The PRESTO Report
Highlights

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Annual research seminar of the RESTORE project
29 March 2023
A unique collaboration

The PRESTO project is a unique collaboration between the RESTORE project and the PHSSR programme

PHSSR- Partnership for Health System Sustainability and Resilience

A multi-country rapid review of health systems led by the London School of Economics and Political Science, the World Economic Forum and a number of public and private partners.

No funding from private sector sources
The PRESTO Report

PRESTO Report Structure - 7 Domains

- Governance
- Finance
- Human Resources
- Service Delivery
- Medicines and Technology
- Population Health
- Environmental Sustainability

Case Study: Traveller Health

• Highlights
• Recommendations
Governance-COVID-19 Responses- the Positives

**Good Communication**

-Politicians and members of NPHET and HSE appeared regularly on national media and social media

-Daily press briefings with CMO and others from NPHET, HSE held weekly press briefings

**Timeliness**

-Ireland was rated among the strictest in the EU for reducing population mobility, indicating a relatively rapid response between March and May 2020

**Trust and support among stakeholders**

-High levels of public trust in science and NPHET

**Coordination of activities**

“The system was perhaps amazingly flexible when COVID [sic] hit and, for example, organising separate pathways for COVID [sic] and non-COVID [sic] patients happened almost overnight. The management of the limited facilities that were available was really well done.”
Challenges

- Initial slow expansion of the limited testing capacity, long waits for tests
- Failure to block travel from heavily infected regions earlier and late cancellations of public events
- Delayed decisions in mandatory face mask use
- The removal of restrictions and the opening up of society and international travel over Christmas 2020, leading to Ireland having the highest infection rate in the world in early January 2021

- Failure to support nursing homes, especially those run by voluntary and private providers
Going too far?
Do you think the reaction of the government to the current coronavirus outbreak is appropriate, too extreme or not sufficient?

Source: Amárach Public Opinion Tracker 2022
Annual Change in Real Current Government Health Expenditure per capita 2009-2021

Proportion of Total Health Funding from Different Sources

<table>
<thead>
<tr>
<th>Year</th>
<th>% Government Spending</th>
<th>% Voluntary Healthcare Payments</th>
<th>% Household Direct Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>12.8%</td>
<td>14.5%</td>
<td>72.7%</td>
</tr>
<tr>
<td>2017</td>
<td>12.6%</td>
<td>14.4%</td>
<td>73.0%</td>
</tr>
<tr>
<td>2018</td>
<td>12.0%</td>
<td>13.9%</td>
<td>74.1%</td>
</tr>
<tr>
<td>2019</td>
<td>11.7%</td>
<td>13.7%</td>
<td>74.6%</td>
</tr>
<tr>
<td>2020</td>
<td>10.0%</td>
<td>11.0%</td>
<td>79.0%</td>
</tr>
<tr>
<td>2021 Estimates</td>
<td>10.3%</td>
<td>11.3%</td>
<td>78.4%</td>
</tr>
</tbody>
</table>

Source: CSO 2022
Human Resources - Acute Versus Community WTEs

Source: Fleming et al. 2022

* includes 3390 staff from child and family services who were transferred out of the health service in 2014

Trinity College Dublin, The University of Dublin
## Human Resources - Turnover

### Table: Turnover Rates for Different Roles (2018-2022)

<table>
<thead>
<tr>
<th>Role</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>6.0%</td>
<td>5.9%</td>
<td>6.7%</td>
<td>10.2%</td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>6.5%</td>
<td>7.7%</td>
<td>6.8%</td>
<td>9.8%</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>6.5%</td>
<td>6.0%</td>
<td>6.4%</td>
<td>7.7%</td>
<td></td>
</tr>
<tr>
<td>HSCP</td>
<td>8.0%</td>
<td>8.1%</td>
<td>7.9%</td>
<td>9.6%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Man Admin</td>
<td>5.6%</td>
<td>4.6%</td>
<td>5.2%</td>
<td>5.3%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Gen Support</td>
<td>5.1%</td>
<td>4.6%</td>
<td>5.2%</td>
<td>6.0%</td>
<td>7.7%</td>
</tr>
<tr>
<td>PCC</td>
<td>4.8%</td>
<td>4.9%</td>
<td>7.7%</td>
<td>7.7%</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

**Source:** HSE 2022

### Bar Chart: Turnover Rates by Role and Year (2018-2022)

- **Total:**
  - 2018: 6.0%
  - 2019: 5.9%
  - 2020: 6.7%
  - 2021: 10.2%
  - 2022: (data not shown)

- **Medical:**
  - 2018: 6.5%
  - 2019: 7.7%
  - 2020: 6.8%
  - 2021: 9.8%

- **Nursing:**
  - 2018: 6.5%
  - 2019: 6.0%
  - 2020: 6.4%
  - 2021: 7.7%

- **HSCP:**
  - 2018: 8.0%
  - 2019: 8.1%
  - 2020: 7.9%
  - 2021: 9.6%
  - 2022: 12.6%

- **Man Admin:**
  - 2018: 5.6%
  - 2019: 4.6%
  - 2020: 5.2%
  - 2021: 5.3%
  - 2022: 7.4%

- **Gen Support:**
  - 2018: 5.1%
  - 2019: 4.6%
  - 2020: 5.2%
  - 2021: 6.0%
  - 2022: 7.7%

- **PCC:**
  - 2018: 4.8%
  - 2019: 4.9%
  - 2020: 7.7%
  - 2021: 7.7%
  - 2022: 6.8%

**Source:** HSE 2022
Service Delivery

Low Capacity Before COVID-19-Acute Sector

In 2019

- 2.9 Hospital Beds per 1,000 population, third lowest in the EU.
- 5 intensive care beds per 100,000 population, EU average is 12.9
- Ireland was one of only four out of 27 OECD countries with an acute care bed occupancy rate above 85%
  (Ireland average 89.9%, OECD average 76.2%)

Source: OECD Health Statistics
Service Delivery

Increasing capacity during COVID-19 – Critical Care Beds

- In March 2020, Ireland had 256 critical care beds
- Reached 348 critical care beds (increase of 36%) and reached 95% occupancy in Jan 2021

ICU Bed Information System (BIS) provided real-time data and information on trends for decision-makers in the HSE and Department of Health.

Measures Taken

- Suspending non-urgent care
- Designating more spaces to critical care
- Redeploying staff to ICU from other duties (with upskilling and clinical support for staff in these roles) and
- Transferring patients to private hospitals

The Mobile Intensive Care Ambulance Service (MICAS) transferred 129% more patients in the first quarter of 2021 than in the same quarter in 2019.

Source: Dwyer, R., et al. (2021)
E-Health Strategy for Ireland

- Progress during COVID-19: Individual Health Identifiers (IHIs) and ↑ Telemedicine
- Many of the objectives set out in the 2013 eHealth Ireland strategy have still not been achieved

Electronic Health Records

- Ireland currently has no universal electronic health record system
- Siloed IT solutions across the system with EHRs only in specific populations or systems

- In 2021, approx. 0.8% of the public health budget was spent on e-health and health technologies, compared to a spend of up to 3% in peer countries
Recommendations

GOVERNANCE AND REFORM

• Invest in **enhancing public trust by building on the successes of the response to the COVID-19 pandemic to co-produce** a vision of the implementation and realisation of Sláintecare operating as a universal health care system.

WORKFORCE AND RESOURCING

• Prioritise workforce planning for Sláintecare and **new models of care in primary and community settings**. Enhance career opportunities and progression within primary care and community care to **offer competitive alternatives to well-established acute services**.
Recommendations

SERVICE DELIVERY

• Maintain the increased use of telemedicine and virtual clinics for patient care, where appropriate.

• Establish more appropriate pathways to access care outside of emergency departments.

• Prioritise reducing waiting lists and shortening waiting times through enhanced funding for buying care for long waits, enhanced capacity and improved information systems and accountability for both providers and the public.

MEDICINES AND TECHNOLOGY

• Increase the proportion of the health budget that goes towards health information systems and health technologies to at least 3%.
Preparedness for Future Shocks

- Review governance protocols and scenario planning for future shocks and invest in the development of these and back-up systems, alongside mechanisms for making available finances for fast deployment.

- Evaluate flexibility of workforce deployment and infrastructure for future shocks.

- Evaluate how day and night respite services and community care could be better protected in future pandemics.
Recommendations

PREPAREDNESS FOR FUTURE SHOCKS-COST OF LIVING CRISIS

• Evaluate health care system **readiness for renewed austerity** in health care.

• Revisit lessons from the austerity era (2008–2013) and assess **likely areas of impact** for the health care service, given a cost-of-living crisis.

• **Secure financial protection** of health care services and health facilities from cost hikes (e.g., extra funds for energy, fuel, etc.)

• Consider **dropping access costs/implementing free health care** to preserve access to health care during a cost-of-living crisis.