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EASTERN REGIONAL HEALTH AUTHORITY

Údarás Réigiúnda Sláinte an Oirthir

Submission to the Department of Health and Children

National Health Strategy 2001

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Background and Purpose

The Health Strategy 2001 is critically important to the shaping of our health system over the coming years. The ERHA is committed to playing the fullest possible role in contributing to its development. This submission is tangible evidence of that commitment.

We have set ourselves the task of producing a concise document focusing on high-level issues that are appropriate to a national strategy. The submission is intended to complement the contributions that are being made by others in the East, be it in an individual capacity or on a representative basis. The attached analysis and proposals are built on a consultation that centres on key stakeholders responsible for overseeing, planning and delivering healthcare in our region. At all times we are conscious that this analysis of system strengths and weaknesses must keep the needs of the patient to the fore and our proposals are drawn up with this fundamental concept in mind.

In preparing the submission we organised structured workshops with:

- Board of the Authority
- Area Health Boards
- Voluntary Acute Hospitals
- Maternity Hospitals
- Paediatric Hospitals
- Voluntary Intellectual Disability service providers

Contributors were briefed on the central themes and tenets of the new Strategy and asked to relate these to the specific strategic issues relevant to the Eastern region. Having done this, it was possible to group our issues under eight broad headings, some of which exactly match the national framework. These headings cover significant issues which emerged from the workshops. Our tests for inclusion are:

1. Is the item critical to the ERHA in discharging its statutory function?
2. Does it require action at a national level?



Background and Purpose

The eight headings dealt with in the following pages are:

- Planning, Organisation and Delivery of Services
- Capacity
- Linking levels of Care
- Acquiring and Allocating resources
- Public/Private mix
- Human Resources
- Information for Health and Quality
- Technology for Care

In each case we have explained why we identify the issue as strategically important to the mission of the ERHA, what the practical implications for services and patient care are and how we feel the issue needs to be addressed in Health Strategy 2001. This is preceded by a brief analysis of the regional healthcare environment within which the ERHA operates, setting out the demographic, infrastructural and other characteristics of the East which have a major impact on how we plan and deliver healthcare to the population of the region, and beyond.

The time-scale for the national consultation process is short for an undertaking of this scale. The ERHA has put considerable work into this contribution because it feels it can add real value to a process that is extremely important in national and regional terms. We welcome the opportunity offered by the Minister to participate in the development of the new Strategy and the Authority looks forward to assisting in any further way possible in the significant implementation challenges that lie ahead.

Finally, we would like to acknowledge the participation and co operation by healthcare providers in the Eastern region in this process.



Environmental context

Background

The Eastern Regional Health Authority is the statutory body with responsibility to plan, arrange and oversee health and personal social services for the 1.5 million people living in Dublin, Kildare and Wicklow. The Authority was established on 1 March 2000.

The ERHA's responsibilities include the strategic planning of services, the commissioning of services through service agreements with the 39 individual service providers and monitoring and evaluating the services provided by these agencies.

Some of the main reasons for introducing these organisational reforms were the particular challenges arising from the vastly increased population of the Eastern region, the scale and complexities of the health and social service issues in the region and the recognition that there was a need for a single authority with responsibility for all health and personal social services in the region.

The Authority is not involved in direct service provision but rather commissions services from three new Area Health Boards, the voluntary hospitals, voluntary intellectual disability agencies and other voluntary agencies. The mix of providers who come together to deliver services in the East is particularly diverse and each of these - whether statutory, voluntary or private - bring their own unique strengths.

In addition to arranging services for the 1.5 million people living in the East the Authority must provide for a range of services delivered to people from outside the region. Many national services which serve the total needs of the country are located in the East (e.g. tertiary acute care provided in national specialty centres, the Central Mental Hospital, etc.)

The total budget for all services in the current year is approximately £1.8 billion. Underlying the approach to the expenditure of these public funds is an ethos which emphasises equity and public accountability.

Some 33,000 staff are employed in delivering public health services in the region. The range of services developed in the region, against a background of often very limited resources, is a tribute to these staff who have displayed an ability to innovate, meet best international standards and respond positively to the changing and increasing demands placed on the services.



Demographic and Social Challenges

The Eastern region has many health and social challenges which are unique or found to a considerably greater degree than in other regions. Demographic change caused by rapid population growth and ageing is more pronounced than in any other area of the country and is placing pressures on the entire range of health services required in the Eastern region. Population growth in the Eastern Region represents 55% of national growth since 1981. Over the 30 year period 1981-2011 the population will increase by 33% compared with 22% nationally. Heretofore the Eastern region has benefited from having a relatively young population but the age profile will shift in the period ahead with major service implications. The population over 65 years has the greatest demand for health care and accounts, for example, for 49% of all acute hospital bed days. This age group will increase by 29% by 2011.

Table 1 below shows that over the period 1996-2011 the projected population increases in the Eastern region are greater in every age cohort than the national average.

% expected population change in the Eastern Region and Nationally 1981 - 2011

1996-2011 Age group	1.3 - 1.59 m Eastern Region	3.62 - 4.2 m National
Under 15	13.5 ↑	2.1 ↑
15-44	15.4 ↑	10.1 ↑
45-64	47.9 ↑	42.6 ↑
65-74	28.5 ↑	21.7 ↑
75+	21.1 ↑	18.9 ↑
Total	22.4 ↑	15.9 ↑

There is also a great deal of social deprivation concentrated in particular communities in the region which means that the health services, in cooperation with local communities and other relevant parties, must address deep-seated social problems. It is estimated that 98% of those receiving methadone treatment nationally are in the Eastern region. The number of asylum seekers living in the region is 15,000 and is growing significantly each year. Similarly, the problems of adult and youth homelessness are much more prevalent in the Eastern region than in the rest of the country (it is estimated that 70% of the national homeless population is in the Eastern region.)



Infrastructural Challenges

The Eastern Regional Health Authority acknowledges that there is considerable under-provision of services relative to need and this is manifest in unacceptable delays experienced by the public in accessing many services. The principal reason for this situation is that insufficient investment has been made in the past in developing and maintaining the physical and human infrastructure necessary to deliver an accessible and quality service. This could be explained in part by the absence prior to the establishment of the Authority of a coherent planning framework for the region as a whole. In recent months in the context of the Authority's bed capacity review it has been in a position to highlight the extent of the need in this area and the urgent requirement for investment in capacity in order to align the services with those needed.

In the acute hospital sector, this investment must cater for the continuing inflow of patients from outside the region. Some 20% of all hospital admissions and day cases in the Eastern Region are for patients who live outside the Region. This inflow has remained broadly constant despite developments in other health board areas and the policy of self-sufficiency set out in the 1994 Health Strategy. Under current eligibility arrangements, the Authority has no role in relation to inter-regional patient movement. Specifically, there is a need for an evaluation of the impact of the investment in regional self sufficiency.

The investment in acute services must also recognise that the weight of bed reductions implemented nationally in the 1980s largely fell on services in the East. There has been a 31% drop in acute hospital beds in the Eastern Region since 1980. Of the 3150 beds closed nationwide, 219 beds were closed in the East. (ie 70% of the national bed reduction occurred in the East). As a result, bed supply per 1,000 population for residents of the Eastern Region is lower than the national ratio, the NHS ratio, and OECD average.

In a range of other areas such as intellectual disability services, orthodontics and drug treatment services, the waiting lists are a reflection of capacity problems in the region that are proportionately much greater than those found elsewhere.

Other Challenges

Traditionally the different sectors engaged in the delivery of care in the region have developed quite separately with poor linkages. A key challenge for the new structures in the East is to realise major improvements in this area. The multiplicity of providers engaged in the delivery of care means that this objective will require explicit recognition in policy development, investment and prioritisation.



The concentration of private providers in the East will also need to be addressed in this context. There are significant potential benefits in building greater collaboration with this sector. The relationship with the private sector does, however, need careful definition. The questions for policy makers and those delivering the services are most profound where private care is provided alongside publicly funded services since total provision is not seen to be based solely on equal access for equal need.

It must also be acknowledged that the challenge of providing integration is a difficult one where there are major gaps in services and the capacity of key sectors is under-developed. In this context, there is a particular need to provide for a more developed role for primary and community care so as to assist in responding appropriately to the needs of patients. The development of this area will require both investment and a reshaping of current arrangements so that a greater range of needs are met in this setting and greater focus is achieved on assisting the public in reaching their full health potential.

Finally, problems external to health are impacting on providers in a major fashion. The effects of labour shortages, traffic congestion and affordable housing are most pronounced in the East. They pose major challenges in attracting and retaining staff. Providers in the East require greater support in striving to ensure the availability of staff necessary to deliver enhanced services. Similarly, the price of land and construction in the East also means that the development of a range of services (e.g. intellectual disability, mental health, child care, etc.) is more expensive than in other Regions.

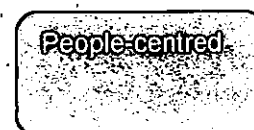
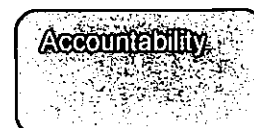
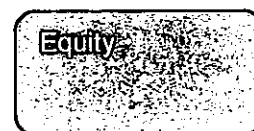
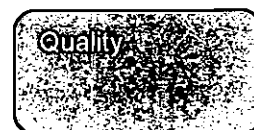
This analysis points up the unique characteristics and features of the Eastern region. In the pages that follow, we have highlighted specific issues that require action at national level but which would have specific impact on the East.



Planning, organisation and delivery of services

In many respects, the vision set out in the 1994 Health Strategy, *Shaping a Healthier Future*, remains unfulfilled. In particular, the lack of firm policy definition in relation to a number of service areas and of a clear implementation plan have made the achievement of an integrated high-quality and equitable service difficult. In an environment as complex as healthcare, these deficits or ambiguities may result in individual patients, or whole groups of patients, falling through gaps in the system, or receiving a poor quality service. The new Strategy offers a chance to rectify these shortcomings.

<i>Issue</i>	<i>Implication</i>
1. Absence of coherent and comprehensive policies defining the roles of certain sectors and their functions in the system overall	<ul style="list-style-type: none">• Fragmentation of care across the system• Provider-determined priority setting, rather than needs-based• The contribution of individual providers to the implementation of coherent disease based strategies is constrained by a lack of clarity about overall roles• Concentration on service provision emphasises the treatment of illness rather than the promotion of good health• Insufficient recognition of the unique requirements within certain care groups in the delivery of mainstream services (e.g. Intellectual Disability, children in A & E services, adolescent psychiatry)
2. National level service planning and investment evaluation is underdeveloped	<ul style="list-style-type: none">• No clear mechanisms for assessing the appropriateness of workload by type or quantity across the system nationally• Investment decisions can be isolated in approach and unpredictable in impact
3. Absence of nationally defined primary care model	<ul style="list-style-type: none">• Inhibits the shifting of funding to alternative models of care• Impacts on developing links with related adjoining community services





Planning, organisation and delivery of services

<i>Issue</i>	<i>Implication</i>
4. In the acute sector, ambiguities in relation to key issues such as free movement of patients, role of national specialties and regional self-sufficiency. There is also a need to optimise the complementary role of specialist hospitals	<ul style="list-style-type: none">• Funneling of cases to the Eastern region. The lack of clear definition of these issues imposes severe constraints on ERHA in discharging its accountability. This is exacerbated by the fixed budget system where funding does not follow the patient.• Challenge to management in reconciling multiple roles of major acute hospitals, and maximising the potential role of specialist hospitals (e.g. maternity, paediatric, rehabilitation, orthopaedics)• Diminishes the focus of teaching hospitals in improving quality of care, raising training standards and promoting integrated care. Detracts from the development of a leadership role as national centres of excellence and new partnership approaches to care
5. Wide range of statutory and professional regulatory and training bodies which impact on the planning of service delivery	<ul style="list-style-type: none">• Frequent lack of coherence between 'competing' functions of these agencies• Lack of national co-ordination of these functions in the interest of patients and quality care. The overall integrated responsiveness of the system is significantly compromised as a result
6. Infrastructural planning outside of, but impacting upon, the sector has no health input (transport, environmental, education, social)	<ul style="list-style-type: none">• The health sector has to accept inefficiencies dictated by external circumstances• Opportunity cost to all sectors involved through fragmentation of planning and service delivery
7. Approach to problem-solving too often reflects existing physical or organisational structures	<ul style="list-style-type: none">• "Medicalisation" of problems which might benefit from a broader response - particularly in the community area• Few advocates for innovative approaches to care. Services which do not exist are less often lobbied for



Planning, organisation and delivery of services

<i>Issue</i>	<i>Implication</i>
8. Inter-Departmental relationships are not functioning effectively in the interests of health	<ul style="list-style-type: none">• Failures in service provision due to demarcation disputes, policy vacuums, fragmented planning (e.g. families in needs of support, education for clients with special needs)• Recourse to legal intervention in response to these failures• Criteria for State support to providers and / or clients may conflict (e.g. capital funding for Intellectual Disability agencies, housing aid for older persons)



Planning, organisation and delivery of services

What does the National Health Strategy need to address?

The Strategy needs to:

- Put in place a clear policy framework, defining the role of key services and an implementation plan, with resources to address strategic objectives. High level political and professional commitment will be essential to make this a reality
- Review legislation in relation to patient entitlement and Health Board obligations within and across regions in line with the above policy framework
- Enhance service planning and commissioning process at national level significantly
- Service planning needs to be cross-sectoral from national level down. This must ensure consistent and accurate planning and accountability at regional level for regional needs, except for defined services
- In particular, there is a need to develop new structures to support a multi-sectoral approach to health planning
- Introduce multi-annual planning cycles within the lifetime of the new Strategy
- Strengthen and resource new structures to deal with inter-regional issues
- Develop funding model to relate more closely to service planning requirements within accountability framework



Capacity

Capacity issues in the broadest sense are at the heart of many health sector challenges in the ERHA region: facilities, people and technology. Many of our clients suffer directly from these shortfalls in capacity. These problems are exacerbated by the effects of very specific demographic shifts, the presence of several major national healthcare providers and the additional capital costs which apply to the Eastern region.

Issues

Implications

- | Issues | Implications |
|--|--|
| 1. The demographic profile of the Eastern region is changing: <ul style="list-style-type: none"> • Rapid population growth overall • Growing older population • Increasing non-national community | <ul style="list-style-type: none"> • Increased demand for all services across the system • Under-provision of acute beds will be compounded by these demographic shifts • Need for new models of care delivery to allow for appropriate care of people in the community |
| 2. One-year planning cycle for revenue funding and service planning | <ul style="list-style-type: none"> • Difficult to match capacity to demand shifts without continuity of funding and planning over medium term |
| 3. Shortage of acute beds overall. Historic bed reductions hit the Eastern region disproportionately. This resulted in difficulties in meeting elective and emergency demands for people from the East. | <ul style="list-style-type: none"> • Waiting lists for the region are greater than in other regions • Equitable access to the region's population not guaranteed • Unplanned workloads and excess demand result in inefficiencies in use of facilities and dysfunctional responses • Heavy toll on staff morale and skills |
| 4. Unnecessarily rigid capital planning and commissioning process | <ul style="list-style-type: none"> • Inhibits quick responses due to lead-in times of capital planning cycle |
| 5. Inadequate use of new approaches to matching capacity with need | <ul style="list-style-type: none"> • Single response to multi-faceted problems, resulting in over demand for some services and underdevelopment of alternatives (e.g. older persons in acute beds) |

Quality

Equity

Accountability

People-centred



Capacity

Issues

Implications

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- | | |
|---|---|
| 6. Unplanned expansion of health service remit on an ad-hoc basis in response to new crises (e.g. homeless issue) | <ul style="list-style-type: none">• Opportunity cost of introducing additional services over the maintenance and improvement of existing services• Increased pressure on staff and resources• Response is often inadequate and fragmentary |
| 7. Under-investment in maintaining core services: buildings, equipment, personnel | <ul style="list-style-type: none">• Adverse effects on patient safety and well-being• Significant medico-legal implications (viz maternity sector)• Inhibits the capacity of staff to deliver a quality service• Restricts ability to attract and retain new staff |



Capacity

What does the National Health Strategy need to address?

In terms of capacity, there is demonstrable evidence that targeted investment brings real gains in terms of access and quality. The Strategy's approach therefore, needs to:

- Provide for significant increases in resources for physical and personnel capacity to match new Strategy and regional plans. Specifically, there is a need to re-examine capital funding in the context of over-riding imperative to address capacity deficit, in particular dedicated elective bed capacity. This needs to build on the clear gains from recent investment in services such as cardiac surgery
- Re-formulate capital decision making to explicitly flow from business objectives
- Examine potential for changes to capital procedures to fast-track new building solutions
- Promote new models of health delivery as an integral part of capital development decision making process
- Move to multi-annual budgeting cycle that incorporates capital investment
- Review opportunities for exploiting potential in existing capacity by renegotiating restrictive IR practices at central level



Linking levels of Care

The 1994 Health Strategy stresses the importance of integrating care across programmes. This has proven to be a monumental task. The challenges arise from a combination of organisational, personnel and structural issues. This results in very real difficulties for all health service users in terms of accessing timely and patient-focused services. The new Strategy provides an opportunity to remove the barriers at national level to create the desired linkages.

Quality

Equity

Accountability

People-centred

<i>Issue</i>	<i>Implication</i>
1. Effective national approaches to implement the stated objective of integrated care are under-developed.	<ul style="list-style-type: none"> • Limited integration between institutions and across care settings, even within Health Board provided services • Difficulties in providing seamless service to clients • Opportunity to take advantage of critical life episodes (viz maternity services) to build packages of care is forfeited
2. DoHC structures largely re-inforce discrete sectors	<ul style="list-style-type: none"> • Difficulties in developing multi-sectoral responses to service proposals • Funding shares remain broadly static
3. Insufficient development of primary care model to allow for tailoring of care to suit the needs of the patient in the community	<ul style="list-style-type: none"> • Insufficient emphasis on health promotion and preventive measures • Difficulties in providing services in a primary care setting for patients where appropriate e.g. out-patient physiotherapy, occupational therapy, warfarin clinics, diabetic clinics • Difficulties in providing out of hours services • Additional pressures on acute care services (e.g. inappropriate A & E and OPD attendances) • No clear access points to health system for many client groups



Linking Levels of Care

<i>Issue</i>	<i>Implication</i>
5. Perverse incentives within existing eligibility arrangements and operational structures	<ul style="list-style-type: none">• Preferential access to residential care for acute care patients (vis-à-vis community patients)• Unnecessary "funneling" of primary care patients through acute system• Therapies and care often based in residential settings



Linking levels of Care

What does the National Health Strategy need to address?

Integrating levels of care will only be possible with clearly defined roles for each of the existing system components.

- Funding programmes must be planned and implemented on a cross-sectoral basis
- Resources should be made available for alternative care models in appropriate settings. These need to be developed in consultation with patients and providers of care.
- Specific challenges of primary care provision in a metropolitan setting, for example access to GP services in deprived areas, need to be recognised in the Strategy and in any national review of primary care
- Information and communication mechanisms linking primary, acute and community services need to be designed and funded. Basic structures should be agreed nationally
- Policy should address the need to promote development of primary care and specifically focus on areas of deprivation



Acquiring and allocating resources

The overall level of funding and the national approach to allocating resources have not kept pace sufficiently with the growing complexity of health services in Ireland, nor with the strategic objectives of equity, quality and accountability. Improvements in the level of resources and the manner in which they are allocated have the potential to greatly increase the level of responsiveness to individual needs.

Quality

Equity

Accountability

People-centred

<i>Issue</i>	<i>Implication</i>
1. The tension between fixed global budgets and the developing expectation of a right to treatment	<ul style="list-style-type: none"> • Public perception of failure to deliver services and care based on entitlement • Difficulties in moving towards a needs-based system for purchasing care • Recourse to legal action to pursue perceived entitlement
2. Existing eligibility arrangements allow for unlimited inter-regional patient flows, in particular for acute hospitals	<ul style="list-style-type: none"> • Potential displacement of resident populations by patients outside of the region • Difficulties in developing protocols around referral practices and patterns • Difficulties in linking resources to national specialties: projecting demand for tertiary services, ensuring equity in services across the regions
3. The NDP is fixed in time and purpose	<ul style="list-style-type: none"> • May not always align with current or emerging service requirements • Its absolute level will not address capacity constraints
4. Insufficient measures at a national level to link funding to outputs and outcomes	<ul style="list-style-type: none"> • Funding continues to flow on a historic basis • Emphasis is on volume as opposed to quality and impact • Limited capacity of funders to challenge agencies on productivity and outcomes due to incremental model and information deficit
5. Absence of clear criteria for developmental funding	<ul style="list-style-type: none"> • Funding is often distributed on a pro-rata basis without regard to differing regional / sectoral needs



Acquiring and allocating resources

What does the National Health Strategy need to address?

The Strategy should:

- Ensure funding matches strategic objectives and the implementation plan set out for the Health Strategy 2001
- Provide clarity on entitlement versus eligibility within the fixed budget environment
- Identify mechanisms for linking funding to performance measures of quality and impact
- Consider the development of national fund allocation process which is informed by need
- Recognise the specific funding implications for the Eastern region of unrestricted patient flows, changing demographics, the impact of technology developments and local cost inflation
- Need for significant additional capital resources outside of the prescribed limits of the NDP



Public / Private mix

The ERHA acknowledges the national policy consensus for a "mixed system" of healthcare funding and delivery. However, there are a number of issues related to how the public / private mix currently operates, which work against principles such as equity, quality and accountability, and against the provision of needs-based care. Given that the overriding reason for purchasing private insurance is to ensure access and that over 50% of private care is provided within the public system.

Quality

Equity

Accountability

People-centred

<i>Issue</i>	<i>Implication</i>
1. There is a lack of clarity in policy definition of how the public / private system should operate	<ul style="list-style-type: none">• Systematic bias in system in favour of private patients• Impacts on monitoring and control of system
2. The high proportion of the population insured in the Eastern Region	<ul style="list-style-type: none">• Operational difficulties in managing the public / private mix e.g. emergency admissions to acute hospitals
3. Perverse incentive effects due to current eligibility arrangements	<ul style="list-style-type: none">• "Cross-subsidisation" of private sector operations by the public system• Patients may seek care in an inappropriate setting for financial reasons (eg use of return OPD visits rather than GP provided service)
4. The non-provision of A & E or complex care in private facilities	<ul style="list-style-type: none">• Displacement of elective work and the generation of waiting lists in the public sector
5. The consultant's Common Contract reflects the current public-private mix and its inherent ambiguities	<ul style="list-style-type: none">• Difficulties in delivering consultant-led services which match the principles of equity, quality and accountability
6. Open access for private patients to public diagnostic facilities and therapeutic care (rehab. etc.) in public hospitals	<ul style="list-style-type: none">• Potential displacement of public patients (leading to longer stays)• Difficulties in monitoring and controlling
7. The absence of regulation of the development of, and monitoring the delivery of, private care	<ul style="list-style-type: none">• "Cherrypicking" in terms of service provision by private sector• Fragmentation of service planning overall• Deficit in consumer protection



Public / Private mix

<i>Issue</i>	<i>Implication</i>
8. Ambiguities in eligibility structures, the operation of the public / private mix and fiscal incentives	<ul style="list-style-type: none">• The ability of Health Boards to develop and provide coherent public health policies is undermined (e.g. orthodontics, therapies)• A flexible response to service needs is difficult to provide
9. Financial incentives do not promote location of GPs in deprived areas	<ul style="list-style-type: none">• Poorly developed GP services in health black spots• Knock-on implications for other services



Public / Private mix

What does the National Health Strategy need to address?

If a public / private mix is to be maintained within the State funding system, it must be fair.

The National Health Strategy therefore, needs to:

- Provide for a clear policy on eligibility and State supports (including fiscal and other incentives) which reflects the fundamental objectives of the new Health Strategy and the roles of different types of healthcare provider in the delivery of these objectives. Policy review in this area must include analysis of the appropriateness of existing incentive structures for consultants, hospitals, insurers and primary care practitioners.
- Establish a clear policy Statement on the appropriate balance between public / private patient workloads within the publicly funded system. The strengthening of the bed designation regulations (1991) to allow better management of the public / private mix within hospitals is also required.
- The revision of current eligibility arrangements so as to eliminate cross-subsidisation in the acute sector
- Provision of appropriate capacity to match policy regarding the public / private mix
- Strengthened accountability provisions in the consultant's Common Contract
- The introduction of licensing for all acute healthcare service providers linked to requirement for supply of data to allow for whole system planning



Human Resources

Health services staff are key to the provision of quality healthcare. However, the traditional focus of strategic planning and resource allocation in the health services has been on services delivered and infrastructure, with much less emphasis on staff as a resource. A significant number of issues at national level impact negatively on the development of a culture of valuing staff, and in turn, on the quality of service delivered by staff to patients.

There is a clear need therefore, for a co-ordinated series of national measures to help us develop and retain existing staff, as well as attracting the best talent for the future. With 33,000 healthcare workers, the ERHA can play a major role in the context of national initiatives to maximise the value which these staff can bring to all those they care for.

Quality

Equity

Accountability

People-centred

<i>Issue</i>	<i>Implication</i>
1. Lack of national HR strategy	<ul style="list-style-type: none"> • Insufficient national support and leadership for change, adaptability and personal development in health sector staff (including middle management) • Status of HR function within agencies not sufficiently strategic
2. Absence of manpower planning at a national level	<ul style="list-style-type: none"> • Training facilities, educational providers, and registration bodies operate in a vacuum from service delivery and its needs • Significant environmental changes, such as the shift towards increased part-time female participation in the medical workforce, are not adequately catered for • Professional training, in particular, tends to reinforce differences between clinical staff, rather than their common purpose. Inhibits multi-disciplinary teams within and outside the health sector
3. Lack of nationally driven service wide performance management programme	<ul style="list-style-type: none"> • Developmental issues not being identified and tackled • Over focus on inputs and not on results • No reward for good performance / no sanctions for bad performance • No career path planning to match organisational / personal needs • Limited funding for HR initiatives



Human Resources

<i>Issue</i>	<i>Implication</i>
4. Over-centralised and rigid regulatory framework (viz 10/71) in relation to HR matters (grading structures, work practices, recruitment)	<ul style="list-style-type: none">• Limits ability to attract best talent• Limits ability to retain existing staff• Staff development also impacted
5. Restrictive IR practices, and mismatches between national and local agreements	<ul style="list-style-type: none">• Industrial relations issues acting as an impediment to change• Difficulties in implementing national agreements at local level
6. Lack of parity between equivalent grades across social services	<ul style="list-style-type: none">• Difficult to attract and retain staff in certain areas (e.g. Department of Education pay rates versus Department of Health equivalents)
7. No organised approach to change management across the health sector	<ul style="list-style-type: none">• Ad-hoc responses to external changes such as staff shortages, new technology, organisational reform, demographics and ethnic diversity• Governance functions underdeveloped
8. Mismatch between demand for staff resources in Dublin and supply	<ul style="list-style-type: none">• Difficulty in retention of skilled staff to deliver care to patients in the East• Impact on the capacity to deliver national specialty services• Resources diverted to recruitment dilutes focus on strategic HR• Manpower shortages restrict take-up of training and development opportunities for staff in post



Human Resources

What does the National Health Strategy need to address?

The measures required include:

- A national HR policy for the health service which will give a context to regional and inter-regional actions in this sphere. The implementation of such policy, to be integrated into the annual service planning process.
- Formal health service performance management programme
- More flexibility at Board level to decide on numbers / grades within overall budget
- Link regulatory / training bodies within formal national manpower planning structures
- Moves to reduce elements of clinical training which lead to segregation of disciplines. Consider a common "core year" for health workers
- 'Ring-fence' funding for training and development of staff
- Partnership structures need to be developed to incorporate views of users of the service



Information for Health and Quality

There is a marked absence of standardised information available at a national level concerning all aspects of healthcare status and service. This deficit has a serious impact on patients, health professionals and healthcare organisations. The ERHA welcomes the work in hand on the development of a new national Health Information Strategy, which should provide the opportunity to address the issues identified below.

<i>Issue</i>	<i>Implication</i>
1. Lack of common national data standards	<ul style="list-style-type: none"> • Inability to measure and compare outcomes within and across regions, in terms of: <ul style="list-style-type: none"> • Quality • Efficiency • Appropriateness • Equity
2. Lack of unique patient identifier	<ul style="list-style-type: none"> • Inability to track the patient through the health system and move to development of Electronic Patient Record • Impacts on preventive measures in primary care setting (screening programmes etc.) • Inefficiencies created around duplication of care • Difficulties in validating waiting lists and targeting resources • Inhibits ability to plan according to need and assess impact of interventions
3. Absence of planned investment programme in management information systems	<ul style="list-style-type: none"> • Underdevelopment of information systems • Ad-hoc, stand-alone solutions • Lack of integration between existing systems
4. Patient advocacy mechanisms built on timely and clear information flows are completely underdeveloped	<ul style="list-style-type: none"> • Limited information available to patients to enable them to make informed choices about rights to services and care choices • Constrains providers' potential to disseminate information to clients on the services available • Ability of providers and planners to use feedback to improve services is hampered

Quality

Equity

Accountability

People-centred



Information for Health and Quality

What does the National Health Strategy need to address?

The Strategy needs to ensure that:

- The forthcoming national Health Information Strategy is resourced and implemented without delay
- National standards and mechanisms are put in place to facilitate:
 - Provision of reliable, high quality, relevant and timely information by health service providers, and the Department of Health and Children
 - Access to information by providers, service users and general public
- Internet technologies are harnessed for the effective delivery of information within the health service to all clients
- Mechanisms such as hospital accreditation, patient satisfaction surveys and patient advocacy programmes are established and used to promote information use, quality care and patient empowerment
- Office of Health Ombudsman is established to promote best practice in care



Technology for Care

Technology in this instance is meant in its broadest sense, not just equipment but also drugs and new therapeutic practices. It is particularly relevant for the ERHA, given the role of the major acute teaching hospitals, their University links and the national specialty referral services they provide. Patients expect to benefit from the latest advances in therapy and diagnostics. They rely on the health service to evaluate these benefits on their behalf.

In health care, the impact of technology is both significant and evolving. Faced with these realities, our funding and management systems need to be able to respond to the challenges and opportunities presented.

Quality

Equity

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<i>Issue</i>	<i>Implication</i>
1. Absence of national technology assessment programme	<ul style="list-style-type: none"> • Technology development has occurred in an ad-hoc manner, preventing appropriate management of the proliferation of new therapies and equipment • Local managers are constrained in objectively assessing bids for new technology or offers of third-party funding • Difficult for service providers to evaluate the impact of funding decisions or technology shifts
2. Insufficient funding for maintenance of existing equipment	<ul style="list-style-type: none"> • Current funding is not covering depreciation costs – equipment is either forgone or obtained at price of alternative service provision
3. Requirements of services as a whole, and in particular, sectors such as teaching hospitals have not been matched by sufficient funding	<ul style="list-style-type: none"> • Opportunity presented by technology for efficiencies and quality gains cannot be achieved • Opportunity for using technology as a tool for service integration has not been fully exploited, e.g. telemedicine links between acute hospitals and primary care services



Technology for Care

<i>Issue</i>	<i>Implication</i>
4. Technology advances are creating new capabilities, but also new demands	<ul style="list-style-type: none">• Improved life expectancy, but greater levels of morbidity and dependency are impacting on resources and service planning• Challenging ethical dilemmas are likely to emerge and need to be addressed
5. Under-utilisation of existing high cost, high tech plant due to inflexible work practices	<ul style="list-style-type: none">• Significant loss of potential output adding to waiting lists, and capacity problems overall
6. Poor co-ordination of R & D within health sector	<ul style="list-style-type: none">• Potential advances in therapies may remain hidden• Move from research to clinical environment is haphazard



Technology for Care

What does the National Health Strategy need to address?

- The establishment of a national framework for assessing new equipment, drugs and therapies, including the ethical implications involved
- Link the above with resource allocation, and “post purchase” evaluation so as to ensure the dissemination of best practice
- Funding for depreciation costs should form part of overall resourcing and of a scheduled programme for equipment replacement
- Nationally negotiated work practices that inhibit the optimal use of high-tech equipment need to be reviewed.