

REFORM OF THE HSE

The HSE is not working. When the Government established it more than 3 years ago they set out clear objectives. The new structure was to make the system more responsive to the needs of patients, more accountable, and better value for money.

It has failed to deliver on all 3 counts.

If there was some light at the end of the tunnel, some sense that we were moving in the right direction, perhaps the right thing to do would be to press on with a strategy to achieve the goals set out. However, there is no evidence whatsoever that things are getting better. In fact they are getting worse. What we have is a monolithic system, distanced from the patient, divorced from Ministerial accountability, driven by budgetary concerns rather than patient need. The result is inefficiency, confusion, increased administrative costs, loss of public trust and of staff morale. Swingeing cuts across the service are now proposed to address a budgetary shortfall that is already €95 million overspent for the first 4 months of this year.

The rush to get the HSE up by the politically driven deadline of January 1st, 2005 gave us a cobbled-together structure with weak foundations designed by an architect who refuses to be accountable for the outcome.

Health is too important for this mess to be allowed to continue. Equally, the crisis in health is too urgent to allow anyone the luxury of going back to the drawing board to start again with a blank sheet of paper. Accordingly, the Labour Party is bringing forward a set of six concrete steps to reform the HSE, which, once implemented would have a significant impact on the existing situation, while also facilitating a more radical reform of the way in which health care is delivered in Ireland.

May 2008

ILL-CONCEIVED, ILL-DESIGNED AND BADLY EXECUTED

'It is striking that the one reform which the Government has decisively advanced has been a reform of the system of health administration. This reform does not address the two-tier access to care, the consultants' contract, the deficiencies in primary care, the inadequacy of acute care or the needs in community and continuing care' How Ireland Cares, Tussing & Wren, 2006

The establishment of the HSE is the core component of the Government's flagship Health Service Reform Programme. It is also an abject failure. Despite all the reports and all the studies that were commissioned, the Health Reform Programme was ill-conceived, ill-designed, and badly executed. The crisis in the HSE today is the direct result of Government ineptitude and bad political decisions.

Ill-conceived

The Health Service Reform Programme is centred on the creation of a unified Health Service Executive. Thus, it effectively ignores what are the core problems in the Irish health service that make it inefficient and inequitable. These are the two-tier structure in the system, the perverse incentives that dualistic structure creates for hospitals and clinicians, the inadequate bed capacity in the acute hospital sector, the lack of community care beds and other community based services that impose undue pressure on the acute sector, the inadequate numbers of consultants and GPs, the poor design of GP services, and so on.

Despite this litany of problems, the focus of the Health Service Reform Programme was on designing a better bureaucracy. Meanwhile, the problem of capacity in particular was to be left to be dealt with through the construction of a series of super-private clinics.

In focusing on administration while ignoring capacity, equity and incentives, the Health Service Reform Programme was doomed to failure.

Ill-designed

While there was, and continues to be, a need for better administration of the health service, the HSE as created was ill-designed to meet this need. From the outset, it was based on two separate reports (Brennan and Prospectus) which had quite different visions of how the HSE should function.

Despite the completion of a 'Composite Report', what emerged at the end had a number of crucial design flaws. For example, the spin was widely put about that the problem in the health service was reform being delayed by elected representatives on Health Boards who were putting local interests ahead of national need. This argument failed to distinguish between the provision of acute hospital services with national reach, and highly localised social services. They were all bundled into the same structure.

The HSE as created effectively removed any kind of democratic accountability from the health service. The legislation establishing the HSE sets the Minister at the centre of health policy, in control of the appointment of the HSE board and through it the appointment of its chief executive (though Minister Harney appointed Professor Drumm directly), with the power to require changes to its service plans and the power to veto planned capital investments. Democratic accountability has to mean ministerial accountability for the actions of the HSE. But the Minister has managed to side-step this accountability, in particular by directing Dail questions to the HSE and introducing regulations which place very little onus on the HSE to answer them.

It also created a structure which was intended to manage a very wide range of activities, often bearing little relation to each other, and involving over 106,000 staff, through a single hierarchical structure. Thus, a single organisation was to be created, with ten times as many staff as the defence forces, covering every aspect of health and social services from heart transplants to meals on wheels.

Badly-executed.

From the outset, the execution of the reform programme was bungled at political level. The HSE was not able to appoint a CEO for more than 12 months. The HSE came into being without clarity on important issues arising from the merging of 11 health boards into a single organisation. To avoid industrial action, the sensitive question of necessary redundancies was ducked, and senior personnel found themselves in jobs without meaningful roles. The legislation creating the HSE was rushed through the Dáil and guillotined, with amendments being introduced right up to the last minute. The crucial question of how the HSE was to account for its spending of public funds was the subject of significant differences within Government and not satisfactorily resolved.

LABOUR'S SIX STEPS TO A HEALTH SERVICE EXECUTIVE THAT WORKS FOR PATIENTS

Untangling this mess won't be easy, but there are a series of steps that can be taken which will make a major contribution to improving the situation. The Labour Party is proposing 6 core changes to re-structure and re-focus the HSE to serve the health needs of people. We want to put the patient back at the heart of the health services in Ireland.

Reforming the HSE is essential to achieving this. Its structures make it very difficult for staff across all categories in the health service to make decisions and focus resources on the needs of patients. They come with a clear health-warning – unless the Government also addressed key issues including capacity, the consultants' contract and more rational incentive structures, the crisis in health care will continue.

The six steps are:

1. Establish clear lines of authority, responsibility and reporting within the HSE, with standard-setting at national level and as much day-to-day decision making devolved to local level as possible.
2. Make the Minister for Health answerable to the public through the Dáil for all aspects of Health Service policy and delivery, and make the Secretary General of the Department the Accounting Officer for the HSE
3. Offer a voluntary early retirement, redundancy and re-deployment scheme, as part of the rationalisation of management structures
4. Give each hospital and each community care area autonomy to spend its budget, allocated according to national norms. Require each hospital to establish a management board
5. Accountability to the public through Local and National Public Representatives should be at network and community care area rather than regional level and regional structures should be abolished.
6. Each hospital and community care area should be required to establish a patient liaison programme in accordance with recommendation 11 of the HIQA Report on Rebecca O'Malley's case.

Establish clear lines of authority, responsibility and reporting, with the patient at the centre

The HSE is currently a tangle of confused structures, with duplication, overlap, and highly centralised decision making. Far too many people are involved in making simple decisions, and far too many decisions require sign-off at national level. The system needs to be rationalised, so that more decisions are made at local level, with proper accountability.

There is an urgent need to establish clear lines of authority, responsibility and reporting within the HSE. This involves remaining true to one of the original objectives, which was to ensure uniform national standards in service provision. So policy, standards, national norms and fair allocation of budget should be the responsibility of those at the centre.

However, the vast majority of decisions should be made at local level, i.e. the closest possible level to the patient. It should be a clear policy objective to deliver care, where possible, at community level which is better for the person and their family and cost effective. But it should also be the case that local managers, working within assigned budgets have authority to make decisions about how they deliver their service – decisions for which they are accountable.

Restore Full Accountability to the Oireachtas

A key assumption underlying the creation of the HSE and the 2004 Health Act was that there could be a separation of responsibility and accountability for policy on the one hand, and its implementation on the other. Such a separation may perhaps be possible, but it hasn't been tried. From day one, the HSE which is supposed to be responsible for implementation, has strayed into the policy area, and the Minister, notionally responsible for policy, has involved herself in implementation issues. However, the main effect of this theoretical concept has been that no-one can be held accountable for anything. The Minister for Health in particular, has used the policy/implementation structure to avoid responsibility for anything.

Equally, this policy/implementation structure has been used to avoid answering questions in the Oireachtas. Oireachtas members are not able to get timely answers to parliamentary questions, and these

answers are not recorded in the official record. So, whereas once public representatives on health boards could hold the system to account, there is virtually no real democratic accountability for the health service.

The flawed accountability structure has also undermined both the Department of Health and the Board of the HSE. The decision to make the CEO of the HSE the accounting officer for that body has created serious problems in democratic accountability and corporate governance. It undermines the capacity of the Department of Health to drive policy, since, in the words of the Mullarkey Group on Accountability of Secretaries General and Accounting Officers

'From the beginning it was considered that the best person to discharge the Accounting Officer Function was the permanent head of the Department ... [this] also recognised that finance was an essential element in all policy questions and that financial responsibility had wider implications for efficient management'

Making the Chief Executive of the HSE the Accounting officer – a last minute change to the HSE legislation made by the Minister shortly after her appointment – has weakened the policy-making and accountability function of the Department of Health, and by extension, the Minister. It has also imposed a series of financial strictures on the HSE, and on its hospitals, which are not necessarily intended or desirable. The HSE is, for example, obliged to produce two sets of accounts – the appropriation accounts prepared by the CEO, and the annual accounts which are signed off by the board. This imposes additional accounting requirements and weakens the board's control over the CEO. A legislative patch was put in place to mitigate this problem, but it does not remove the underlying potential for conflict.

Labour is proposing that proper democratic accountability for the health services be restored. The Minister for Health should be responsible to the Oireachtas for all aspects of health policy and implementation. This does not mean that we return to the old fiction that a Minister can be personally responsible for the actions of everyone in her department and for what happens to every paperclip. It does mean that the Minister is accountable for her own actions, and when things go wrong, for what she did about it.

Members of the Oireachtas should be entitled to put parliamentary questions to the Minister, and they should be answered in the normal time frame and recorded in the normal way. The General Secretary of

the Department of Health should be the accounting officer for the expenditure of public funds by the HSE, thereby ensuring that the HSE is obliged to conform to the Department's policies in the expenditure of funds. The CEO of the HSE should continue to appear before Oireachtas Committees, including the PAC, but not as the accounting officer.

Along with her roles in policy and overall direction of the service, the Minister and her Department should ensure that budgets for new development and policy focus (for example developing more care in the community, implementing 'A Vision for Change' and the Disability Act) are ring-fenced and not diverted to other purposes. They should also drive national programmes of Health promotion addressing issues such as obesity and alcohol abuse.

Offer a voluntary early retirement, redundancy and re-deployment scheme.

The HSE is an amalgamation of up to 40 different administrative bodies tacked to each other without any design plan. The new bureaucracy was attached to the old ones without any rationalisation or removal of duplication and was brought into being without a proper analysis of how the various layers of management in pre-existing organisations could be brought together. In order to achieve a meaningful streamlining of the chaotic organisation that now exists, it will be necessary to put in place a voluntary re-deployment, early retirement and redundancy scheme.

This should not be haphazard but be expressly designed to remove levels of administration which currently clog-up the decision-making process within the organisation. This work should have been done at the start and is essential now. There have been examples elsewhere in the semi-state sector, where rationalisation has been successfully achieved, involving detailed negotiation with staff and unions.

There are short-term costs associated with early retirement and redundancy schemes but long-term significant savings in a simplified slimmed-down structure with spending directed towards primary care and frontline services. There should be a monitored and audited time-frame of implementation.

Strengthen Decision-Making At Local Level

In the HSE as presently constituted, too many decisions are made too high up the hierarchy. It is necessary therefore, to give each hospital and each community care area autonomy to spend its budget, allocated according to national norms. This will require the establishment of a board in each hospital that would include clinicians, the director of nursing, a representative of the GPs who refer to the hospital, a community representative and a microbiologist with the hospital manager as the executive arm of the board. It is also necessary that hospitals are linked together in networks, and that there are regular scheduled meeting with other hospitals in the regional network and with representatives of Primary Community and Continuing Care.

Labour is committed to reform of the Health Service through the introduction of Universal Health Insurance (UHI). For UHI to work effectively, it is necessary to strength local management and local decision-making structures, and to enhance corporate governance at hospital level. These kind of reforms, therefore, will contribute in the long-run to a more effective use of resources in the health service.

Restore Local Accountability

When the health boards were being abolished, it was argued that local politicians on health boards were holding up decisions for local political reasons. While this was an important issue, there was insufficient acknowledgement of the different types of activity that health boards were engaged in. Although health boards ran hospitals, they also delivered very localised services. This is significant, since as the NESC argued in 2001

'a key issue in determining the appropriate level of geographical devolution is the importance of specifically local information in decision-making ...achieving the appropriate level of devolution is important as it will crucially affect the information available for making decisions and the incentives facing those who make them' NESC, 2001, pp118-120

In other words, there is a balance to be struck between having access to relevant information, and having the right incentives in place which ensure that decision makers take account of the full social impact of their decisions. How this balance is to be achieved is likely to be very different for different types of service.

Hence, while, at the time the HSE was set-up, the Labour Party accepted the argument that there was a need for a national hospitals office, we did not accept that local accountability for the provision of social services should be abandoned. The one-size fits all approach has not worked. Indeed, as described above, it has effectively removed accountability from the system altogether.

Equally, it is important to recognise that accountability comes in different forms. It is not necessary to have the full functions and powers of a health board to hold a hospital network or a community care director to account. Local policing committees, for example, can enhance the accountability of the Gardai, simply by virtue of the fact that senior officers in the area are required to attend meetings and answer questions put by public representatives.

Labour is proposing that the present regional structures in the HSE should be abolished and replaced with a new system of accountability. In respect of hospitals, this would be located at the hospital network level, and would involve local and national public representatives, who would meet regularly, and have the power to insist that health officials attend meetings and answer questions. The focus would be on delivery of services. In respect of social services, there would be a structure in each community care area, which would similarly invigilate the delivery of social services and where public representatives could hold local social services to account, again within budgets set out by the HSE, and according to national norms.

Patient Liaison Programme

Each hospital and community care area should be required to establish a patient liaison programme in accordance with recommendation 11 of the HIQA Report on Rebecca O'Malley's case.

One of the continuing and certainly unwelcome developments in the delivery of the health service over the past few years has been failures in patient diagnosis, sometimes on an individual level, but often involving a group of patients. More often than not, those affected have been women.

While the reasons for the failures have been diverse, the effect has been the same – patient health has been put at risk, and public trust in the effectiveness of our health service has been undermined.

What has emerged clearly, however, arising from these incidents, has been the urgent need not only for a robust clinical governance

procedure, but also for the development of a Patient Liaison Programme. This was identified by HIQA in the report on the Rebecca O'Malley case and forms one of their key recommendations – recommendation 11.

This recommendation includes the appointment of an independent advocate as well as a hospital-appointed dedicated patient liaison person as part of a complaints procedure. We want to see this recommendation being implemented as soon as possible and to see it in practice.

Patients who have concerns need to have somewhere to go with those concerns and to know that they will be heard. The process must be transparent and accessible and built on principles of advocacy and accountability. The O'Malley recommendations point the way forward.

Health Policy: A New Approach

The Labour Party believes in a public health service that is accountable, equitable and makes best use of resources. We take a fundamentally different approach to the current Government's growing reliance on purchasing 'for profit' private health care instead of building public provision. The most extreme example of this is the co-location of super private clinics on the grounds of public hospitals which could cost some €1.3 billion in tax foregone and other lost revenue streams. This form of health apartheid, supported by the exchequer, should be abandoned.

Alongside these structural changes there is a need to develop the quality and value for money of the service countrywide by ensuring that models of best practice are implemented. The way in which patients are admitted to Kilkenny Hospital, for example, is often cited as a good model. It makes sense to transfer this system to other hospitals in other regions. We propose the development of a support team which would identify good models of practice and would travel around the country to give expertise, training and support where weakness is identified.

We need to clearly define the relationship between primary, secondary and tertiary care and what is the appropriate role of each level. Ireland has only half the number of GPs per head of population as Germany and one third that of France. We will never achieve the goal

of directing more care from hospital to the community unless that gap is addressed.

Primary care has got little attention in recent debate. Keeping people healthy is much better than treating them when they are sick so investing in primary care is good value for money and good for the health of the nation. To work best it requires an accessible team of people including family doctors, public health nurses, physiotherapists, social workers, speech and occupational therapists. Failure to develop primary care encourages people to use more expensive hospital services.

We also need to utilise our secondary hospitals to deliver the maximum benefit for the communities they serve. The Hanly Report proposed reducing their role but they are cost effective, close to home for many patients and, with good network links to GPs and tertiary hospitals, have a clearly-defined remit. They are an important resource within the overall delivery of service.

A HEALTH SERVICE THAT DELIVERS TO ALL

The Labour Party is committed to introducing a single-tier Health Service through Universal Health Insurance. We first proposed this model in a discussion document 'Curing Our Ills', published in 2000 and, following widespread consultation, presented it in a detailed policy document entitled 'Our Good Health', published in 2001. We have advocated it since then and welcome the increase in support it has gained recently from a wide variety of sources. The document 'Social Health Insurance: Further Options for Ireland' recently published by The Adelaide Hospital Society provides valuable research into the benefits of such a system and the steps necessary to bring the Irish Health Service to the point where such a model of care could be introduced.

The reform of the HSE is needed if we are to reach this longer-term goal. It is more urgently needed because the system is failing patients. The 6 steps recommended in this proposal have the clear purpose of reforming and simplifying the bureaucracy, providing accountability and putting the patient first.