mothers. In response, the minister stated that the Act did not provide for the publication of such details on the grounds of confidentiality between patients and their doctors (Dáil Éireann, 2015c).

There was also significant Southern interest in the decision of a Belfast High Court Judge, Mr Justice Mark Horner, who held in November, in response to an application from the Northern Ireland Human Rights Commission, that the abortion legislation in Northern Ireland breached Article 8 of the European Convention on Human Rights – the right to privacy – in relation to 'fatal foetal abnormality' and pregnancy as a result of rape or incest (Northern Ireland Court Service Online, 2015). The judge later added that 'fatal foetal abnormality' was not a medical term as such but 'a shorthand description' for a cluster of conditions. The Attorney General of Northern Ireland, John Larkin, QC, stated in November that he was 'profoundly disappointed' with the judgement and was considering grounds for appeal. In December Mr Justice Horner ruled that any change in legislation would be a matter for the Northern Ireland Assembly.

Considerable discussion also took place in the Republic in 2015 on the future of the Eighth Amendment, the amendment passed by the people in 1983 to provide constitutional protection for the unborn, and on related matters. In February the Dáil defeated a private members' bill from the independent socialist TD Clare Daly that sought to permit abortion in cases of 'fatal foetal abnormality'. Support groups for parents with poor prenatal prognoses have taken opposing views on such legislation, with Termination for Medical Reasons Ireland supporting a change in the law while One Day More has opposed such change and highlighted instead the importance of perinatal hospice care.

In June an Amnesty International report was highly critical of the impact on women of Ireland's abortion legislation and was itself criticised for lack of attention to the rights of the unborn. In

November, as the debate on both sides of the argument intensified, the Taoiseach, Enda Kenny, TD, indicated that if Fine Gael is returned to power after the general election, he would set up, within six months of taking office, a citizens' convention to discuss possible changes to the Constitution in relation to abortion. He also indicated that, at the end of the consultation process, and contrary to the position at the time of the 2013 parliamentary discussions, he would permit a free vote to his party's members in the Oireachtas.

HIQA report on Portlaoise Hospital

The 2005 healthcare reforms established the Health Information and Quality Authority (HIQA), a body independent of the HSE and with responsibility for healthcare standards and quality.

Tensions between the HSE and HIQA surfaced in March when publication of a HIQA report into service standards in the Midland Regional Hospital, Portlaoise, was delayed because of the HSE's unhappiness with the draft document. The report of this statutory HIQA investigation, which focused mainly, though not exclusively, on maternity services, but which did not review individual cases, was eventually published in May 2015.

Concerns had originated from an RTÉ investigation in January 2014 which reported on the deaths of four babies over a six-year period, either during labour or within seven days of birth, in what the families regarded as failures of care. This investigation led to a number of developments, set out in last year's review (Curry, 2015), including the establishment of the HIQA enquiry.

The HIQA report criticised 'an ongoing failure on the part of the HSE to evaluate the services provided at Portlaoise Hospital against the risks and recommendations identified in previous local and national reviews and investigations conducted by the Authority and the HSE' (HIQA, 2015, p. 16). It found that the HSE failed to take decisive action on defining the role of Portlaoise Hospital and its model of care in the context of the findings of previous investigations. The hospital viewed itself as a 'model-3' hospital with 24/7 emergency departments, acute surgery, acute medicine and critical care; however, HIQA found, it had not been resourced appropriately to deliver such a model safely. The report also found that clinical governance and cooperation arrangements between Portlaoise and the Coombe Hospitals were still not in place some thirteen months after the publication of a recommendation to this effect by the Chief Medical

Officer of the Department of Health; but it did acknowledge that progress was being made in this direction.

Key HIQA recommendations included, among others, the establishment of an independent patient advocacy service; the development of a national maternity strategy as a matter of urgency; the conclusion of the process linking Portlaoise and the Coombe; and the appointment of a director of midwifery, before September 2015, in all statutory and voluntary maternity units and hospitals in Ireland that currently do not have such a post. It also recommended that the HSE publish an action plan outlining the measures and timelines to address the safety concerns and risks at Portlaoise Hospital, to include both general and maternity services, with a named person responsible for implementation.

The minister promised, in his response, to publish a national maternity strategy, and this strategy was launched in January 2016. The minister also agreed to the establishment of the independent patient advocacy service recommended by HIQA.

In its budgetary commitments for 2016, the Department of Health (2015b) stated that a National Women and Infants Programme would be set up in 2016 to standardise and improve maternity care across all nineteen maternity units and address front-line staff pressures, and that directors of midwifery and bereavement teams would be appointed to maternity units as standard. This funding will also support the Maternal Neonatal Clinical Management System, which will be implemented on a pilot basis in 2016.

In its response to the HIQA report, the HSE (2015c) accepted its recommendations and stated that significant improvements were already completed or underway in the hospital, that the measures taken ensured a safe level of services and that Portlaoise Hospital was now on a path to being an excellent hospital as part of the wider Dublin Midlands Hospital Group. It restated its apologies to the families impacted by past failures. It also maintained that HIQA's procedures lacked objectivity and fairness; for example, that HIQA refused to acknowledge the challenges posed by exceptional spending cutbacks and staffing reductions, and that staff – for example, midwives as a group – had not had an opportunity to comment on adverse comments or findings made against them.

The families of the babies who had died welcomed the HIQA report and called for appropriate disciplinary procedures relating to failures in care and for a process of accountability involving the Oireachtas Health Committee or a public enquiry.

The fundamental issues raised by the HIQA report are clinical: that is, what is required to offer best-practice maternity and other care to the patients of this hospital? There are various difficult balances to be achieved – for example, between transparency about, and accountability for, serious failures in service delivery, on the one hand, and a commitment to positive quality improvement, on the other hand, in which there is a genuine effort to assist conscientious and competent local staff to learn from past issues or problems. Another important balance is that between the central and the local. The 2005 reforms led to a significantly centralised health service, led by a national delivery body (the HSE) and monitored by a national quality body (HIQA), and to a significant focus on concentration of hospital resources, with concerns being expressed in several reports about standards of care in smaller hospitals. On the other hand, the potential strengths of those hospitals – related to their proximity to the local population, transport convenience, ‘human’ scale and staff knowledge of local services and circumstances – should also be taken into account. Finally, the apparently adversarial relationship between the HSE and HIQA has caused unease, though the independence of HIQA is also an important guarantor of standards under the current system.

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