Implementing universal healthcare: from paper to practice

Mapping the Pathways to Universal Healthcare (UHC) Final seminar 26 September 2018

#PathwaysToUHC

Steve Thomas, Sara Burke, Sarah Barry, Bridget Johnston, Maebh Ní Fhallowín

Centre for Health Policy and Management, Trinity College Dublin

https://www.tcd.ie/medicine/health_policy_management/research/current/health_systems_research/
#PathwaysToUHC

**Agenda:**

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<tr>
<th>Time</th>
<th>Session</th>
<th>Chair/Speakers</th>
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<tbody>
<tr>
<td>8.30</td>
<td>Registration &amp; coffee</td>
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<tr>
<td>9.00</td>
<td><strong>First session</strong></td>
<td><strong>Chair: Dr Sara Burke</strong>&lt;br&gt;Prof Steve Thomas (PI of Pathways project &amp; Director of Centre for Health Policy and Management) Dr Bridget Johnston (Pathways team member &amp; Research Fellow)</td>
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<tr>
<td>10.00</td>
<td>Q &amp; A</td>
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<td>10.25</td>
<td>Coffee</td>
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<td>10.45</td>
<td><strong>Second session</strong></td>
<td><strong>Chair: Prof Steve Thomas</strong>&lt;br&gt;Dr Sarah Barry (Pathways team member &amp; Assistant Professor in Health Services Management) Maebh Ni Fhalluin (Pathways team member and Researcher)</td>
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<tr>
<td>11.30</td>
<td>Q &amp; A</td>
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<tr>
<td>11.55</td>
<td>Critiquing progress on the Sláintecare Oireachtas Report</td>
<td>Dr Sara Burke (Pathways Project co-ordinator and Research Fellow)</td>
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<td>12.20</td>
<td>On her approach to Sláintecare implementation</td>
<td>Laura Magahy, Executive Director of Sláintecare Programme Office</td>
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<td>12.30</td>
<td>Open discussion with the panel, including questions from the audience</td>
<td>Laura Magahy, Sara Burke and Rob Yates</td>
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<td>13.00</td>
<td>Lunch</td>
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Mapping the Pathway to Universal Health Care in Ireland

Health Research Award from HRB (2014-2018)
Centre for Health Policy and Management, Trinity College Dublin
WHO Barcelona Office for Health Systems Strengthening
European Observatory for Health Policy and Systems

Website -
https://www.tcd.ie/medicine/health_policy_management/research/current/health_systems_research/

Twitter: @TCDhpm
Scope of the project

**Aim: to provide an excellent evidence base that will inform strategic direction and implementation of universal healthcare in Ireland**

1. Assessing the gap between current Irish health system performance and universal healthcare

2. Evaluating the strengths and weaknesses of different models of universal healthcare and assessing their feasibility of implementation

3. Assessing the organisational challenges of moving to universal healthcare by reviewing the experience of other countries & exploring the current capacity & constraints facing decision makers throughout the system
Publications

Burke, S, Normand, C, Barry, S, Thomas, S. (2015). *From universal health insurance to universal healthcare? The shifting health policy landscape in Ireland since the economic crisis.* *Health Policy*


Coming up…

*Embracing and Disentangling from private finance: The case of Ireland* (Book chapter, In press)

*WHO Financial Protection Case Study on Ireland*, part of broader WHO Financial Protection project, to be published by end 2018

*Private health expenditure in Ireland: Assessing the affordability and sustainability of private financing of health care* Submitted to Social Science and Medicine
# Recent presentations

<table>
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<tr>
<th>National conferences</th>
<th>International conferences</th>
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<tr>
<td>RCPI/HSE Acute Medicine Conference, 18 September 2018</td>
<td>Utrecht International Conference on Integrated Care, 24 May 2018</td>
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<tr>
<td>TCD MSc in Health Service Management Annual lectures, 7 June 2018</td>
<td>Workshop and seminar hosted by King of Jordan, 29 April 2018</td>
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<td>Health Reform Alliance briefing, 30 May 2018</td>
<td>Is Two Tier the Future, Canadian conference, 7 April 2018</td>
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<td>Geary Institute Seminar, 27 February 2018</td>
<td>The Future of Healthcare Cyprus, December 2017</td>
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<td>2018 SPHeRE Network Spring Seminar, 26 Feb 2018</td>
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<td>RCSI National Healthcare Outcomes Conference, 20 February 2018</td>
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<td>National Health Summit, 8 February 2018</td>
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<tr>
<td>SPHERE Annual conference, 11 January 2018</td>
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</table>
And there’s more…

- Website updated
  https://www.tcd.ie/medicine/health_policy_management/research/current/health_systems_research/

- WHO Health Systems & Policy Monitor

- Shortlisted for Trinity College Registrar’s Civic Engagement awards

- Policy brief on Sláintecare

- And of course…more articles in the pipeline
  
  (i) Entitlement expansion in Sláintecare;

  (ii) Conceptual work on universal healthcare in Ireland (from the cube, to the triangle, to the quadrant)

  (iii) Integrated Care case studies and survey on organisational challenges

  (iv) Comparative health system reform with Cyprus and Greece
What if... Ireland with Sláintecare - Imagining an Integrated and Well-Resourced Health & Social Care System

Steve Thomas

Centre for Health Policy and Management, Trinity College Dublin

September 2018
You see things; and you say ‘Why?’
But I dream things that never were;
and I say ‘Why not?’

George Bernard Shaw
Whereas...

"Nobody knew that health care could be so complicated. I have to tell you, it's an unbelievably complex subject"
1. Entitlement
   - Legislate for entitlement & wait times
   - Eliminate or reduce charges

2. Integrated care
   - Primary and Community Care
   - eHealth, expanded integrated workforce

3. Funding
   - Bolstered Beveridge (+ ring-fenced)
   - Transition fund, Private Care out of Public Hospitals

4. Implementation
   - Office to drive reform
1. Patients with Rights

Whose voice is the loudest?

Entitlements and not Eligibility

• Free care
• Waiting time guarantees

Legislation

Accountability

Culture Shift

“There are many in the medical profession who are not very supportive of the proposal to extend free GP care to an extra 250,000 people per year. People are very naive if they think that the medical profession is fully behind this because it is not.” Taoiseach Leo Varadkar, 30th May 2018

2. Changed Financing

Share of Funding from different sources

- **2017**
  - Government: 69.0%
  - Out of Pocket: 15.4%
  - PHI: 12.7%
  - Other: 2.9%

- **2028**
  - Government: 81.8%
  - Out of Pocket: 7.5%
  - PHI: 8.5%
  - Other: 2.2%
Changed Financing – an International Comparison

International Comparisons

- Government schemes
- Compulsory health insurance
- Out-of-pocket
- Voluntary health insurance
- Other

Trinity College Dublin, The University of Dublin
Expensive? MYTHBUSTERS!

4th most expensive country - NOPE!

For 2014 data, Eurostat (updated 14th Sept 2018)

• 8th most expensive in terms of overall Euro per person
• 11th most expensive in terms of Purchasing power standard per inhabitant
• 12th most expensive in terms of Government funding per inhabitant (11th PPS per person)
• 3rd most expensive for Voluntary Health Insurance spending per person (2nd PPS per person)

Better Efficiency

Key Themes in Sláintecare

Care provided at the right level
Care provided by the right staff
Care provided more cheaply in the public sector

Secondarily

Expansion of ABF
Better use of HTA
Lower Drug Prices
Better Financial Protection
The role of user charges on access

• There are potential advantages to charging people at least a proportion of the cost of healthcare services they utilise…

• However, payments also often have unintended consequences and can exacerbate inequities in healthcare funding and utilisation.

• Irish evidence on impact of user charges:
  • Deter people from visiting their GP (O’Reilly et al. 2007)
  • Reduced medication adherence (Sinnott et al. 2016)
Better Financial Protection
The role of user charges on access

• At 40.6% Ireland had the second highest rate of unmet need for health care due to cost, distance or waiting lists in 2014 (EU average =26.5%) - costs were the most frequently cited factor (35.9%).

• Unmet need for different types of care due to cost was also much higher than the EU28 average.
Better Financial Protection
How many are experiencing financial hardship?

![Graph showing financial protection levels from 2009-10 to 2015-16]

- **No PHE**
- **No risk of PHE exceeding CTP**
- **At risk of PHE exceeding CTP**
- **PHE exceeding CTP**
- **Negative CTP**
- **Unaffordable PHE**

- **2009-10**
  - No PHE: 14.3%
  - Risk of PHE exceeding CTP: 10%
  - Unaffordable PHE: 0%

- **2015-16**
  - No PHE: 17.3%
  - Risk of PHE exceeding CTP: 20%
  - Unaffordable PHE: 0%
Better Financial Protection
Who is experiencing financial hardship?

2009-10

2015-16

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

- Med/GP Card
- Double
- PHI Only
- No Coverage
Better Financial Protection

Who is experiencing financial hardship?
## Better Financial Protection

Household factors contributing to lack of protection

<table>
<thead>
<tr>
<th></th>
<th>2009-10</th>
<th>2015-16</th>
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<tbody>
<tr>
<td>Household size</td>
<td>1.25 (1.16 - 1.34)***</td>
<td>1.08 (1.03 - 1.15)**</td>
</tr>
<tr>
<td>Anyone over 65</td>
<td>2.22 (1.70 - 2.90)***</td>
<td>2.56 (2.12 - 3.10)***</td>
</tr>
<tr>
<td>Rural</td>
<td>1.00 (0.80 - 1.25)</td>
<td>0.92 (0.76 - 1.10)</td>
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### Quintile

<table>
<thead>
<tr>
<th>Quintile</th>
<th>2009-10</th>
<th>2015-16</th>
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<tbody>
<tr>
<td>1</td>
<td>50.13 (29.21 - 86.05)***</td>
<td>87.54 (48.17 - 159.09)***</td>
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<tr>
<td>2</td>
<td>14.70 (8.47 - 25.51)***</td>
<td>36.58 (20.13 - 66.47)***</td>
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<tr>
<td>3</td>
<td>4.99 (2.72 - 9.15)***</td>
<td>6.02 (3.22 - 11.23)***</td>
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<tr>
<td>4</td>
<td>1.95 (1.00 - 3.80)***</td>
<td>2.34 (1.19 - 4.63)***</td>
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<tr>
<td>5</td>
<td>1</td>
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</tbody>
</table>

*Note:* All results are weighted

*** p<0.001

** p<0.01
Better Financial Protection
What are they spending on?

- Insurance
- Home Help
- Nursing Home
- Inpatient
- Diagnostics and laboratory
- Dental
- Outpatient fees
- GP fees
- Medical goods
- OTC drugs
- Prescribed Drugs
Human resources – Austerity and recovery

HSE 2018
3. Changed Human Resources

- Expansion – 6,600 staff
- Most in primary and community care
- Investment in Additional Training - €665m over six years
4. Other Key Changes

Resource Allocation

1. Resource Allocation Formula
2. ABF
3. Pooled funding across hospitals, primary and community care for local health system geographies

Information, Data and Communication (to facilitate Integrated care)

1. Massive Investment in eHealth
2. Better Waiting Time Data better communicated
And so we will have a different system...

New pathways to care
New workforce, new financing
New resourced allocation models
New ways of working and collaboration
New IT systems

With different needs...
ESTIMATED FISCAL SPACE LEFT OVER AFTER SLÁINTECARE IS IMPLEMENTED (€ MILLIONS)

Goldrick-Kelly and Healy (2018) NERI

- Benign Scenario
- Moderate Scenario
- Recession Scenario
Options

SláinteCare Report

- Ten year implementation period
- Front-loaded by year 6
- Maximum €460 million expansion per year

What if?

- 12 year implementation plan
- Not front loaded
- Pushed back (fee removal IP Y2; ED Y11)
- Stretched Phasing (UPC Y1-Y6)
- Pushed back and Stretched Phasing (GP Care Y3-Y9, Replacing Private Income Y4-Y10)
Re-Phased II - Costings

![Graph showing costings over years with two lines: one for increase on previous year and one for cumulative spend. The y-axis ranges from €0 to €400,000,000, and the x-axis lists years from Yr 1 to Yr 12.]
Big Bang vs Steady Progress
Entitlement Expansion – Additional Funds per year
Big Bang vs Steady Progress
One off Transition Costs
Reflections

• Vision and voice

• Whole system approach
  • Entitlements, funding, integrated care and implementation
  • Phasing reflects system adjustment

• Efficiency
  • Location, skill-mix, Public

• Affordability, Sustainability
  • Options for Phasing
  • Political Discourse
Thank you
Implementing UHC, reasons for hope from international lessons – it’s all about political leadership!

Mapping the Pathways to Universal Healthcare Seminar
Trinity College, Dublin
26 September 2018

Robert Yates
Senior Fellow and Head of UHC Policy Forum
Chatham House
UHC is Driving the Global Health Agenda

• UNGA Resolution on UHC December 2012
• Designated UN UHC Day from Dec 12th 2018
• Tokyo UHC Summit 2017
• UNGA UHC Summit 2019
• SDG Target 3.8
• WHO, World Bank and other agencies promoting UHC as best way to reach SDG 3
What is Universal Health Coverage?

A simple definition on UHC:

All people receive the quality health services they need without suffering financial hardship
UHC is fundamentally about EQUITY

- Universal = Everybody. Nobody left behind
- Health services allocated according to need
- Health financing contributions according to one’s ability to pay
- Healthy-wealthy cross-subsidise the sick and the poor
What are the benefits of UHC?

- **Health Benefits:** Better outcomes, improved health security, lower inequalities

- **Economic Benefits:** Faster growth, lower inequalities, reduced poverty, greater efficiency, creates employment, aids tax-collection

- **Political Benefits:** reduces anxiety, improves social solidarity, harmonious society

- **UHC = votes = power!**
Global lessons on health financing for UHC

- Market-driven privately financed health systems do not result in UHC
- The state must force the healthy-wealthy to cross subsidise the sick and the poor
- The state must be heavily involved in all three main financing functions of raising revenues, pooling and purchasing services
- Replace private voluntary financing with compulsory public financing - this process is inherently political
Health Financing Transitions in the OECD

7.1. Health expenditure per capita, 2016 (or nearest year)

USD PPP

0 2000 4000 6000 8000 10000

United States, Switzerland, Luxembourg, Norway, Germany, Ireland, Sweden, Netherlands, Austria, Denmark, Belgium, Canada, Australia, France, Israel, Iceland, Japan, United Kingdom, New Zealand, Italy, Spain, Portugal, Korea, Czech Republic, Slovak Republic, Hungary, Estonia, Latvia, Lithuania, Poland, Russia, Costa Rica, South Africa, Turkey, Mexico, Brazil, Colombia, China, Indonesia, India.
WHO’s new DG is targeting political leaders

WHO Director General says political will is needed to transform African health systems

WHO Director General Tedros Adhanom Ghebreyesus says universal health coverage is his ultimate priority - however it will require engagement with political leaders.
UHC leaders can become national heroes

Tommy Douglas “Greatest ever Canadian”

Aneurin Bevan Founder of the NHS
We British Love Our NHS
This love can be exploited
There will always be opponents of UHC.
PM Thaksin became a hero in Thailand when he brought the people UHC in 2002
Governor Jokowi launched UHC reforms in Jakarta one month after coming to power.
3 months before the election surveys showed Jokowi’s health reforms were most successful.

The study revealed that the Jakarta Health Card (KJS) and Jakarta Smart Card (KJP) programs launched by the Jakarta administration were among Jokowi’s most successful achievements in the eyes of the public, in addition to his rejection of the cheap car policy that was launched by the central government.

Fifty-seven percent of respondents nationwide said that they were familiar with the KJS program and that the program was beneficial to citizens; however, only 46 percent knew about the KJP program.
In the televised Presidential debate he promised to bring UHC to all Indonesians.
India: At last UHC is climbing the political agenda in the world’s biggest democracy
But other leaders have a different strategy.

Kofi Annan
Chair - Elders

UN Former Secy.
Gen Mr Kofi Annan
writes to CM Arvind Kejriwal on
Mohalla Clinics

Gro Harlem Brundtland
Deputy Chair - Elders

Ban Ki-moon
Member

A Delegation of "The Elders" to visit
Delhi in Sept 2018 to meet the CM
and visit the Mohalla Clinic

This is what Modi Govt and BJP is scared of

/AamAadmiParty
www.AamAadmiParty.org
Who will win the political battle in India?

AAP celebrates ex-UN secretary-general's praise for mohalla clinics

Former United Nations secretary-general Ban Ki-moon and former Norwegian prime minister Gro Harlem Brundtland with Delhi Chief Minister Arvind Kejriwal and Health Minister Satyendar Jain at a mohalla clinic | PTI
President Mandela’s first major social policy was to extend free healthcare.
Does South Africa have sufficient political commitment to launch UHC?

**MOTSOALEDI: NHI PAPERS READY FOR CABINET**

The white paper on the National Health Insurance scheme is ready to be presented to government.
Health coverage US-style

US man stages $1 bank robbery to get state healthcare

Unemployed and without health insurance, man in North Carolina has himself arrested in order to receive treatment
Obamacare – The US’s first big step towards UHC. History will judge him well.
A golden opportunity for UHC in the USA
Gavin Newsom bringing UHC to California?
UHC advocates taking on Trump in 2020

<table>
<thead>
<tr>
<th>DEMOCRATIC NOMINEE</th>
<th>Kamala Harris</th>
<th>Joe Biden</th>
<th>Gavin Newsom</th>
<th>Bernie Sanders</th>
<th>Mitch Landrieu</th>
<th>Elizabeth Warren</th>
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<tbody>
<tr>
<td>Single Payer</td>
<td>7/2</td>
<td>11/2</td>
<td>7/1</td>
<td>7/1</td>
<td>15/2</td>
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Ireland’s UHC Hero?
Concluding thoughts

- UHC is mostly political especially introducing an equitable public financing system
- UHC is popular with people and politicians across the world – it brings politics into health systems
- Worldwide political actors are the main driving force behind UHC
- The stage is set for Ireland’s UHC hero to take her/his place in history
The challenges & opportunities of implementing Integrated Care – a key mechanism for UHC

Mapping the Pathways to Universal Healthcare team,
Centre for Health Policy and Management, Trinity College Dublin
Sarah Barry, Maebh Ní Fhallaún, Sara Burke, Bridget Johnston, Rikke Seirsbaek, Steve Thomas
Pathways Component 3: Building an evidence-base to inform UHC implementation

1. Explore organisational challenges and opportunities
   - Systematic review of international literature on UHC implementation
   - Identification & survey of people implementing change in the Irish health system - Integrated Care Programme for Older Persons
   - Conducting a case study of current implementation work in the Irish health system - Integrated Care Programme for Older Persons

1. Situate these findings in the context of UHC implementation
   - in theory (various literatures)
   - and practice (Sláintecare/UHC for Ireland)
Systematic Review - Design

**Question** - what organisational challenges can be identified during implementation of universal health care/coverage policies in health systems in countries with a GDP per capita greater than $22,000?

**Approach** - realist, connecting policy and practice (CIMO)

**Methods**
- review designed & registered with PROSPERO (CR42015020373)
- 11 databases searched - 2,058 papers identified, screened (#5) = 9 reviewed
- quality and matrix analysis - characteristics of implementation, policy context etc. CIMO used to identify challenges & opportunities
- study limitations identified
Systematic Review - Challenges Identified

- **Dearth of studies** - the organisation/implementation lens is new for health system & whole-system reforms (such as UHC) = low evidence-base/practical theory, unconsolidated ...

- **UHC implementation challenges**
  - deficits in provider engagement skills
  - difficulties with different understandings & fixed mindsets
  - provider maldistribution, recruitment and retention
  - provider workload with coverage expansion
  - drifts to private practice
  - performance variation across regions
  - building new forms of leadership, alliances, networks and collaboration
  - system constraints with new practices, distributed decision-making
  - getting the pace and approach to implementation right
Systematic Review - Mechanisms Identified

- Change Mechanisms employed in response
  - new or enhanced roles/new forms of team-working
  - co-development of products, technologies & services
  - review and re-design of performance, M&E
  - leadership and collaboration building initiatives
  - provider training programmes
  - health insurance expansion (social and private) - coverage
  - financial incentives, consolidating services
  - monitoring patient registration with recruitment & retention data
  - fast-tracked implementation
Implications for Implementation Policy & Approach

- continue/enhance provider education & training re UHC
- build capacity for collaboration & create optimal environments for cross boundary working, partnerships for leadership, regionalised resource allocation etc.
- institutional support for distributed decision-making & team working
- build on provider positive outcomes (e.g. continuity of care) for recruitment & retention, couple coverage expansion with incentives re provider distribution, monitor patient registration with provider distribution data over time
- improve performance monitoring with dialogue, link to learning & service improvement work
- build evaluative, reflective, adaptive initiatives into implementation
ICP OP Survey of ‘implementers in action’

Context Analysis for Practical Action (CAPA) - theory of change

To understand how implementation is going, we asked:

- what are you talking about?
- what/how contextual factors impact on implementation?
- how useful are the tools for change?
- what/how actions & decisions influence implementation?

80/220 potential respondents - 36% rr
from pioneer sites across 7 CHOs & national programme level
ICP OP Survey - what are you talking about?

- **working together**
  communications, governance, leadership, resources, spanning boundaries

- **client/patient care needs**
  access to services, pathways, referrals process, community services, patient selection

Less frequently ...

- **system issues & parameters**
  - budgeting, development/future of ICP OP
  - do we need it?
  - GP contract
  - culture change
  - M&E
ICP OP Survey - what/how contextual factors impact implementation?

- the history of good integrated working between acute & CHO
- senior clinical leadership
- scaffolding to enable roles such as case management
- underdevelopment/resourcing of core services
- adapting to existing culture in the community
- different hospital structures/conflicts
- split between social & primary care
- Communication between the national & local office

Contextual Factors across 7 CHCs & National Dir
ICP OP Survey - how useful are the tools?
ICP OP Survey - what/how actions & decisions influence implementation?

- All team members assess, regardless of discipline
- Developed an ICPOP governance group
- Comprehensive geriatric assessment
- Relationships built with other community services
- Holding out for the adequate team
- Lack of appointment of community geriatrician
- Process of appointment is unwielding & slow
- Development of key nursing roles

Actions & Decisions across 7 CHO's & National Dir

Trinity College Dublin, The University of Dublin
UHC Implementation - Challenges & Patterns/Review

Implementation success is determined by

- system capacity for boundary disruption & crossing
- the quality of professional/disciplinary collaboration
- the experiences of health & social care providers implementing change – mind-sets, understandings, learning, conclusions about the system
- skills building and feedback loops
- appropriately paced implementation processes

Creating the environment for implementation means systems with

- meaningful M&E, performance engagement
- useful data (e.g. patient/provider behaviours etc.)
- participation in innovation & design
- practical adaptive capacity
- mechanisms for culture change
UHC Implementation - Challenges & Patterns/Survey

- Much of the talk is process-focussed
  - unsurprising - people need clarity & engagement to get there
- New forms of patient access/pathways animate the system
  - but challenge it to change also
- System/organisational issues matter for sustainability/implementation over time (Sláintecare - 10 yrs+)
  - capacity for adaptation is essential
  - timely address of organisational barriers
  - counter fatigue, lethargy etc.
- Framework tools (i.e. 10 Steps) set useful parameters, but are not enough
  - support context engagement and translation
- Actions & decisions at local level animate, but are limited & need system-based adaptation
Component 3 – The Case Study

1. Integrated care and UHC
2. The Case: Integrated Care Programme for Older People (ICPOP)
3. Case Study Methods
4. Analysis
5. ICPOP findings
6. Findings relevant to Scaling up / UHC
1. Integrated Care and Universal Health Care (UHC)

*Sláintecare* describes integrated care as:

1) The **new model of health and social care** to meet the needs of an ageing population

**AND**

2) The **key mechanism** through which UHC will be delivered
2. The Case: Integrated Care Programme for Older People (ICPOP)

**Background:**
- Evolved from National Clinical Programme for Older People
- Core funding secured in 2016
- 14 pioneer sites by 2018

**Mission:**
- To develop new models of care for older people with complex care needs, by supporting them in their own homes and communities, and reduce hospital admissions.

**Activities:**
- **National Programme Office**
  - Funding for multidisciplinary teams (MDTs)
  - Strategic guidance and administrative & IT support
  - Outreach
- **Pioneer sites**
  - Developing new local governance structures and work practices across healthcare settings and organisations in collaboration with patients, carers and local agencies.
3. Case Study Methods

**Research Goal:** To examine ICPOP implementation challenges which may inform approaches to achieving systemic change (such as those required to deliver UHC) through:

1) A brief **literature review** of implementation theory and complexity science

2) A process of **co-designed participant observation** in three ICPOP pioneer sites (A, B & C)

3) **Documentary analysis** of materials provided by pioneer sites relating to governance

4) **Semi-structured interviews** with key senior stakeholders, including clinician and non-clinician managers (n. 7)

5) **Thematic analysis and CIMO analysis** (Context, Intervention, Mechanism, Outcome)
## 4. Analysis - Pioneer Site Characteristics (A)

<table>
<thead>
<tr>
<th>Site A</th>
<th>Site B</th>
<th>Site C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Geography</strong></td>
<td>Urban &amp; large rural area</td>
<td>Urban &amp; large rural area</td>
</tr>
<tr>
<td><strong>Population (vs national average)</strong></td>
<td>Older</td>
<td>Significantly older population</td>
</tr>
<tr>
<td><strong>Hub Location</strong></td>
<td>Day hospital for older people on the grounds of a model 4 acute hospital</td>
<td>Community hospital close to a model 3 acute hospital</td>
</tr>
<tr>
<td><strong>Pioneer Site Background</strong></td>
<td>Green-field site (few services for older people outside of GP)</td>
<td>Evolved from integrated care activities for older people in the acute hospital.</td>
</tr>
<tr>
<td><strong>Project Sponsors</strong></td>
<td>1) Hospital Geriatrician 2) Manager of Older People's Services</td>
<td>1) Acute Hospital General Manager 2) CHO Head of Social Care</td>
</tr>
<tr>
<td><strong>ICPOP-funded MDT Members</strong></td>
<td>1) Senior Physiotherapist 2) Senior OT 3) Administrator 4) Clinical Nurse Specialist 5) Social worker</td>
<td>1) Clinical Nurse Specialist for Dementia 2) Senior Grade Occupational Therapist 3) Senior Grade Physiotherapist 4) Administrator</td>
</tr>
</tbody>
</table>
4. Analysis - Pioneer Site Characteristics (B)

<table>
<thead>
<tr>
<th></th>
<th>Site A</th>
<th>Site B</th>
<th>Site C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referrals</strong></td>
<td>From GP and acute hospital</td>
<td>From acute and community hospital</td>
<td>From GP and acute hospital</td>
</tr>
<tr>
<td><strong>Domiciliary Visits</strong></td>
<td>Provided by social worker</td>
<td>Home visits and assessment provided by physio and OT</td>
<td>Domiciliary visits undertaken by all members of the team.</td>
</tr>
<tr>
<td><strong>Governance</strong></td>
<td>Weekly MDT meetings. Steering Committee meets quarterly; Working groups (for ambulatory care, rehabs and early mobilisation) meet quarterly</td>
<td>Weekly MDT meetings. Steering Committee meets bi-monthly; Implementation Team meets bi-monthly.</td>
<td>Weekly MDT meetings. Steering Group meets every two months. Multidisciplinary business meetings held monthly.</td>
</tr>
<tr>
<td><strong>Outreach Activities</strong></td>
<td>GP educational meetings; roadshow to raise awareness among public health nurses, presentation at Integrated Care Conference</td>
<td>Stakeholder planning workshop including patient advocates to map existing services and to set priorities for the year</td>
<td>Presentations to GPs, Nurses, at Integrated Care Conference, Attendance at South Dublin Age Friendly County Alliance, Relationships built with Alzheimer's Day Centres/services</td>
</tr>
<tr>
<td><strong>Next Steps</strong></td>
<td>Secure funding for a dietitian, psychologist, pharmacist, speech and language therapist, and a Community Geriatrician.</td>
<td>Increase ICPOP services, scope supports for nursing homes (esp for dementia patients), develop end of life care, frailty and delirium education and training</td>
<td>Support long term care residents through the development of a nursing home liaison service and recruit a dietitian</td>
</tr>
</tbody>
</table>
### 4. Analysis - Pioneer Site Characteristics (C)

#### Key Assets, Opportunities & Challenges

<table>
<thead>
<tr>
<th></th>
<th>Site A</th>
<th>Site B</th>
<th>Site C</th>
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</table>
| **Key Assets & Opportunities** | Strong leads, champions, connectors  
• Experienced team members  
• Supportive team  
• Focus on communications  
• enabling movement into the academic space  
• enabling a more holistic approach  
• disciplines/specialties for older people area becoming more attractive, less stigma  
• a path for career progression has opened up | Home assessments  
• established links between community and acute hospitals  
• institutional knowledge and experience  
• motivated individuals  
• local services mapping | Good relationships between CHO, hospital, GPs and Primary Care reps  
• Funded MDT  
• Strong community ethos  
• Good hospital data (e.g. attendance)  
• Clinical champions  
• Motivated team  
• Clear referral protocol  
Interdisciplinary teamwork/ task-sharing  
Established rotating community geriatrician  
• Good profile within hospital and growing profile in community |
| **Key challenges** | Mostly hospital-delivered services  
• No Community Geriatrician  
• geography and travel constraints  
• geographic areas of unmet need  
• Early stage operational e.g. issues around triage - what is labelled a crisis, where does ICPOP fit in the jigsaw of these patients | Turnover in steering group  
• delayed appointment of community geriatrician & case manager  
• Lack of GP& PHN involvement  
• Under-resourced primary care & home help  
• paper-based systems  
• lack of standardised referral, lack of community data  
• performance indicators – quality vs quantity  
• geographic limitations | Patient/citizen involvement  
• Gate-keeping  
• Appropriate/co-designed activity/outcome measures  
• Reporting structures  
• Perceptions/fears among colleagues  
Professional boundaries (organisations rather than individuals)  
Communication |
5. ICPOP findings (A)

- ICPOP shows many promising signs:
  - successfully building **partnerships** across professions and institutions and challenging front line staff to develop creative solutions to the problems they face – “earned autonomy”
  - potential to **shift our approach** to older peoples’ care from a heavily medicalised and hospital-centric one to a more holistic, community-based social care approach.
  - **bringing hospital and community together** through joint leadership of pioneer sites and joint-funding of MDTs to work across those settings.
5. ICPOP findings (B)

- The MDT is potentially one of the most important mechanisms for change – the implementers
- Understanding the fears of MDT members is the first step to addressing those fears.
- Many of the causes of frustration among MDT members – lack of home care services, under-developed primary care, progress measurement – are policy issues which they perceive to be outside of their control.
- The status quo influences the scope and level of ambition of individuals and MDTs.
- ICPOP depends on a small number of individuals with strategic knowledge, experience and energy to drive progress.
- Professional identification and traditional hierarchy remain strong
5. ICPOP findings (C)

- **Communications and outreach**, including framing messages in different ways, takes time and resources but it’s necessary to build trust!

- Each site is unique. **Context is everything**. Contextual factors combine to support or restrict progress. Identifying contextual factors helps us to understand the problems….but there are so many….and we don’t have the tools to deal with the complexity!

- **Different interpretations** of terms such as community, integration, primary care etc.

- Conversation focused on integration at the individual level (“an integrated ethos”) and at the clinical level (integrated care pathways) BUT many of the barriers to implementation are due to a **lack of professional, organisational and system integration**
5. ICPOP findings (D)

- ICPOP is primarily a geriatrician-led targeted approach (5-10% of older population), with a strong hospital focus. There is a lack of clinical leadership capacity in the community.

- ICPOP is heavily focused on creating new patient pathways, for frailty, rehabilitation, falls, memory and dementia...”but some patients don’t fit the system”.

- ICPOP highlights how important it is to see older people in their own homes BUT not all teams are equipped to provide this service.

- Important to align goals with Sláintecare and seek out synergistic activities between ICPOP and other programmes.
6. Findings relevant to Scaling-up or UHC (A)

1. Understanding **contextual factors** at different levels for implementation – micro (clinical), meso (organisational & professional), macro (national policy)

2. ICPOP is a micro/meso level intervention informed by implementation science. For whole system change it may useful to look at ICPOP through a **policy process lens** and consider policy implementation research, e.g. top-down and bottom up approaches to implementation, ICPOP as a policy subsystem, MDT as a group of policy actors

3. The limitations of a programme approach to whole system change (i.e. the importance of a strong national policy to facilitate local innovation; reaching the **implementation sweet spot**)
6. Findings relevant to Scaling-up or UHC (B)

4. Danger of integrated care operating as a separate programme rather than a horizontal/system-wide movement

5. Acknowledge complexity. Complex Adaptive Systems (CASs) challenge policy-makers to consider the health system as a whole entity that cannot be explained solely through examination of its constituent parts.

6. The measurement quandary – why are we measuring what we are measuring? Who does it serve?
6. Findings relevant to Scaling-up or UHC (C)

7. Advantages and disadvantages of developing a strong programme brand

8. Innovators running out of steam

9. Elephants in the room - public-private interfaces, where are the GPs, the language we use

10. Change management, implementation or emergence?

*Go raibh mile maith agaibh!*
From Paper to **People** to Practice

- **Context matters**
  - support & resource engagement & innovation
  - build system/organisational adaptability - meaningful processes & change
  - continuous feedback loops/communication
  - address culture

- **We need an implementation approach that relates to the politics involved**
  - power relations
  - strategies for ‘elephants’

- **Emergence & complexity**
  - implementation that is NOT only ‘project management’
  - raising a child ....
Critiquing progress on the Sláintecare Oireachtas Report

Mapping the Pathways to Universal Healthcare team,
Centre for Health Policy and Management, Trinity College Dublin
Sara Burke, Steve Thomas, Sarah Barry, Bridget Johnston, Maebh Ní Fhalluín, Rikke Seirsbaek
Overview of presentation

– Timeline
– Assessing the Sláintecare Strategic Implementation with the Sláintecare Oireachtas Report
  • Vision & principles
  • Entitlements
  • Integrated care
  • Funding
  • Implementation
  • What’s new?
– Some concluding thoughts
The Sláintecare policy process timeline

- General Election
- Special Committee on the Future of Healthcare established
- Ongoing public hearings and consultation
- Dáil debate on Sláintecare
- Cabinet discussion of Sláintecare and statement by the minister
- Sláintecare Implementation strategy published, new website

- Minority government formed
- First meeting of the Committee
- Launch of Sláintecare report
- Cabinet decision to set up Implementation Office in Dept of Health and appoint a lead
- Announcement of Laura Magahy as Executive Director of Sláintecare Programme Office and Prof Tom Keane as Chair of Advisory Council
- Laura Magahy starts as ED of Sláintecare Programme Office

Dates:
- 26 Feb 2016
- 6 May 2016
- 1 June 2016
- 23 June 2016
- June '16 - March '17
- 30 May 2017
- 20 June 2017
- 20 July 2017
- Oct 2017
- 12 July 2018
- 8 Aug 2018
- 3 Sept 2018
Shared vision

Oireachtas Sláintecare Report

- The vision of the Committee is a universal health system accessible to all on the basis of need, free at the point of delivery (or at the lowest possible cost)
  - Set up by the terms of reference

Sláintecare Implementation Strategy

27 mentions of the ‘Sláintecare Vision’

We are all united in our vision for the health service. We want health care to be organised and delivered in a joined-up way and designed around the needs of people. We want more care provided at home, or close to home in communities. We want people to be able to access care when they need it in a timely manner, and we never want a situation where someone needs care but can’t access it for financial reasons. Implementing change of this scale will not be easy and it won’t happen overnight.

Our goal is to translate the Sláintecare Vision into a living Implementation Process.

First line of the report
Shared principles

Oireachtas report principles replicated in Sláintecare Implementation Strategy
**Sláintecare Implementation Strategy**

### 4 Goals

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Deliver improved governance and sustain reform through a focus on implementation.</th>
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<tbody>
<tr>
<td>Strategic Action 1</td>
<td>Improve governance, performance and accountability across the health service.</td>
</tr>
<tr>
<td>Strategic Action 2</td>
<td>Put in place an effective implementation and governance structure for Sláintecare and establish a Sláintecare transition fund to support key reforms.</td>
</tr>
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<thead>
<tr>
<th>Goal 2</th>
<th>Provide high quality, accessible and safe care that meets the needs of the population.</th>
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<tbody>
<tr>
<td>Strategic Action 3</td>
<td>Improve population health-based planning and develop new models of care to deliver more effective and integrated care.</td>
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<tr>
<td>Strategic Action 4</td>
<td>Expand community-based care to bring care closer to home.</td>
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<tr>
<td>Strategic Action 5</td>
<td>Develop and modernise the acute care system to address current capacity challenges and increase integration between the hospital sector and community-based care.</td>
</tr>
<tr>
<td>Strategic Action 6</td>
<td>Expand eligibility on a phased basis to move towards universal healthcare and support a shift to community-based care.</td>
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<thead>
<tr>
<th>Goal 3</th>
<th>Ensure the health system is financially sustainable.</th>
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<tbody>
<tr>
<td>Strategic Action 7</td>
<td>Reform the funding system to support new models of care and drive value to make better use of resources.</td>
</tr>
<tr>
<td>Strategic Action 8</td>
<td>Implement measures to address inequities in access to public acute hospital care based on the independent impact assessment.</td>
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<th>Goal 4</th>
<th>Enable the system to deliver its goals.</th>
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<tr>
<td>Strategic Action 9</td>
<td>Build a sustainable, resilient workforce that is supported and enabled to deliver the Sláintecare vision.</td>
</tr>
<tr>
<td>Strategic Action 10</td>
<td>Put in place a modern e-Health infrastructure and improve data, research and evaluation capabilities.</td>
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Progressing Sláintecare Oireachtas Report recommendations

Establishment of Sláintecare Programme Office, appointment of Executive Director & Chair of Advisory Council

Sláintecare Implementation Strategy published – focus on first three years – detailed action plan by Christmas 2018

Early priorities have been urgently progressed

Translating the Sláintecare vision into a new reality has meant moving forward on a number of fronts at once. Soon after the publication of the Sláintecare report, the Government put in motion a series of actions which are essential to implementing the Sláintecare vision. These included the


• Publication of legislation to reform the governance of the HSE, published July 2018, at first stage of the Seanad, HSE Board executive chair announced 18 September 2018

• A public consultation on the geographical alignment of Hospital Groups and Community Healthcare Organisations – awaiting a decision on geographic alignment...
‘Reform is already underway’

1. Reform that is happening anyway
2. Reform that is in the Oireachtas Sláintecare Report where action has been taken
3. Reform in the Oireachtas Report where no action has been taken

– Need to keep eye on Sláintecare vision
Critiquing Sláintecare Implementation Strategy through the Oireachtas Report lens, whole system/process approach
In Oireachtas Sláintecare Report

- Legislate for entitlement for all residents to health & social care & wait time guarantees
- Defines universal healthcare, defines the basket of care, all at no or low cost

In Sláintecare Implementation Strategy

- *Expand eligibility on a phased basis to move towards universal healthcare...* Our vision is that all citizens will have universal access to healthcare, in both acute and community settings... Enhancing eligibility is not simply a matter of reducing charges or expanding access to existing services. It also means considering what new or reformed services need to be provided on what basis. Eligibility expansion also has to take account of capacity constraints within the health system, the trade-offs between intensification of services to those currently eligible and broadening entitlement and improving financial protection. Careful analysis and policy development will be required to determine how universal eligibility can be achieved on a phased basis drawing on evidence to determine how best to achieve maximum impact at a population level

- The Sláintecare Vision is that a broad range of services will be universally available at low or no cost... that this be achieved on a gradual basis
**Sláintecare versus Sláintecare implementation Strategy**

**Integrated care**

In Oireachtas Sláintecare Report – a whole system approach, all care integrated at lowest level of complexity, in primary & community care (access to diagnostics), empowered patient, strong public health, eHealth, expanded integrated workforce

In Sláintecare Implementation Strategy: Separate strategic actions for community based care and hospital care, emphasis on interlinked actions

Alignment of CHOs & hospital groups

Regional integrated care structures restated, underpinned by legislation

Strong population health focus provides opportunity, eHealth, community diagnostics

Integrating corporate & clinical governance

New Integrated Care Fund to fund & accelerate existing Integrated Care Programmes & Clinical Programmes shown to be effective

Focus on pilots & new models of care rather than a whole system approach?
**Sláintecare versus Sláintecare implementation Strategy**

**Funding**

**Oireachtas Sláintecare Report**

- Bolstered Beveridge (+ ring-fenced) – a national health fund
- Transition fund
- Eliminate or reduce charges
- Removal of private care from public hospitals

**Sláintecare Implementation Strategy**

**Goal 3 – Ensure Health Service is Financially Sustainable**

- Emphasis on productivity and achieving value for money
- No national health fund, no recognition of household financially sustainability, little about eliminating or reducing charges just reviewing...
- De Buitléir work in progress, population based resource allocation model
- Action: ‘to design, establish and resource a multi-annual transition fund with appropriate governance to support the change process’; refers to National Development Plan
Oireachtas Sláintecare Report
Office to drive reform
Specific timelines & targets

Sláintecare Implementation Strategy

Goal 1: Deliver improved governance & sustain reform through a focus on implementation

Implementation ‘up front & centre’ with a structure map

Lacking the specifics & detail of Sláintecare in terms of targets, phasing, timelines, milestones & budget needed to deliver it
What’s new in Sláintecare Implementation Strategy

Detailed action plan to follow by December, commitment to biannual progress reports – ministerial accountability

Mandatory open disclosure

Governance framework that integrates clinical & corporate governance

Begins to dovetail what’s happening anyway with Sláintecare

Public engagement on health & well being

Workforce engagement plan

Citizen Care Master Plan
Sláintecare Implementation Strategy: snakes and ladders

- Backtracking on universalism/entitlement
- Pilots and ICF could undermine a whole system approach to integrated care
- Commitment to funding Sláintecare reform
- Routed in Sláintecare vision & principles
- Public health, community services, eHealth
- De Buitléir report, integrated governance, RA funding based on population need through Regional Integrated Care Structures
- Office & momentum to drive reform, action plan by Christmas, stakeholder engagement & Citizens Care plan....
Thank You