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**RENEWING HEALTH SERVICES MANAGEMENT RESEARCH: REDRAWING THE
CITIZEN-CLIENT IN IRISH HEALTH CARE POLICY**

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WORKING PAPER

Abstract:

Ireland has a history of health policy which is not explicit as to its aims and objectives. In light of this fact, this paper examines the position and direction of the Irish Health Services, five years on from the advent of the setting up of the Health Services Executive (HSE) and the restructuring of the health services. The Irish health system policy is guided by the Health Strategy of 2001; in that there should be equitable distribution of health services focused on the need of the citizen-client, and also by the Primary Care Strategy (2001:7); in that there should be an increase in primary care provision by ‘building on existing strengths to develop a high quality, user-friendly service to meet people's health and personal social service needs in the community’. However, health policy in the last five years, in terms of the statements made and the actions taken by the Minister for Health and Children runs counter to this stated policy; in terms of advocating increased provision of private health care facilities in the acute care sector and their subsidisation by the state both financially and through the provision of public lands and through the increased centralisation of health care structures with reduced transparency. Tritter, Koivusalo, Ollila, and Dorfman, (2010) note that tensions between commercialisation, consumerism and patient and public involvement in healthcare have emerged in health policy debates in the last twenty years. In a recent book, they explore the health policy agenda with regard to England, Sweden and Finland. This paper reports on comparative research which seeks to add to this discourse by looking at the health policy agenda in the Irish health care context and also reports on findings from field work in Canada. The paper also reflects on these ambiguities and tensions in Irish health care policy that can create difficulties for the stakeholders in the system both in access to, and in the planning and management of health care services.

In order to strategically manage the health services; a fundamental question in strategic management according to Johnson and Scholes (2008:13) is ‘what business are we in?’ This paper reports on the uncertainty about answering that question in the Irish case as to whether the ‘business’ of health care is directed towards the provision of services for the citizen or client, or whether it is directed towards private investment and providing services for those that can pay for them. In the Irish health care context, it is that crucial decision that must be made before proceeding any further along the path of health care reform.

INTRODUCTION

According to the Irish Minister for Health and Children Mary Harney, the OECD confirmed that Irish spending on health has gone from 15 per cent below the OECD average to 17 per cent above in the period 1997-2003. At present, the 2010 allocation of €14 billion has been significantly pared down and has seen a retreat from growth in public sector spending due to the severe economic downturn. According to the OECD Public Management Review (2008) of Irish public management; health care is one of the most important priorities for many users of Irish public services. Therefore, even before these cuts, the demands from the public for

further financial resources to be put into the health service still remained strident. However, many commentators from 2002 onwards began to question the use of the resources already invested in the health care system (Barrett 2003, Wren 2004). Public debate has raged over the need to catch up and maintain the average EU health spend; however, increases in expenditure have not alleviated what is seen as a crisis and lack of planning in the Irish health care system (Tormey 2003).

The Government, the Minister for Health and Children and the Department of Health and Children (DOHC) are at the head of health service provision in Ireland. This health service provision is publicly funded through taxation. Until 2005, the Irish healthcare sector comprised a health board management structure, 11 health boards in all, it is now replaced by health regions with local health offices (which follow the outlines of the original health boards geographically) managed centrally by the Health Services Executive (HSE) and is described as an integrated public health care system. The HSE is now the main provider of health and personal social care. The formation of the HSE was the result of the most significant and recent reform programme in Irish health services delivery. To synthesise the Irish health care structure as per the OECD (2008;287) review; the ‘HSE is responsible for the management and delivery of health and personal social services within the policy, legislative and resource allocation framework determined by the Minister for Health and Children and the government.’ Therefore, the CEO of the HSE is the Accounting Officer for expenditure but the Minister is politically accountable for the implementation of policy by the HSE as well as the overall performance of the health service.

In this paper, the use of the Canadian experience provides an interesting comparator to the Irish health care reform programme. Canada’s health care system is highly decentralised with the provinces (and territories) primarily responsible for health care (Marchildon 2005). Most public health services are organised or delivered by regional (or district, in the case of Nova Scotia) health authorities that have been delegated the responsibility to administer services within defined geographic areas by their ministries of health at a provincial level. The Canadian system would also be described as an integrated public health care system. For the purposes of this paper the Capital Health District Health Authority (DHA) in Nova Scotia is

used as a comparative case. This forms an interesting contrast with the health regions and their local areas (Health Boards prior to 2005) in the Irish situation. In comparison to the Irish developments which focus on increased centralisation of services into one national Health Services Executive (HSE), the Canadian system has developed in a decentralised fashion with local control and consumer choice.

An overview of Irish health policy and legislation

Irish Health Policy has been represented for the past 10 years by the National Health Strategy; Quality and Fairness, A Health System for You (2001). Wiley's (ESRI) critique in 2001 emphasised the need for a new health strategy to address the issue of growing socio-economic inequalities. According to Bond and Cunniffe (2002) this second National Health Strategy was drawn up to address this crucial concern also identified in the Irish health services by the DOHC; that of equity. This principle along with three other key principles of the strategy; quality, accountability and people-centeredness were to underpin planning and management of the Irish health services. Another focus of the Strategy that has particular pertinence to a comparison with the Canadian case was the adoption of a population health approach (Wilde 2001). The Canadian health system has embraced this concept (Davies 2002, Public Health Agency 2005), which recognises that many factors exert a strong influence on health and that intersectoral collaboration and promoting public participation are crucial for strategic planning. In the Irish case this approach has yet to be incorporated in the health management process.

However 10 years on, many of the goals and objectives of the National Health Strategy have not yet been implemented and have little influence on the planning at the front line or the policy espoused by the Minister for Health & Children. The Strategy (2001a:53) had identified problems with organisational issues in the health services. It pointed to the problems with the role and functions of the health boards; in particular, achieving a balance between local and national decision making and the need to achieve greater clarity with regard to the levels at which decision making occurs. In order to deal with these issues in more detail a number of reports were commissioned by the DOHC. In June 2003, the Prospectus group of consultants reported on their review of the structural and organisational elements and recommended

structural reform of the organisation of the health system. Their findings focused on the complex and fragmented structures in the health system and the need for rationalisation of certain agencies. In terms of supporting processes, service planning was a focus, with a recommendation for its strengthening and alignment to new structures. The need for service evaluation, stakeholder participation, integration and a formal performance framework were all emphasised. The key recommendation of the Prospectus Report was system-wide structural reform, comprising a restructured DOHC, which would hand over its executive functions to a new Health Services Executive (HSE). The HSE would be the body through which accountability for all operational matters within the health system would be channelled and would be underpinned by the creation of four regional management structures to replace the health boards.

The legislation providing for the establishment of the HSE, the Health Act 2004, bringing about the first significant reform in the Irish health services passed all stages in the Dáil in a guillotined debate in late December 2004, without time for many provisions to be discussed and fully understood within or outside the Dáil, and even by the government, which promulgated them (Tussing and Wren 2005). There was no previous White Paper outlining the intent of the legislation. Thus, the Health Act [no 42] 2004 focused on the top down application of administrative reforms and did not deal with the issues such as equity, as identified as a core principle to underpin planning by the National Health Strategy. When questioned about this, the Minister for Health & Children responded that adopting a 'rights based approach' would result in a citizen-client being able to argue in court for a certain clinical approach which was not desirable and this in effect would remove 'autonomy from clinical independence to legal independence, as it were' (Mary Harney, Dáil Debate, December 2004).

In contrast, Canada has a strongly egalitarian, one tier system of health care (Bhatia 2010). The health system also delivers results; life expectancy in Canada for women and men, is nearly two years above that of Irish women and is exactly two years above that for Irish men. (OECD 2005). Underpinning the importance of public participation in health care in Canada is the Social Union Framework signed by all provincial and territorial governments in 1999

(except for Quebec). The framework attempts to reflect and give expression to Canadian's fundamental values. Its relevance to healthcare is the commitment to ensure 'adequate, affordable, stable and sustainable funding for social programs'. Abelson and Eyles (2004) note that it also includes agreement for governments to improve public accountability and transparency by ensuring mechanisms for Canadians to participate in developing social priorities and reviewing health system outcomes.

Crucial to underpinning the delivery of Canadian Health Care are the principles originally set out in the Medical Care Act of 1966, or medicare (with a small "m") as it is referred to in Canada. In comparison to the Irish health legislation at this time (1970 Health Act), the Canadian legislation was underpinned by four key principles; universal coverage, comprehensive services, portability, and public management (Lasseby, Lasseby and Jinks 1997). The 1984 Canada Health Act reiterated these four key principles and added a fifth; that of reasonable access which have become enshrined in Canadian health care. The Act sets out the primary objective of Canadian health care policy, which is 'to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.' The provinces to qualify for federal support (originally about half of total provincial costs) are required to meet these principles. These elements ensure that all essential services are covered; that everyone is covered and can receive care in any province; and that health care is administered by a nonprofit public agency. The key to the Canadian system is that there is only one insurer - the government. So, similarly to the Irish system when fiscal cuts are called for, these can be administered at the funding source.

Principles and Health Services Planning

For the principles of a health care system to be put into action, there must be a coherent planning system. Service (business) planning was introduced into Irish health care back in 1998 and it was described at the time by the DOHC (1998:26) as a 'strategic management tool' as it would establish the basic principles of the Strategic Management Initiative, by involving multiple stakeholders in the planning process. The Health Acts of both 1996 and now, 2004

are not specific on how service plans are to be developed. There is no acknowledgement of the strategic principles that would underpin the service planning process, no delineation of the participants, including the citizen-client and the nature of their involvement and no mention of the use of performance indicators in the legislation. Initially service planning became operational at health board level as a set of guidelines and a template.

A welter of publications has emanated in the health arena in the past ten years with a focus on the restructuring of the health services and not on the fundamental issues such as planning evaluation and performance management. The establishment of the HSE and the legislation that underpins service planning does not demonstrate any significant changes to the process that was set up under the 1996 Health (Amendment) Act No. 3. A number of developments including participation by the public on advisory panels are very limited in their prescription and very much within the control of the Minister for Health & Children. The Irish health care system tends to revert to a 'command and control' model in planning, management and implementation with little regard for engagement with health professionals, middle management and the citizen-client. This results in a planning system that tends not to engage the hearts and minds of the operating core in the health services and is isolated from the real health needs of the community.

The HSE now underpins its annual service planning with a three year corporate plan. It is guided by six key objectives that differ from the four key principles of the National Health Strategy already outlined. One of the key objectives of the corporate plan that has been constantly emphasized in the reform programme of the HSE is that of 'sustainable services'. Its translation according to the HSE is that of reconfiguring services by; co-location of private hospitals on public hospital sites, the National Childrens' Hospital Project, maintaining an 80:20 Public-Private mix ratio in hospitals where appropriate, developing specialist centres for hospitals and laboratory services, the National Cancer Control Programme, implementation of new consultants (contract), review of the roles of external service contractors, and rolling out additional Primary Care Teams as well as value for money (VFM). Although spending in health care continues to dominate political debate. The absence of consumer involvement in health care planning and allocation in Ireland is in direct contrast to the experience of many

other OECD countries¹. There is no consideration in the drafting of this legislation, that in core public services, service delivery is most appropriately seen as an outcome of relationships between all the key stakeholders and therefore the control system must reflect this complexity (McKevitt 1998).

Underlying all the difficulties that the Irish health service has, and is experiencing, is the focus on administrative control since the passing of the Health Act in 1970, the 1996 Health Amendment Act (introducing service planning) and now the Health Act of 2004. The health services need to be managed not administered. The health service had developed without a mission, a direction and underlying objective until 1994. However, the Health Strategies of 1994 and 2001 have never been properly implemented nor any of their principles given any impetus in legislation. According to the ESRI (2001) critique as a result of this, the issue of patient equity has continued to grow as a problem and there are copious reports regarding the growing crisis in Irish health care (Tormey 2003, O'Connor 2007, Burke 2009). It is evident that the DOHC has over the years been strong in the area of policy development. On the other hand, implementation of policy throughout the system has been poor and inconsistent.

In contrast in the Canadian case, not only are the principles for underpinning the planning and delivery of health services enshrined at federal level in the health system; at provincial level in the case of Nova Scotia the legislation allows for the setting up of Community Health Boards (CHBs). Under the Health Authorities Act, the CHB must prepare and submit to the District Health Authority (analogous to a health board/health region) a Community Health Plan that includes recommended priorities for the delivery of community based health services and a list of the initiatives recommended by the CHB for the improvement of the health of the community (DOH 2002). The CHBs are each made up of fifteen volunteer members. The DHA is then required to take the Community Health Plan into consideration when preparing their yearly health-services business plan, and, should they fail to include the plans in their service planning, to publicly explain why. Therefore the CHBs operate in an advisory capacity to the DHA and the DHA's function is that of policy implementation and evaluation (DOH

¹ For example; Canada (Community Health Boards), UK (Health Councils), Finland and Sweden (Health Councils), etc

1999). This has paved the way for needs based planning in the Nova Scotian health services, an aspect of planning that is notably absent in Irish health care planning. The legislation not only mandates community participation in health planning but it directs that the DHA administratively supports the work of the CHBs.

The NPM influence on Irish Policy

In order to this paper theoretically; the reform of the health services in Ireland as well as those in Canada can be seen as part of a wider set of public sector reforms which are characterized by the umbrella heading 'New Public Management' (NPM) (Hood 1991, 1995). Lapsley and Pallot (2000:215) acknowledge this broadly based international movement, which they describe as 'propelling public sectors of many economies towards convergence on how best to manage their activities'. Though, they also differentiate between intentions and consequences. The intention of NPM, according to Osborne and Gaebler (1992), being to make fundamental changes to management structures, processes and practices in the public sector. However, Lapsley and Pettigrew (1994) and Petterson (1995, 1999) have explored the consequences of NPM reforms in the public sector and in health care by deploying an institutional perspective to reveal the use of management or accounting practices mainly as legitimating devices. Since the mid 1980s and the 1990s (in the Irish case) the problem according to commentators (Pettigrew, Ferlie and McKee 1992, McKeivitt 1998), has been the over mechanistic transfer of concepts from the private to the public sectors. Collins, Hunter and Green (1994) explain the drive for this type of public sector reform as the point having been reached where spending more money on health care was no longer an end in itself nor sustainable politically and therefore, issues of effectiveness and efficiency came to the fore. They blame this new orthodoxy of health reform on the rise of the 'new right' where the private sector is seen as more efficient at producing goods and services than the public sector. It is a driver of health care reform in a diverse number of OECD countries including Ireland.

Dent, Howorth, Mueller and Preuschoft (2004) note, that while these NPM reform processes may vary in depth and scope they are remarkably similar in the goals they pursue and the technologies they utilize. There may be a number of different facets or ingredients to NPM,

but some of the key features include: the move in focus from inputs towards outputs; a shift towards more measurement and quantification (performance indicators); a preference for more specialized lean, flat organisations (Pollitt and Talbot 2003); an increase in contract like relations; the use of markets; an emphasis on service quality and consumer orientation and a shift towards the values of efficiency and individualism (Hood 1991). In a given situation according to Pollitt (2003) the different NPM ingredients can exist from the ideas level to plans and strategies to accomplished processes and practices.

The UK, according to Jackson and Lapsley (2003), is seen as a country, which has been driven by reformers and modernisers and is viewed as a leader in the area of public sector reform. In that regard, it continues to be used as a model of reform by Irish policy makers. As a model, Pollitt and Bouckaert (2004:295) contend that UK reform has been continual, often intense and sometimes harsh. It has focused on privatisation and intensification of central target-setting, with contracting out and 'best value' initiatives. Yet, as Olson, Humphrey and Guthrie (2001) warn there are possible dangers in persisting with reform programmes under NPM with financial management as their focus. They argue that the pursuit of efficiency and effectiveness potentially results in fewer public services being provided at higher costs, described as the 'evaluatory trap'. For example in the Irish case, the development of information systems to gather non-financial information and outcomes has been extremely slow and piecemeal compared to the development of financial indicators. There is a drive to encourage private investment in the acute care sector with a business and financial focus, rather than to look at the root problems in the health care system. Thus, the focus has been on hard measurable performance indicators rather than measuring the real but less measurable outcomes from health service interventions. MacCarthaigh and Hardiman (2010) contend that some of the organisational and procedural changes in Irish public administration do bear similarities to those that would be expected as a result of adopting principles of NPM but due to the absence of strong political drivers the reform initiatives haven't fundamentally altered the configuration of the Irish public administration. Boyle's (2010) interpretation of Irish style public management reform is that it has been driven more by pragmatism and less by any particular ideology. This may also explain the 'mixed messages' arising from health policy.

Conclusion

According to Bourgon (2010) public sector administration has reached a crucial point in its development. It has to date offered prescriptions and recipes for planning and management that bear little relation to either practice or classical theory. Bourgon (2010) emphasizes the need for governments to build *resilience* in society. A resilient society is characterized by active citizenry and resilient communities. She goes on to note the importance of governments in tapping and harnessing the power of others through approaches that draw on collective intelligence, self organizing networks and distributed decision making. Her clarion call is echoed by other academics (Haarman, Klenk and Weyrauch 2010, Osborne 2010) that note that a turning point has been reached in public management and that the delivery of public services requires negotiation in inter-organizational relationships and multi-actor policy making processes. In the Irish case there is a 10 year old national health strategy without legislative impetus, thus ensuring that existing patterns of resource allocation and existing stakeholder relationships are maintained. In contrast in the Canadian case, it is the legislation at federal level articulating the basic principles for health services delivery and the legislation at provincial level mandating community involvement in the planning of services and underpinning its strategic management, that averts tensions and allows for needs assessment and health planning that is not vulnerable to the vagaries political short-termism.

In Irish healthcare management despite warnings about large scale importation of private sector principles, NPM remains fashionable. As Pollitt (2003) notes NPM is by no means over. So why, with concerns in the wider public arena as well as the lessons outlined about the burgeoning inequities and costs in the US health care system due to its private sector management basis, does the NPM view or its pragmatic application continue to be the practice in Ireland? As Tritter et al (2010) warn, values, principles and politics matter and they should emphasise patient or citizen-client voice, as it not only improves quality but creates an accountability mechanism in relation to needs assessment and service delivery. For Irish health care and for the citizen-client the choice to be made in healthcare reform should at least be made explicit.

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