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Working Paper No. 358

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Towards a better and sustainable health care system – resource allocation and financing issues for Ireland

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* Frances Ruane chaired the Expert Group on Resource Allocation and Financing of the Irish Health Care System which published its report to the Minister for Health and Children in July 2010. While drawing on this Report, the views expressed in this paper are personal and do not necessarily reflect those of the Expert Group. The Report can be found on the Dept. of Health and Children Website at http://www.dohc.ie/publications/resource_allocation_financing_health_sector.html

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Towards a better and sustainable health care system – resource allocation and financing issues for Ireland

1. INTRODUCTION

The key to any efficient and sustainable system is coherence – the various elements must lead in the same direction so that actions do not conflict and mixed signals are avoided. In the context of a complex system, such as health, coherence means that the policies and practices in place are aligned with the stated goals for healthcare. Resource allocation mechanisms are ways of ensuring that these goals are achieved on the ground. They set out how and where decisions need to be made, over what domains they should operate, and what incentives need to be put in place in order to make sure that the goals are achieved. Financing mechanisms are designed to ensure that access by users to services align with stated policy objectives.

This paper draws on the recently published report of the *Expert Group on Resource Allocation and Financing of the Irish Health Care System*. This Report reviewed extant resource allocation and financing arrangements in the Irish health care sector to assess their coherence in terms of achieving the stated goals of health policy, and what is required to achieve coherence. The findings of the Report suggest that the present system lacks coherence, is not fit for purpose and is unsustainable. For example, there is no system of integrated planning of resources across healthcare, the medical card system fails both equity and efficiency tests and there are very serious cost factors and contractual arrangements that undermine sustainability.

Ireland needs a system that covers national policy setting and local delivery, standards of care and clinical pathways, capital and current spending, and integrated care delivery, both public and private. Systematic reform of the medical card system would increase equity of access and promote the use of safer and more cost-effective care. Resources would be more effectively used if the incentives faced by both patients and providers are aligned with stated health-care objectives.

Drawing on the Report, this paper discusses how poorly the current system fares in terms of meeting its stated objectives, suggests the guiding principles that should be used to direct the strategic changes required to improve efficiency, sustainability and accessibility, and outlines some specific actions that would help to reduce the gap between policy aspirations and deliverables.

2. CONTEXT

Like most other developed countries, Ireland is grappling with the challenges of providing quality health care to those in need at an affordable cost. These challenges are

set in a context where the population is rising and individual expectations in relation to health-care provision continue to grow. More effective medical interventions are allowing individuals to have better and longer lives, and those with chronic illnesses can increasingly be cared for in primary and community care settings, especially if they engage proactively in the management of their own health alongside health professionals.

The health sector internationally is responding to these developments by integrating care across the primary, hospital and community settings focussing on prevention and successfully managing chronic disease.¹ These changes have exposed the need for clinical leadership that understands and engages with cost-effectiveness as well as quality of care, and promotes the development of multidisciplinary teams.

For this new model of care to work, the system of allocating resources in the health care sector has to change radically. In particular, there needs to be an alignment of the quality and financial incentives faced by providers and users of care. This requires that reimbursement systems for providers and payment systems for users lead them to the best care outcomes possible with given resources. Payment systems must ensure that access is fair and charges do not deter effective use of healthcare.

In the very recent past Ireland has begun the process of moving to these new models of care, which are essential to promote safe delivery of healthcare. For these new models to be effective there must be agreement on what exactly is to be delivered and how this is to be done,² a financial management model that moves the resources to support the new delivery model and the redesign of incentives across the system so that care and funding drivers are compatible and reinforcing.

Against this background and relevant policy documents issued over the past decade, the Minister for Health and Children convened an Expert Group and requested it

- *to analyse the strengths and weaknesses of the current resource allocation arrangements for health and personal social services*
- *to recommend appropriate changes in these arrangements which would support and incentivise the achievement of the core objectives of the health reform programme*
- *to take a view (in the light of its work) on the most appropriate financing mechanism for the Irish health service and*
- *to base its examination and recommendations on the existing quantum of public funding for health.*

¹ Chronic diseases include cancer, epilepsy, asthma, diabetes, dementia, chronic multiple sclerosis and hypertension.

² This involves the definition of and adherence to clinical protocols throughout the healthcare system.

3. METHODOLOGY

The Group combined the key policy makers from the Dept of Health and Children [DoHC] and the Health Service Executive [HSE], together with health professionals, managers and economists, whose disciplines are involved in the resource allocation process. The Group adopted an evidence-based approach drawing on its own experience, invited submissions³ and research that reviewed the relevant international literature and the health care systems in eight jurisdictions.⁴ The Group examined the present resource allocation and financing systems in terms of the stated objectives of policy and then articulated the changes that it saw as necessary if the new models of care are to deliver what is needed at a sustainable cost. The Group's approach was to set guiding principles for healthcare, which are independent of the precise envelope of resources available to the sector – in effect, they apply whether the budget rises or falls.

4. THE PRESENT SYSTEM

Broadly speaking, the Group concluded that the present system was not fit for purpose in key areas such as planning, incentives, financing and sustainability.

Planning: The current resource allocation arrangements for health care lack coherence. Specifically, there is no framework in which to link policy objectives with resources. For example:

- planning of current and capital expenditure is not integrated
- planning of public provision of care takes no systematic account of private provision
- planning of care provision across the country is not based on current (population) need.

A consequence of having no framework is that the value of what we get for expenditure on healthcare, both public and private, is much less than it could be.

Incentives: Many of the reimbursement systems for providers and the payment systems for users of health care currently used by the HSE create incentives which run contrary to the direction suggested by key health policies. For example:

- The primary care strategy favours the transfer of activities into the primary and community care settings, yet many individuals pay less for their care if they attend hospital outpatient departments rather than their GPs or other care providers in the community.
- Cost-effective management of chronic diseases promotes the use of multi-disciplinary teams to deliver care, much of which should be community based, yet there is no governance or funding system in

³ Over sixty submissions were received.

⁴ This research was undertaken by ESRI economists (Aoife Brick, Anne Nolan, Jacqueline O'Reilly and Samantha Smith).

place to develop the primary and community care systems needed to meet this important demand.

- Safe and cost-effective care is a key goal for the hospital system, yet current funding systems do not reward either, and the absence of resources in the community means that length of stay in hospital is often longer than it should be.
- Disease prevention is known to be an effective tool to promote health and well-being, yet there is scant reward for any activities that achieve this.
- While there are aspirations for the ‘money to follow the patient/user’, current structures do not facilitate this and individualised care solutions seem to be used less often than would be indicated by cost effectiveness.

A consequence of the failure to ensure that incentives are appropriate is over-reliance on hospitals as a source of services for users, and inefficient resource allocation leading to poor value for money for the total health envelope.

Financing: In relation to the financing of the health-care system, the current financing system lacks transparency, gives rise to serious inequities in access to care, and results in numerous anomalies in terms of incentives for users of care. For example:

- Over two thirds of the population receive GP and many community-based services on a pay-as-you-go basis, which takes no account of ability to pay.
- High pay-as-you-go GP charges, such as we have in Ireland, are known to deter use of care, increasing the risk of later detection of medical problems, with the likelihood of higher costs in terms of health care in the longer term.
- Individuals with private health insurance can access some hospital services faster than uninsured individuals with equivalent or greater health need.
- There are widespread anomalies in the current Long Term Illness system; some important diseases are covered, but equally serious ones are not.

Sustainability: In relation to the sustainability of the health-care system, there is considerable potential for cost savings, building on the approach taken in relation to drugs. For example, many of the current contracts in use in the health sector are not designed to deliver services in an efficient and accountable way. There is also potential to increase sustainability by increasing efficiency, e.g., significant resources could be saved if all Irish hospitals were to move to the level of the most efficient hospital, and still more, if the levels of efficiency of Irish hospitals were to move to the best international norms.⁵

⁵ Estimates produced for the Group, based on the efficiency frontier analysis, suggested that this could be very significant

In terms of the stated objectives of policy, it is clear that changes could be made to the current system to promote greater equity and fairness, to support better service quality, to generate clear accountability for public funds and to facilitate a greater focus on the patient. In recent times some very positive developments have taken place which support a movement to address some of these major issues. For example, the integration of the two pillars (Acute Hospitals and the Primary, Continuing and Community Care (PCCC)) within the HSE. However, these changes are inadequate and do not integrate hospital care, primary care and continuing and community care into decision making at every level [DoHC, HSE corporate and HSE at local level]. Rather than incur the cost of replacing the HSE with a new structure, and the consequential costs and delays that this would involve, the Group concluded that it is possible to develop the existing HSE structures. This would mean bringing in new governance arrangements in the primary and continuing and community care sectors, and developing their relationship with the hospital sector so that hospitals can play an appropriate role in care delivery across the country. Clearly there is considerable potential arising from the Croke Park agreement to reallocate resources to support this, if the unions cooperate and management has sufficient drive and skills to implement the very significant changes required.

5. RESOURCE ALLOCATION MECHANISMS

The Group concluded that Ireland needs a healthcare structure with integrated decision making taking account of quality, accessibility, safety and cost effectiveness. This structure must link explicitly policy, implementation and delivery, so that the process of decision making is transparent at every level. Key steps involve greater clarity in relation to governance, with the DoHC responsible for policy and strategy and the HSE responsible for national implementation of policy through its local offices, which are in a position to meet local needs most appropriately. The concept of integrated care should be mainstreamed so that policies and actions are properly connected. Five guiding principles, drawn up on the basis of a review of Irish health policy documents and of international best practice, should inform the resource allocation changes needed, and actions for change should reflect these.

Principle 1: There should be a transparent resource allocation model based on population health need.

This implies that the DoHC should move to a system of coherent integrated planning of the health care sector, covering both public and private providers, and integrating both capital and current funding decisions. It also means shifting resources so that they link systematically to current population health need. This principle involves a major overhaul of how the DoHC operates. The five specific recommendations are:

Recommendation 1: The DoHC, supported by the HSE, should establish a common framework that incorporates all dimensions of health and social care expenditure, populated by the best available data, so that decision makers confront openly and

transparently the impacts and costs of their actions across the range of care areas and care programmes.⁶ *Timeline for completion: end 2011.*

Recommendation 2: Henceforth the DoHC and the HSE should agree priorities for a 5-year planning cycle, based on published care pathways and entitlements (as informed by new care protocols currently being implemented) and the envelope of resources available to the health and social care sector. *Timeline to start: 2011.*

Recommendation 3: An operational population health needs allocation model should be developed immediately, together with a plan for steady transitioning to basing allocations on this model over a 5 year time horizon. Explicit top-slicing should cover (i) public health campaigns; (ii) education/high-level training; (iii) research; and (iv) national specialities where there is usually just one national centre of specialisation. *Timeline: Model to become operational in 2012 and be fully implemented by 2015.*

Recommendation 4. The basis for geographic allocation of resources within the population health model should be areas with a population of at least 250-300,000 people, and that there should be no upper limit on the range where the areas represent integrated geographical units. *Timeline: immediate review of any plans for defining local HSE delivery areas which are at variance with this approach.*

Recommendation 5. Priority should be given to making immediate use of the personal identifier for the health-care sector and the adequate resourcing of the management information system to underpin its use, and there should be a national strategy to encourage all members of the population to register with a GP. *Timeline: immediately, starting with the hospital sector and extending into the other sectors.*

Principle 2: The resource allocation model should support local implementation of national priorities based on nationally-set clinical accountability and governance standards.

This effectively means a move to a geographically distributed system, with local implementation of national standards which are set by and supervised by HSE corporate. It is important to note that this proposal is NOT a return to the old health board system. The four specific recommendations made were:

Recommendation 6. The HSE should ensure that its management systems (at corporate and local level) are compatible with, and can incorporate, a formal resource allocation process based on population health and integrated care. Furthermore, the system currently being developed should be tested to ensure that the incentive structures being generated are compatible with the implementation of a population health resource allocation model. *Timeline to completion: no later than end 2011.*

⁶ The data should include estimates of known current and future population health and social care needs; estimates of total (public and private) current expenditure on health care; estimates of the current and planned stock of capital (buildings and equipment) in the health and social care system (both public and private); and estimates of the current human capital in the health and social care system (both public and private).

Recommendation 7. The HSE should be charged with ensuring the robust implementation of national priorities and standards at local area level by (i) providing formal resource allocation models to be used locally, (ii) resourcing local levels appropriately and monitoring adherence to national priorities and standards and (iii) ensuring that management teams include competencies in primary, community and acute care. *Timeline: Implementation should commence no later than 2012.*

Recommendation 8. As a matter of urgency, the DoHC and HSE should enhance their financial and management information systems so that that they can support rational decision making and achieve satisfactory standards of public accountability and transparency. *Timeline: expected to take up to three years.*

Recommendation 9. The HSE should review and reduce to a minimum the number of layers of decision making in relation to resource allocation systems in the context where budgets held at local level should cover all three sectors and be subject to central controls. *Timeline: This should be completed by end 2011.*

Principle 3: *The resource allocation model should support the delivery of safe, sustainable, cost-effective, evidence-based care in the most appropriate setting, whether public or private.*

This means having a funding model that ensures resources systematically follow the requirements of the new integrated model of care, while promoting greater quality and safety. This should ensure that what is planned is resourced and resources are not provided without planning. The specific five recommendations made were:

Recommendation 10. National reference prices should be developed for all care protocols. *Timeline: This will be done on a phased basis as the protocols are agreed over 2011, with a view to priority implementation in 2012.*

Recommendation 11. The determination of the prices of care (defined using case-mix adjustment) used to reimburse providers should be the product of a visibly independent process. When this function is undertaken within the HSE while it is still both a purchaser and a provider in the health care sector, an independent group should oversee the process. *Timeline to establish an independent transparent process: 2011.*

Recommendation 12. The HSE should implement a rigorous and transparent system of incentives to ensure that providers meet delivery plans and agreed quality standards in all three care areas in order to ensure public accountability. The Hospital Inpatient Enquiry (HIPE) System could be used immediately as a basis for challenging hospitals retrospectively on their inappropriate use of bed resources and fining them as appropriate. *Timeline: Hospitals should be advised immediately of potential penalties for use of less efficient methods given set clinical standards. This could be made to apply in 2011 ahead of the full prospective funding system.*

Recommendation 13. The role of HSE corporate should evolve systematically to build care factors directly into strategic planning at every level. The HSE is responsible for rolling out the protocols and ensuring that they are implemented; the Health, information

and Quality Authority [HIQA] is responsible for ensuring that published standards are being met. *Timeline to completion: 2011.*

Recommendation 14. The DoHC/HSE should develop plans for the greater use of individualised solutions to meeting care needs in the community and continuing care sector and support the local roll out of such plans. This should follow the principle of money following the needs of the patient/user so that care is delivered in the most appropriate setting. *Timeline to commencement: 2011.*

Principle 4: The resource allocation model should promote the integration of care within and across the hospital, primary and community/continuing care sectors at local level.

This means that resources must support integrated care so that users can get the best combination of health care to support them on clearly defined pathways across all sectors. The current governance and infrastructure in the primary care and community/continuing care sectors currently are inadequate to support this. The three specific recommendations made were:

Recommendation 15. Following the successful agreements with trade unions in regard to flexibility,⁷ priority should be given to planning, over a three-year time horizon, for the transfer of resources within and across HSE local areas to meet health-care needs in a more cost-effective manner. *Timeline to commence: 2010.*

Recommendation 16. A group of experts should be established immediately to develop a new suite of contracts for professionals in the primary care sector, drawing on international best practice. The contracts should take account of the changes in the new role of primary care within an integrated health-care system. In addition, the system should be designed to address the appropriate governance structure for the long-term development of primary care, embracing all of the relevant professionals. *Timeline: The process should begin in 2010.*

Recommendation 17. The development of the primary care system should be devolved to local level, but, as with all aspects of devolved delivery, to standards set at national level. The HSE at local level would then have a coordinating role in planning and delivering the type of primary care suited to given localities. *Timeline to start: 2010.*

Principle 5: Financial incentives should align as far as possible across all actors (including users and providers) in the system, consistent with promoting health and well-being and in line with nationally-determined priorities.

This principle implies that the HSE must develop new contracts that fund health-care providers on a prospective and transparent basis, and reward quality of care and cost-efficiency throughout the system. For example, contracts for the primary care sector must have clearly defined deliverables, while hospital contracts must move from historic block

⁷ These arrangements were reached as part of the Croke Park agreement.

budgeting to budgeting based on deliverables.⁸ To complete this process a split will be required between purchasers of care (on behalf of users on waiting lists) and providers of care, which will involve a major change in governance within the HSE. There were five specific recommendations made:

Recommendation 18. The contractual arrangements used by the HSE to reimburse providers should be extended to all care areas as soon as possible and developed to clarify the link between activity and cost in a changing resource allocation environment. *Timeline for extension: end 2010. A project to explore the use of more performance based contracts to start by 2012.*

Recommendation 19. National plans should be drawn up immediately for prospective based funding to be introduced into all relevant areas of the health and social care system on a phased basis. *Timeline: planning process to start in 2011, with a view to implementation starting in 2012.*

Recommendation 20. The National Treatment Purchase Fund (NTPF) should be abolished in line with the roll out of prospective funding, and resources transferred back to the HSE. Where public and private providers undertake public activity, the same basis of payment mechanisms should be applied. *Timeline for phasing out of NTPF: three years, starting in 2011.*

Recommendation 21. Full economic costing should apply to all private activity in public hospitals. *Timeline to commence: 2011, with completion across all sectors in 3 years.*

Recommendation 22. Proper protocols and costing for diagnostic services should be introduced. *Timeline to commence: 2011, with completion across all sectors in 3 years.*

6. FINANCING MECHANISMS

In relation to financing, the Group concluded that reform of the present system is necessary on the grounds that the current system does not encourage appropriate behaviours and is not equitable. The Group took the view that such reform could take place **either** through a social health insurance system **or** by the development of the mainly tax-funded system currently in place. What matters crucially is the system's effectiveness and not whether it is financed by taxation or social insurance. The Group identified five characteristics of a quality health-care financing system:

- **Equity and fairness**, i.e. those who can afford to pay more, should pay more
- **Transparency**, i.e. everyone should be able to understand the system and know their entitlements

⁸ This can be seen as mainstreaming the type of approach currently in use in the National Treatment Purchase Fund.

- **Promotion of good attitudes to care**, e.g. encourage patients to be registered with a GP, and to seek help when needed (requiring prepayment⁹ for at least some services)
- **Consistency with policy objectives** (e.g. promotion of integrated care)
- **Sustainability** (e.g. promotion of treatment of chronic disease within the community).

In its Report, the Group provided an illustrative framework to show how such a system could be introduced in a rational and systematic way, with the pace of restructuring dependent on the availability of resources, starting with eligibility for services in the community. In essence, the framework, which focuses on GP services and Drug Payments, shows how the current complex arrangements in relation to medical cards, GP visit cards, drug payment cards, long-term illness cards, etc., could be replaced by a single integrated stepped system (involving four different levels of primary care card).

In the scheme proposed, each card type would provide the card holder with a level of support that reflects both their income and health status, i.e. a graduated co-payment system. In effect, individuals currently above the medical card threshold would receive graduated subsidies towards the cost of both their GP visits and drugs, and the balance of the cost would be met by co-payments that would be fixed or capped.¹⁰ For example, a person a little above the current GP Visit card level or a person at high risk of a stroke or heart attack might pay a maximum user fee of €30 for a GP visit, and only 60% of the standard price for drugs, and a person who has had a stroke or heart attack might pay €20 out of pocket when seeing a GP and 40% of the standard drug prices.

The essence of the illustrative framework is that subsidies should focus on improving access to care by those on lower incomes (but above current thresholds) and on those with diseases that require continuing treatment (or people at high risk of such diseases where early interventions are needed). Since the subsidies would be progressive, people would not face a large increase in costs when their incomes rise slightly. The Report shows how such a framework might be developed within the current quantum of resources going to support the health-care system, in light of the significant potential savings that would arise if all Irish health care providers were as efficient as the most efficient Irish providers. It also suggests that direct subsidies that would help meet policy objectives would be a better use of public resources than the current tax relief on medical expenses and private medical insurance.¹¹ The Group proposed a single Guiding Principle in relation to financing health care:

⁹ Prepayment means that the cost of care is not paid at the time of use, and the cost to individuals does not depend on how much they use. Typical systems of prepayment are insurance (both private and social) and services funded through taxation. Prepayment is important when needs are uncertain or where it is important not to deter people from using services (e.g. checking or monitoring blood pressure).

¹⁰ Co-payment means the share of the cost of services paid by the user at the time of use.

¹¹ See Page 121 of the Report.

Principle 6: The methods of financing health care should be as effective and equitable as possible.

This means having a coherent system of financing that supports the most efficient use of services across the whole health-care system and removes current inequitable and inefficient barriers to appropriate care. This involves reducing payment or co-payment rates at point of use and supporting the transfer of health care out of hospitals and into the primary and community care settings. Lower co-payments can be achieved over time either by the orderly development of the existing medical card system or by the development of a social health insurance system. Potential resources to fund more equitable and effective care must be found within the current quantum of resources supporting health care by efficiency savings and more targeted use of existing resources. There were five specific recommendations made:

Recommendation 23. A more systematic approach should be taken to financing health services in terms of improving the extent of pre-payment for access to care, increasing transparency and increasing incentives to provide appropriate services efficiently and in the appropriate locations. Specifically, further development is needed in relation to entitlements to services within the community and user fees (where applicable) as well as to changes in entitlements to primary care.

Recommendation 24. A project should be established immediately to set out in detail the way in which a coherent structure of entitlements to primary and community care services and drugs could be implemented. This would include levels of user fees and drug co-payments to encourage appropriate patterns of service use. Primary care providers should be supported with appropriate capitation payments to co-fund entitlements to services for patients registered with them. Public subsidies should be focused initially on supporting those with high levels of needs for services and should also be more closely related to incomes. *Timeline: The project should be initiated by the end of 2010 for completion by end 2011.*

Recommendation 25. As resources allow, user fees in primary and community care should be lowered where they are likely to deter use of services, where they place a heavy burden on sick people, where they make it more difficult to put in place integrated models of care or where they incentivise inappropriate use of secondary care where primary care would be appropriate. This should be done by moving groups into higher categories within a coherent funding framework. *Timeline: to follow on from work done under Recommendation 24.*

Recommendation 26. As part of the reform of user fees and entitlements in primary care, the current tax reliefs on health care use should be abolished to release resources to be targeted on capitation payments to primary care providers. *Timeline: to follow on from work done under Recommendation 24.*

Recommendation 27. Tax reliefs on private health insurance should be phased out and the resources released made available for more targeted health policies, such as an

integrated and coherent medical card framework. *Timeline: to follow on from work done under Recommendation 24.*

7. SUSTAINABILITY

The Group's approach to sustainability is reflected in a single Guiding Principle:

<i>Principle 7: All aspects of the health-care system should be sustainable</i>
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A *sine qua non* for having a sustainable system is an information system that brings together all the costs of health care into a transparent setting, allowing major costs to be continuously subject to careful analysis and value for money audits. The key reference point is that Ireland's cost base for health care can be brought into line with relevant comparator countries, as is currently being done in the safety domain. There were seven specific recommendations made.

Recommendation 28. To ensure full costs in relation to health care are fully counted and understood, that data on health accounts should be placed in the public domain by the DoHC at an early date, and backdated where possible. *Timeline: Data for 2009 should be made available by the end of 2010, and backdated where possible to the mid 1990s at least.*

Recommendation 29. In line with the proposed government modernisation plans for the health-care sector, staff contracts within the health and social care sector should be simplified and standardised, as well as configured to ensure the delivery of health-care services that are accessible and integrated across all sectors. *Timeline: to commence by end 2010.*

Recommendation 30. An evaluation should be undertaken of all high-cost, high-use drugs on the current GMS/DP lists, based on Irish costs and international experience with their outcomes, and the HSE and DoHC should engage immediately in developing official guidelines and clinical protocols on the use of new technologies. *Timeline: to begin no later than April 2011.*

Recommendation 31. The DoHC/HSE should create immediate plans to (i) develop further the recently announced reference pricing system; (ii) review critically the comparator countries currently used for setting ex-factory price of pharmaceuticals with a view to adjusting these as soon as possible and no later than March 2012; (iii) introduce tendering for sole supply contracts for certain classes of pharmaceuticals; (iv) establish treatment and prescribing protocols that promote the use of generics; (v) introduce regulations to mandate that all prescriptions for public and private patients must contain the generic name of the drug prescribed; (vi) introduce regulations to mandate all pharmacists to dispense the lowest cost version of the drug unless the patient specifically requests a particular brand (in which case the patient is responsible for the additional cost) and (vii) extend more widely information on generics among doctors, pharmacists and patients. *Timeline: to begin immediately.*

Recommendation 32. The DoHC should clarify the roles of different bodies in relation to regulation and oversight to ensure that procedures are in place to deal with wrongdoing and that there are no gaps in the system of governance that could leave the health system exposed. *Timeline: to begin in 2010 as part of the overall review of governance.*

Recommendation 33. An evolving performance management system with a limited number of Performance Indicators should be introduced to allow managers to focus on what is considered priority and the key cost and service drivers. *Timeline to agree key performance measures: mid 2011 at the latest.*

Recommendation 34. A task force should be established to develop a new approach to the management of capital resources, looking at best practices in other countries and focusing on removing barriers to efficient use and management of capital resources. *Timeline: to be established in 2010 with proposals by end 2011.*

8. CONCLUDING COMMENTS

There are clearly very significant potential benefits to the Irish health-care system of having a resource allocation system that

- (a) underpins and supports the strategies currently being pursued to improve safety and quality of care and
- (b) links directly with the payment systems used to finance care.

For example, clinical protocols to support better care for those with chronic diseases will not be effective if resources continue to support an older model of care delivery. Resources must move out of hospitals and into the community to deliver care at a sustainable cost, but this cannot be done without appropriate infrastructure and governance in the primary and community care sectors. Central to good management of budgets is having the appropriate incentives to support the protocols at every level in the system. This requires anticipating all possible barriers to implementation before they emerge, so that they do not delay the process of change. Such potential barriers include weak governance and inadequate flexibility on the part of health-care providers, both individuals and institutions.

While the emphasis in the current discourse is on where to make cuts, and these are clearly very necessary, it is important that what is cut is viewed in the context of the total health system. If this is not done, crude cuts now may generate disproportionate losses in health care quality and the growth in hidden costs elsewhere. Despite all that is wrong with the present healthcare system, I personally am optimistic that with a proper approach to reforming its resource allocation and financing systems, we can have a quality, equitable and sustainable health system at lower cost, not just to the taxpayer but to the society as a whole.

Year	Number	Title/Author(s) ESRI Authors/Co-authors <i>Italicised</i>
2010		
	357	An Estimate of the Value of Lost Load for Ireland <i>Eimear Leahy and Richard S.J. Tol</i>
	356	Public Policy Towards the Sale of State Assets in Troubled Times: Lessons from the Irish Experience <i>Paul K Gorecki, Sean Lyons and Richard S. J. Tol</i>
	355	The Impact of Ireland's Recession on the Labour Market Outcomes of its Immigrants <i>Alan Barrett and Elish Kelly</i>
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