

Submission to 'Money Follows the Patient'

May 2013

The Irish Heart Foundation (IHF) is the national charity supporting people with heart, stroke and blood vessel disease. The Foundation promotes policy changes that reduce premature death and disability from cardiovascular disease and advocates for better patient treatment and services.

Summary of comments / recommendations

Overall health reform programme

- Health reform should be developed following public debate and wide engagement with citizens. The IHF believes there needs to be a robust debate about the kind of healthcare system we want in Ireland and what policy mechanism should be used to achieve this.
- The options for healthcare reform, including but not limited to UHI by competition, should be clearly laid out for the public. The different options for healthcare reform, including the implications of the different models in terms of accessibility, levels of care, quality and affordability should be the basis of the initial engagement with citizens.
- As we move into a period of reform there is a clear need for legislation to clarify the core principles which will govern Irish healthcare in the future and to outline citizens' entitlements to healthcare, including primary care, acute care, rehabilitation and health promotion. This is a necessity before embarking on whole scale reform of the financing and delivery of healthcare.
- A realistic and achievable timetable for implementation of health reform should be provided to the public.

'Money Follows the Patient' consultation document

Key concerns

- The IHF is particularly concerned about how the implementation of MFP within hospitals in the absence of similar reforms in primary care may further incentivise hospital care over primary care. There is a need for MFP to move beyond the hospital setting to support the Government's policies on chronic disease management and integrated care.
- Patient data, including unique patient identifiers and disease registries, is required for implementation and monitoring of MFP.
- The structures to monitor and improve quality of care must be in place in advance of the introduction of MFP.

In addition the IHF draws attention to the need for:

- Clarity regarding the funding for health promotion activities within hospitals.
- Appropriate staffing levels in hospitals prior to the commencement of MFP.
- A nuanced pricing system to ensure proper treatment of patients with multiple chronic diseases and complex care needs.
- Transparency in the setting of national budgets and yearly hospital activity levels.
- Further information on how Hospital Trusts would operate in the Irish system.
- A health impact assessment (HIA) of MFP.
- Meaningful and wide engagement with the public on MFP.
- Continued attention must be paid to the fulfilment of other reform commitments, particularly in primary care.

Introduction to this submission

The IHF welcomes the publication of the *Money Follows the Patient (MFP) Policy Paper on Hospital Financing*. The IHF has some key concerns about how the MFP system will operate and particularly how the implementation of this system within hospitals in the absence of similar reforms in primary care may further incentivise hospital care over primary care. The IHF would also like to use this opportunity to make some brief comments on the overall health reform in Ireland, of which MFP is one element.

This submission outlines the IHF's concerns in relation to MFP as currently proposed and raises some questions which it believes should be addressed prior to implementation. In commenting on MFP, the IHF is particularly concerned with how patients with cardiovascular diseases, many of whom have multiple care needs, will be served by the proposed system. The IHF recognises the advantages which could accrue from MFP in tying hospital financing to activity levels, while also recognising the need for checks to be put in place to ensure that the system does not incentivise early and inappropriate discharge of patients, or limit the resources available for health promotion activities in the hospital setting.

This submission provides:

1. Brief comments on the overall health reform programme
2. Comments on the 'Money Follows the Patient' document

1. Comments on the overall health reform programme

Reform in the provision and financing of healthcare is urgently required in Ireland. The IHF strongly supports the introduction of a system of universal access to healthcare, which is based on need and not on ability to pay. In particular for the patients we represent, the IHF supports a move towards a patient-centred health service with a focus on integrated care for chronic diseases.

The need for debate on the model of health reform

The IHF supports the introduction of universal access to healthcare; however this must be achieved through the most appropriate funding model. There are a number of financing systems which could be used to achieve this aim of universal access to care based on need (general taxation, social health insurance, etc.). The model proposed by Government is universal health insurance (UHI) provided by public and private insurers through managed competition (Government of Ireland, 2011). A number of key actors in the health sector have raised concerns about the proposed model, with the Irish Medical Organisation (2012), IMPACT (2012), TASC (2011) and the Adelaide Hospital Society (2010), all calling on the Government to consider other options for the development of universal health insurance, such as a public health insurance fund.

The Government's proposal for UHI by competition provides a new policy departure for Ireland in seeking to achieve universal access to healthcare. However, in seeking to provide such access through compulsory insurance in a managed competition process provided by private and not-for-profit companies, Ireland looks set to remain an outlier in European healthcare provision. The IHF is concerned that a competitive healthcare market based on the activities of competing health insurers may not be suitable to provide the levels of patient access, levels of care, quality of care and affordability which is desired. [For a discussion of the possible implications of a competitive healthcare market see IMO, 2012.]

The IHF believes there needs to be a robust debate, informed by greater access to relevant information, about the kind of healthcare system we want in Ireland and what policy mechanism should be used to achieve this. The current consultation focuses on only one part of the overall reform agenda. While the IHF welcomes this consultation, it should be recognised that the wider health reform agenda requires consultation and debate. To date, there has been little meaningful engagement with the public on the issue of health reform. The Government has based its health reform proposals on increasing competition within the healthcare system. This is a radical departure and necessitates an opportunity for debate and consideration. Whatever reforms are introduced there is a need for informed citizen debate to address how the rationing of limited healthcare resources will be undertaken for the future and how much Irish citizens will be willing to pay towards the new model of healthcare.

Universality in access to healthcare must be achieved. However, the system currently proposed by Government – Universal Health Insurance by competition is just one mechanism which could be used to introduce universal access to healthcare. The IHF calls on Government to consider all the financing options in terms of providing universal access to care, including social health insurance and taxation based systems. In particular, the IHF would recommend the work of the Adelaide Hospital Society (2006, 2008 & 2010) in detailing other possible options for health care reform, which would not require further privatisation of healthcare provision. A Money Follows the Patient (MFP) system would likely be a requirement to establish any of these financing options for healthcare.

A cautionary tale from the Netherlands

In 2006, the Dutch health system was radically reformed through the introduction of regulated market competition. All legal residents were required to obtain health insurance from private, for-profit insurance companies rather than social insurers. The market orientation of the reform made private insurance companies the sole providers of health insurance and Government's role was reduced to an umpire aiming to create fair competition and protect consumers. Prior to 2006, the Dutch system shared some similarities with the Irish system, including a complex, mixed public and private health insurance system with a major role for public financing and a broad respect for the private provision of health care (Rosenau and Lako, 2008). Overall, the reforms have been resoundingly inefficient in reducing the cost of health insurance for individuals (Naderi and Meier, 2010; Rosenau and Lako, 2008; and Turquet, 2012). (In the previous social insurance model, employers had covered the majority of the cost of insurance.) The working out of the system in the Netherlands is particularly concerning for those seeking to import it to Ireland because the Netherlands, unlike Ireland, already had many of the conditions favourable to the introduction of the model – primary and emergency care had been reformed and improved, universal coverage and community rating were already in place and costs per person per year were approximately half of those in the US (Rosenau and Lako, 2008).

Retaining the state's accountability for healthcare

Under UHI by competition the Government, and particularly the Minister for Health, would move from having ultimate responsibility for the provision of healthcare to citizens, to focusing on the development of policy. This policy would then be implemented by insurance companies and regulated by a number of new state agencies: 'There will be one strong public health system, where the state guarantees the level of service and quality and competing insurance companies are responsible for much of its administration' (Fine Gael, 2011: 47). No matter which system of healthcare reform is introduced and whether healthcare services are provided by the public or private sector, the IHF strongly asserts that the state must remain accountable for citizens' access to healthcare and the quality of that healthcare.

Legislative clarity on citizens' healthcare rights

At the time of the greatest reform of healthcare in Ireland in generations, there is a pressing need to outline the values and principles which will govern healthcare provision for the future. Current access to health and social care services is often based on opaque eligibility criteria which are complex, inconsistent and difficult to understand. There is no right to health in the Irish Constitution, or in legislation. Legislation should now be developed to provide clarity about the core principles which will govern Irish healthcare in the future and to outline citizens' entitlements to healthcare, including primary care, acute care, rehabilitation and health promotion. This legal basis should be defined in advance of embarking on whole scale reform of the financing and delivery of healthcare. [For a discussion of the need for a legal guarantee for health see Amnesty International, 2012.] The IHF calls on the government to ensure that the basis of citizen entitlement to health services is underpinned in legislation.

In summary, the IHF recommends that the overall healthcare reform programme should:

- Be developed following public debate and engagement with the public. The Department of Health should lead this process of engagement with citizens through town hall meetings and the provision of easy-to-read documents. (While commendable in its detail the current MFP document is complex and probably not appropriate for citizens who are invested in the overall reform process, but not in the complexities of the detail of implementation.)
- The options for healthcare reform, including but not limited to UHI by competition, should be clearly laid out for the public. This discussion of the different options for healthcare reform, including the implications of the different models in terms of accessibility, levels of care, quality and affordability should be the basis of the initial engagement with citizens. The Minister for Health should outline what UHI by competition would mean for Ireland, the evidence on which this model is based and explanation of why other models have not been selected.
- As we move into a period of reform there is a clear need for legislation to clarify the core principles which will govern Irish healthcare in the future and the entitlements of citizens to healthcare, including primary care, acute care, rehabilitation and health promotion. This is a necessity before embarking on whole scale reform of the financing and delivery of healthcare in Ireland.
- A realistic and achievable timetable for implementation of reform should be provided to the public. In the past, even piecemeal reforms of the health service have failed to be completed on time, or at all. This may have undermined the credibility of current health reform commitments amongst the public.

2. Comments on the 'Money Follows the Patient' document

Comments on the MFP document are grouped under the seven chapter headings of the MFP document.

1. Establishing the Vision

Principles underlining MFP

The IHF supports a system of resource allocation which will incentivise best use of healthcare to improve the health of the population. The IHF is primarily concerned about how MFP will operate from a patient perspective and whether MFP will ultimately be in the best interests of patients.

The MFP document outlines four objectives for the funding model: fairer system of resource allocation; drive efficiency; increase transparency in provision of services; support move to universal health insurance. None of these objectives directly address the need to improve population health and meet the needs of patients. Indeed, throughout the document the role and experience of the patient is given little attention. The IHF recommends, following the core principles outlined in the Department's paper on UHI (2013a), that the additional objectives of 'keeping people healthy' and 'patient-centredness'¹ should be included as objectives for MFP.

MFP is not a cost-saving measure

The MFP document states that MFP '... is not about reducing budgets but, rather, about fairly rewarding the work that is delivered in our public hospitals and facilitating clinicians and management to use resources in the most effective way' (p. 10). Everyone needs to be explicit that the introduction of MFP is not a cost-saving exercise. The IHF is therefore concerned that there are other areas in the MFP document where a desire to reduce costs via MFP is articulated. For example, when discussing the possibility of setting costs below average costs (which the implementation group have decided against for now), the document states: 'This approach has the benefit of driving major improvements in efficiency and could, therefore, be a very desirable option given the current economic situation and the need to reduce costs in the hospital sector' (p. 35).

The 'Fair Deal' Nursing Home Support Scheme is the only major example of a MFP scheme currently in operation in Ireland. Under the scheme individuals rather than facilities are funded through a MFP arrangement. The experience of this scheme in recent years, particularly the mid-year closure of the scheme to new entrants due to limited budget, provides cause for concern for how a MFP system will operate in hospitals.

Appropriate funding must be provided to the hospital system to fulfil the healthcare requirements of the population.

¹The Department of Health's (2013a: 4) preliminary paper on UHI defines these two principles – 'Keeping people healthy – the system should promote health and wellbeing by working across sectors to create the conditions which support good health, on equal terms, for the entire population' and 'Patient-centredness – the system should be responsive to patient needs, providing timely, proactive, continuous care which takes account, where possible, of the individual's needs and preferences'.

2. Understanding the Starting Point

Movement towards the privatisation of care

Government policy is resulting in the increasing use of private funding for healthcare, including patient co-payments for hospital services, prescription charges and the continued use of patient fees for GP services (IMO, 2010).

MFP represents the beginning of a quasi-market for healthcare in the hospital setting. Public hospitals will no longer be centrally managed and will become 'independent, not-for-profit trusts with managers accountable to their boards' (Government of Ireland, 2011: 5). Hospitals will be paid according to the level of care they deliver and will be incentivised to deliver more care through the MFP system. A purchaser / provider split will be established between the insurance companies and the hospitals: 'insurers will not take over the running of hospitals which will be independent providers of care separate from insurers as purchasers of care' (p.5).

The ability of privatisation in healthcare to improve patient access and patient quality is unproven. In other jurisdictions privatisation has often resulted in the cherry-picking of patients (often to the exclusion of chronic disease patients) and procedures, rather than incentivising the best treatment of individual patients. The IHF is concerned that continued privatisation of healthcare provision could negatively impact on the quality of service provided to cardiovascular patients.

Following the patient beyond the hospital setting

Hospitals are places where people with complex illnesses go; they are not the centre of a health service. However, the cost drivers in the current health system (particularly, the need to pay for GP services, but not for hospital services) push people towards using expensive acute hospital care. Despite these cost drivers, stated Government policy is to prioritise care at primary care level. The IHF believes that the Department of Health's policy on primary care is correct but that the implementation of this policy must be properly managed.

It appears unlikely that MFP, as currently proposed, will increase utilisation of primary care services. This is because MFP will only apply to services provided within hospitals; there will be no incentive to encourage treatment at primary care level where this would be preferable. By only improving the financing systems of hospitals we risk hospitals becoming even more active providers of care which could be better delivered in a community setting.

The policy is called 'money follows the patient' but the consultation document reflects a 'money follows hospital-level activity' approach. In its current incarnation the money doesn't follow the patient; it follows hospital activity levels and stays firmly within the hospital system. As such the MFP document describes a way of reimbursing hospitals for the volume of activities / interventions which they carry out, but does not tie this reimbursement to the proper care of individual patients. It is therefore feasible that hospitals would carry out more activity but not provide better care for patients. Only when the system follows the patients through their healthcare journey and across healthcare settings can the resourcing system be said to be truly 'money follows the patient'.

While the MFP document recognises the need to expand before the hospital setting in time, the IHF believes that further consideration should be given to introducing MFP in hospital services in tandem with similar

financing systems at primary care. This is the only way to eliminate the perverse incentives in the location of care.

3. Defining the Service

Patient-level data – unique patient identifiers and disease registries

The data requirements for a coherent MFP system highlights yet again the need for more robust patient information systems. The IHF calls on the Government to publish and enact health information legislation to enable unique patient identifiers which will properly follow patients through their care journey.

MFP will be based on existing information from HIPE and the National Casemix Programme. Careful consideration should now be given to elements of patient treatment and profile which are not currently collected in the HIPE system. Basing MFP on an incomplete data source could mean that only those elements captured in HIPE and thereby reflected in the payment system will be prioritised by hospitals. In particular, as the move to integrated care begins there must be a systematic approach to collecting information on patient use of primary and community services. This information should be prioritised to assist service development outside of the hospital setting.

Patient registries which operate across all healthcare settings are required to ensure effective service planning and quality care for patients across the healthcare system. Patient registries would facilitate adequate surveillance of trends; assessment of quality of care and patient outcomes; and an expansion of research capacity. In particular, given the volume of cardiovascular patients in the system there is a pressing need for the establishment of either a combined CVD register, or separate (but complementary) registers for acute coronary syndrome, stroke and heart failure. A stroke register has already been established by the HSE Clinical Stroke Programme and is currently being rolled out to all hospitals. Additional measurement of primary care outcomes and data collection and reporting on the impact of health promotion and prevention programmes should also be embedded within the health system.

Population health hospital and community services, e.g. health promotion activities

The IHF is concerned that important hospital-based activities, such as health promotion are not accounted for within the MFP system. The Government has made significant commitments to improving population health in *Healthy Ireland* (2013b) which will need to be supported by health promotion activities both in hospital and in community services. The IHF would like to see details on the extent of 'top slicing' of the Health Vote which will be provided for health promotion programmes in hospitals.

The IHF is also concerned that it has been decided not to include outpatient services, long-term care and outreach services in the MFP system. This is likely lead to further diminution of these services.

Chronic disease management

Recent developments in healthcare treatments and our ageing population mean that healthcare provision now primarily focuses on the management of chronic diseases and particularly on older patients with a combination of chronic diseases. It is essential that MFP supports the development of a proper system of chronic disease management in Ireland. MFP was piloted in orthopaedic services for elective surgery. While successful, this pilot does not provide evidence of how MFP would operate in more complex areas of care, such as the management of heart failure patients. MFP should enable hospitals to be paid for the full range of chronic disease management, rather than just discrete episodes of care. In introducing MFP in hospitals it is imperative that hospitals are reimbursed for the non-intervention activities which will be required to

manage patients with chronic diseases, such as getting patients to attend for screening and prevention activities, co-ordinating a patient's records from across different healthcare settings, engaging with the patient's carers and healthcare providers outside of the hospital setting, provision of lifestyle advice, medication reviews, etc. Before national roll out of the MFP, the IHF recommends that this financing system be trialled in an area of complex chronic disease management. As chronic diseases make up the main cost element of Irish healthcare, trialling MFP in this area should be a requisite to national implementation.

Further detail is required on how the initial introduction of MFP in hospital settings only will impact the roll-out of chronic disease management programmes for stroke, heart failure, diabetes and other conditions in primary care. The primary care contracts, yet to be negotiated by the Department, will be crucial in ensuring that primary care providers are properly incentivised to lead chronic disease management. The Heartwatch pilot provides an example of successful management of cardiovascular diseases in the community.²

Integrated care

MFP should be introduced in a way that is conducive to the provision of integrated care; that is care which is coordinated across the primary, hospital and home settings. Integrated care is recognised as the best model to meet the needs of the patient groups which are the primary users of modern healthcare services:

Traditionally, the health-care sector was designed to deal with people with acute or emergency problems that can be quickly resolved through one-off medical interventions. However, this approach does not cater well for the needs of individuals living with chronic disease, individuals with complex health and social problems and older, increasingly frail individuals. In this context countries worldwide are recognising the importance of integrated health care, whereby services are co-ordinated across the full range of service providers'

(Dept. Health and ESRI, 2010: 103).

As discussed earlier, the current system, where citizens pay for primary care but receive free hospital care (albeit with A&E and day bed charges), significantly biases healthcare use in Ireland and has impeded the development of integrated care. The proposal to introduce MFP in the hospital system only at this point further delays a move towards integrated care.

The Expert Group on Resource Allocation for the Health Sector (Dept. Health and ESRI, 2010) outlined the conditions required to establish integrated care for chronic diseases in Ireland, including:

- Formal links [which would likely include formal financing mechanisms] between the primary care system and wider healthcare system.
- Primary care would be seen as a core component of healthcare, rather than as a parallel system to hospital care.
- Primary care would become the centre of chronic disease management, with patients only engaging with hospital for short periods as required.
- Patients would be incentivised (through free primary care at the point of access) to default to primary care for their health needs.

² The Heartwatch pilot covering 20% of GPs has shown itself to be effective. It achieved significant improvements in reducing levels of the three main risk factors (cholesterol, blood pressure and smoking), although little change was achieved in weight and exercise levels; increased the uptake of evidence-based secondary preventative therapies; and improved the quality of care provided by GPs. 81 deaths were estimated to have been prevented or postponed and 522 life years gained over the first 2 years of the programme. The programme was also very cost-effective, with an incremental cost of €7,987 per life year gained. The CVD policy (2010) highlights that building on Heartwatch, a model 'addressing all patients who can benefit, including high-risk patients (as specified in the ESC Clinical Practice Guidelines ...), is needed to provide proactive and cost-effective cardiovascular care to maximise life expectancy and quality of life' and the policy also recommends the development of structured clinical care at primary level, including prevention of CVD. See, Department of Health (2006). *Heartwatch Clinical Report – March 2003 to December 2005, second report.*

The MFP document refers to 'boundary issues' to describe boundaries between care settings (hospital to primary care, to community care, etc.). For the patient there is no boundary in the care they receive, the use of this terminology almost seems to justify the disjunctions in care which patients currently face, and will continue to face until MFP is integrated across the full patient pathway.

As above the IHF would suggest the implementation group reconsider its decision to introduce MFP in the hospital setting only.

Appropriate staffing levels in hospitals

Weaknesses in staffing levels which have arisen in certain hospitals as a result of the moratorium on recruitment should be addressed before MFP is introduced. An assessment of staff needs across the hospital services should be undertaken to ensure that the proper staff ratios are in place so that all hospitals are equally able to engage in the new system of care delivery.

The HSE has developed a resource allocation model based on deprivation and need, designed to provide a mechanism for the allocation of posts in primary care. A similar system should be established for staffing of the hospital system to ensure that hospitals in all areas of the country have the appropriate resources to meet the needs of their patient profile.

4. Designing the Price

Development of a suitably nuanced pricing system

The IHF is concerned that without careful planning of the MFP pricing system, hospitals and Hospital Trusts may try to avoid treating those patient groups, or types of patients (the sickest patients and those with chronic disease) requiring the most complex care. The pricing / reimbursement structure must be nuanced enough to take account of patient-level complexity and not just activity levels. Within this nuanced pricing system maintenance of quality must be a key concern and monitored through regular audits of care.

Hospitals will be penalised for prolonged length of stay but where can patients be discharged to?

MFP proposes that hospitals will be penalised for what are considered unnecessarily lengthy hospital stays. This is a reasonable approach where there are step-down facilities and community supports available to enable timely discharge from hospital. However, in the current system, the lack of financing for community-based services (including home help, community rehabilitation and public health nursing) and long-term facilities means that many, particularly older patients, spend prolonged periods in hospital. For example, the IHF is aware of anecdotal reports that some patients with high support needs are not being accepted under the 'Fair Deal' scheme by some private nursing home providers, i.e. a cherry-picking of residents with lower support needs may be in operation. As a result some patients are remaining in unsuitable acute hospital accommodation for lengthy periods. In other cases patients may be kept in hospital until they can be discharged into rehabilitation units which have age limits for their service (e.g. rehabilitation units only available for over-sixty-fives). Until the appropriate community rehabilitation and community care supports are in place, hospitals cannot be penalised for lengthy hospital stays. The IHF would be very concerned if the MFP system meant that patients, particularly those with long term conditions requiring on-going support, were discharged from hospital without the appropriate care structures being in place.

Patient charges

The IHF welcomes the fact that MFP does not propose the introduction of additional patient co-payments. Equity in healthcare provision comes from the separation of payment from the receipt of care (i.e. not paying at the point of access). Co-payments are a regressive form of financing and are damaging to health because they discourage necessary healthcare use by patients. Co-payments put the focus for over-use of healthcare on the patient, rather than on the medical professionals, who should be in a position to properly apportion care according to medical need. It should be up to the MFP system and its internal controls to manage 'over-treatment' of patients. The worldwide trend away from co-payment systems (including abolishing of prescription charges in Northern Ireland in 2010) indicates that they have not proved a successful mechanism for improving patient health and cutting healthcare costs.

Setting budgets and activity levels

There will be a need to manage the public's expectations about what MFP and the wider healthcare reforms will mean in terms of access to care. The term 'universal' can be understood to mean that all needs for healthcare will be met. However, the reality is that there will still be limited budgets for healthcare and continued rationing of care. Under MFP patients cannot expect increased access to healthcare services. Care will continue to be rationed based on a 'fixed budget envelope' (MFP, p. 46). The IHF calls on the Government to maintain the current level of funding for the Health Vote, with a view to increasing provision as the economic environment improves.

In light of this on-going rationing of healthcare services, the setting of yearly activity levels for hospitals will be a key concern for the public. The activity levels for hospitals will be set annually by the Minister for Health (with a number of agencies). Rationing of healthcare services will then be based on these Government-mandated activity levels. The system to define activity levels will have to be robust and related to population health needs, not just available finances. It is important that the system to decide pricing and activity levels is open to public scrutiny. The development of the current HSE service plans is opaque and not subject to public oversight. In developing this new system to set the yearly goals for hospital activity, the State and citizens should retain access to all the information for oversight purposes. This information should not be held privately by Hospital Trusts, or insurance companies.

5. Governance Structures

Hospital Trusts

The IHF is concerned that the development of Hospital Trusts may lead to increased privatisation of healthcare provision and undermine integration between primary and hospital care. The IHF is also concerned to ensure that any competition which develops between hospitals, or Hospital Trusts (should they be established) focuses on improving quality of care rather than on reducing costs.

The preliminary paper on UHI provided by the Department of Health (2013a) highlighted the difficulties which have been experienced in a number of countries when establishing Hospital Trusts. In particular New Zealand and Scotland (both similar sized countries to Ireland) have moved away from Hospital Trusts and the internal market approach to the purchase and provision of care. This should sound considerable warnings to the development of this system in Ireland, yet the Department's document (2013a: 13) says only that, 'These important findings will inform the detailed design of Hospital Trusts in Ireland, the associated implementation structures and processes, and the wider contextual factors which need to be considered'. In light of the experiences in other jurisdictions, and concerns about possible 'races to the bottom' in terms of quality, further details are required on how Hospital Trusts will be established and operate in Ireland, including the budgets available for their establishment.

Quality of care

In the MFP system – where hospitals are funded by the number of patients they treat and therefore they have a strong incentive to treat as many patients as possible – the quality of the care provided will be a key concern. In the current system reducing waiting lists is often seen as the primary marker of improvements in care. However, reduced waiting lists does not necessarily mean that patients are receiving a better quality of care, just that they now have more timely access to some form of care.

The MFP document has limited information on how the necessary 'bedrock of quality' (p. 48) will be achieved. Quality standards and care protocols must be urgently developed to ensure that patients are receiving the best quality of care. The structures to monitor quality in hospitals are not sufficiently developed, should MFP be rolled out in 2014:

- To date, the National Clinical Effectiveness Committee has not produced a suite of national clinical guidelines.
- There also appears to have been limited progress in establishing the new Patient Safety Authority.
- The Health Information and Quality Authority (HIQA) will play a vital role in ensuring quality of care in the new system. HIQA's budget must be sufficient to ensure it can carry out its functions and undertake investigations. We understand that the delay in the registration of hospitals by HIQA is at least partially the result of budgetary constraints.

The structures to monitor and improve quality of care must be in place in advance of the introduction of MFP.

6. Implementation

Ultimately, there is no one best system for financing the hospital system and MFP will require strict on-going monitoring and auditing to ensure that the incentives are properly aligned across providers and patients to provide best access to appropriate care. To ensure a focus on patient quality and patient experience, the IHF believes that the implementation and monitoring structures should include a strong and independent element of patient oversight.

The MFP document states that MFP will be shadowed throughout the hospital system in 2013 and implemented in 2014. The IHF recommends that realistic and achievable short-term goals be outlined to indicate how implementation can realistically commence in 2014. If given the considerations raised here, and no doubt in other responses to this consultation process, it is decided that implementation will take place over a longer period; this should be announced as soon as possible.

The budget for MFP reform

Notwithstanding the constant refrain 'to do more with less', any systems change requires some upfront resources. The IHF would like clarity on the budget available to establish the MFP system. This budget should not be taken from the already stretched Health Vote, but should be provided from other Government sources, such as from the Department of Public Expenditure and Reform.

Reform implementation process

Much greater levels of transparency regarding the decision-making processes of the Department of Health and the UHI Implementation Group in relation to the health reform programme are required. The implementation group has strong representation from finance, economic and healthcare delivery professionals, yet it does not include representative of patient / citizen interests. The IHF recommends that the membership of the group be widened. In an overhaul of the whole healthcare system it is vitally important that citizens can understand, engage with and influence the reform system so that it meets the needs of society.

Health impact assessment (HIA)

The IHF believes that a HIA of MFP and of the wider UHI by competition proposal should be carried out to ensure that the proposed systems will fulfil the aims of improving healthcare delivery and by extension the overall health of the population. The IHF considers that HIAs should form a part of all legislative, regulatory and policy changes across all sectors of government and most particularly in the health sector. A HIA combining the health and financing implications of the MFP proposal would demonstrate respect for taxpayers, who continue to fund the health system, and would enable any necessary changes to be made prior to implementation.

Consultation with the public

The current consultation document is highly complex and as a result it is unlikely that many citizens will input into this consultation phase. The IHF recommends that information sessions / workshops are organised to engage the public and patient representatives in meaningful consultation on MFP.

7. Next Steps.

Implementation of other reform commitments, particularly for primary care

The IHF is dismayed about the slow pace of progress in providing free access to primary care. The first phase – providing free access to claimants of the Long-Term Illness scheme – was due to have been concluded in 2012, yet this has not yet occurred. Negotiations on the General Medical Services contract with GPs are yet to start and it is unclear when and how the financing of primary care services, including management of chronic diseases by GPs will be achieved. Moving ahead with reforms in the hospital system, without delivering on reform commitments in primary care, will strengthen the perverse incentives in the system encouraging patients to access complex and costly hospital care, rather than often more appropriate care in the community.

In addition, the IHF would welcome clarity on the funding mechanisms which will be applied for social care services, long term care, etc. in the future.

Conclusion

The IHF welcomes the opportunity to comment on the proposal for MFP and hopes that there will be an increasing number of opportunities to engage with the Department on its wider reform programme.

For further information contact:

Cliona McCormack, Research and Policy Officer

Irish Heart Foundation, ARUP Building, 50 Ringsend Road, Dublin 4.

cmccormack@irishheart.ie (01) 6685001

www.irishheart.ie

www.stroke.ie

Registered charity number CHY 5507.



References

- Adelaide Hospital Society (2010) *Policy paper – universal health insurance: the way forward for Irish healthcare*. Dublin: Adelaide Hospital Society.
- Amnesty International (2012) *Conference Report - Guaranteeing the universal in universal healthcare- delivering on the right to health in Ireland*. Dublin: Amnesty International.
- Convery, F. 'Budget 2013 and 'Future Health''. Publicpolicy.ie.
- Department of Health (2013a) *The path to universal health insurance*. Dublin: The Stationery Office.
- Department of Health (2013b) *Healthy Ireland*. Dublin: The Stationery Office.
- Department of Health (2013c) *Money Follows the Patient (MFP) Policy Paper on Hospital Financing*. Dublin: The Stationery Office.
- Department of Health (2010) *Changing Cardiovascular Health*. Dublin: The Stationery Office.
- Department of Health and ESRI (2010) *Resource Allocation and Sustainability in Healthcare. Vol. 1*. Dublin: The Stationery Office.
- Expert Group on Resource Allocation for the Health Sector (2010)
- Fine Gael (2011) *Let's Get Ireland Working – Election Manifesto*. Dublin: Fine Gael.
- Government of Ireland (2011) *Programme for Government*. Dublin: The Stationery Office.
- Irish Medical Organisation (2012) *The Market Model of Health Care – Caveat Emptor*. Dublin: IMO.
- Irish Medical Organisation (2010) *Position Paper on Universal Health Coverage*. Dublin: IMO.
- Naderi, P.S.D. and Meier, B.D. (2010) 'Privatisation with the Dutch context: A comparison of the health insurance systems of the Netherlands and the United States'. *Health*, 14(6), 603-618.
- O'Ferrall, F. (2009) 'The Erosion of Citizenship in the Irish Republic: The Case of Healthcare Reform'. *The Irish Review*. 41, 155-170.
- O'Ferrall, F. (2009) 'Universal Health Insurance what is it and would it be effective in Ireland?' *Working Notes*, 60, 3-7.
- Pillinger, J. (2012) *The future of healthcare in Ireland – position paper on the health crisis and the government's plans for healthcare*. Dublin: IMPACT.
- Rosenau, P.V. and Lako, C.J. (2008) 'An Experiment with Regulated Competition and Individual Mandates for Universal Health Care: The New Dutch Health Insurance System'. *Journal of Health Politics, Policy and Law*, 33 (6), 1031-1055.
- Smith, S (2009) *Equity in Healthcare: a view from the Irish health care system*. Dublin: Adelaide Hospital Society.
- Thomas, S., Normand, C., Smith, S. (2008) *Social Health Insurance: Further Options for Ireland*. Dublin: Adelaide Hospital Society.
- Thomas, S., Normand, C., Smith, S. (2006) *Social Health Insurance: Options for Ireland*. Dublin: Adelaide Hospital Society.
- Turquet, P. (2012) 'Health insurance system financing reforms in the Netherlands, Germany and France: Repercussions for coverage and distribution?' *International Social Security Review*, 65 (1), 29-51.