Rialtas na hÉireann
Government of Ireland

Business Case for the Implementation of Regional Health Areas (RHAs)

DEPARTMENT OF HEALTH

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Contents

Summary

At present, the public system's health and social care is largely provided through seven Hospital Groups, and nine Community Healthcare Organisations (CHOs). These delivery systems do not overlap in terms of management, geographies, clinical governance, or budgets. They are independent delivery structures which operate separately.

This means that decisions are made along organisational lines, as opposed to in line with population requirement. Currently, the HSE structures divide governance and funding along acute and community sector lines, with separate and distinct management and accountability arrangements. The governance divide between acute and community services is a significant barrier to implementing integrated acute and community care, leading to a fragmented experience of care for patients.

In terms of the direct impact on patients, this can lead to a gap in service when transitioning from acute to community services (or vice versa). This exacerbates problems such as delayed discharge from hospitals to community settings which, in turn, impact on Emergency Department waiting times and the organisation of scheduled care. It also means that services offered in their localities are not planned and funded in a way that takes account of the needs of their communities.

The current clinical and corporate governance arrangements inhibit the transparent delivery of integrated care that is planned and funded in line with identified population needs. As it stands, population-based planning is impracticable, clinical governance between care settings is unclear, budget transparency is not possible and diverse corporate, IT and management systems provide bureaucratic blocks to a more seamless patient experience.

The implementation of six new Regional Health Areas (RHAs) will help to align community and acute services and enable population-based resource allocation and governance to better provide integrated care. Restructuring health delivery structures along regional lines will help with the streamlining of multiple corporate and clinical governance lines, provide one budget per regional population, and allow for a joined-up integrated care service with six regional management systems, as opposed to the sixteen that are currently in place across Hospital Groups and CHOs.

The existence of one management structure per region, with their own budgets, would help to deliver more accountable and transparent corporate governance and greater efficiency and innovation at the local level. This model would also provide a clearer population-based framework to inform service planning and performance assessment on a regional basis.

The implementation of RHAs is envisaged to take place within the context of a strong, lean, national centre and that the Sláintecare approach is based on "devolved responsibility for the provision of services in accordance with national policy"[1].

Government Decision

The commitment to establish RHAs was first outlined in the Oireachtas Committee on the Future of Healthcare - Sláintecare Report 2017. It was reaffirmed in the Sláintecare

[1] House of the Oireachtas (May 2017) *Oireachtas Committee on the Future of Healthcare – Sláintecare Report, page 84.* Available at: https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf

Implementation Strategy[2] and Action Plan 2019[3], the Sláintecare Action Plan 2021-2023[4], the HSE Corporate Plan 2021-2024[5], and the Department of Health's Statement of Strategy 2021-2023[6]. As well as approving the geographies of six new regional health areas, the Government decision of July 2019 directed the development of a detailed business case and change-management programme outlining proposals for HSE reconfiguration to align with the regional geographies. The Programme for Government 2020 committed to bring forward detailed proposals on the six regional health areas to enable delivery of local services for patients that are safe, of high quality, and fairly distributed.

[2]Government of Ireland (2019) *Sláintecare Implementation Strategy 2019*. Available at: https://assets.gov.ie/9914/3b6c2faf7ba34bb1a0e854cfa3f9b5ea.pdf

[3] Government of Ireland (2019) *Sláintecare Action Plan 2019.* Available at: https://assets.gov.ie/22606/4e13c790cf31463491c2e878212e3c29.pdf

[4] Government of Ireland (June 2021) *Sláintecare Implementation Strategy & Action Plan 2021 — 2023*. Available at: https://www.gov.ie/en/publication/6996b-slaintecare-implementation-strategy-and-action-plan-2021-2023/

[5] HSE (2021) *HSE Corporate Plan 2021-24.* Available at: https://www.hse.ie/eng/services/publications/corporate/hse-corporate-plan-2021-24.pdf

[6] Government of Ireland (June 2021) *Department of Health Statement of Strategy 2021-2023*. Available at: https://www.gov.ie/en/organisation-information/0fd9c-department-of-health-statement-of-strategy-2021-2023/

This business case considers two different potential models of regionalisation that could meet the objectives of the Sláintecare vision. Here, 'models' refer to descriptions of what new health structures would look like under different scenarios of regionalisation. These model options were developed and refined with input from Department of Health officials and following consultation with clinicians, patient representatives, and HSE staff.

The two models considered are termed 'HSE-Local Model', and the 'Separation Model'.

HSE-Local Model

In this model option, RHAs are set up administratively within the HSE structure. That is, RHAs are regional divisions of the HSE.

- Six RHAs are geographically aligned regional integrated sub-divisions of the HSE which replace the nine CHOs, six Hospital Groups (excluding children's health Ireland), and other existing reporting structures
- Provides regional management authority and accountability
- One population-based budget per region
- RHAs do not have a board
- No legal change required
- The HSE remains the employer
- One leader per RHA
- A strong, HSE centre for national programmes and standards-setting

Separation Model

In this model, RHAs are legally separate organisations.

- Six legally separate RHAs, relationship with the HSE largely contractual (funding/targets/outcomes, etc. set out in contracts)
- Provides regional management authority and accountability
- One population-based budget per region
- Each RHA has their own board, accountable to the HSE board
- RHAs are employers
- A strong, leaner HSE centre for national programmes and standards-setting

Multi-criteria analysis (MCA) methodology[7] was used to appraise the options. In the RHA MCA, two separate streams were developed simultaneously: one developing the alternative proposed models of regionalisation for consideration (as previously detailed), and the second developing the evaluation criteria, against which to consider the alternative models. As well as comparing the two models against each other, a 'no change' option was included in the analysis to test the case for change.

The completion of the MCA process found that the two proposed models clearly outperformed the 'no change scenario' across all sub-criteria except in the 'Feasibility of Implementation' criteria category. The HSE-Local Model and the Separation Model performed similarly in the first three criteria categories of 'Corporate Governance', 'Clinical Governance', and 'Population-Based Funding', 'Service Planning', and 'Integrated Service Delivery'. However, the

[7] Multi-criteria analysis (MCA) is a decision-making methodology which provides a systematic approach to making complex decisions according to pre-determined criteria and objectives. MCA is suitable for complex decision problems that involve multiple objectives and criteria

HSE-Local Model performed substantially better than the Separation Model in the 'Feasibility of Implementation' criteria category.

Therefore, this business case recommends that the HSE-Local model of regionalisation be the approved approach. Doing so provides a means to improve clinical and corporate governance, enables population-based health service planning, and facilitates the integration of acute and community care. This option is considered the most feasible and least disruptive option to delivering on comprehensive reform of health service structures. In the development of a strengthened national health and social care service delivering integrated person-centred care at regional level, it is acknowledged that, while appropriate structures are important, incentives, culture and leadership are also vital elements of the overall reform programme.

Next Steps

The scale of change required to give life to the new regional arrangements - as well as the associated further changes that will be required to the HSE Centre and to the Department itself - are significant. It will require careful and comprehensive design, planning and implementation if the desired objectives from regionalisation are to be fully achieved and the current operations at regional or national level are not destabilised during the transition process. Engagement with key stakeholders at all stages of the process will be prioritised to ensure the broad range of interests are considered.

In line with newly established governance structures for Sláintecare implementation, the Department of Health and the HSE will build on the work set out in this business case and progress the development and implementation of a clear plan for regionalisation with input from the RHA Advisory Group. All health and social care services, networks, and existing structures will be integrated within the regional structures, starting with the new public health teams. The new 96 Community Healthcare Networks (CHNs) are already being established based on the six RHAs. The Sláintecare Programme Board and HSE Board will play central roles in terms of oversight of the planning and implementation of RHAs and the stepping down of CHOs and Hospital Groups.

An implementation plan which will include the detailed design will now be developed based on the agreed model of reorganisation as approved by Government. **This plan is due for publication in Q4 2022**. This implementation plan will be centred around a number of interdependent workstreams. Currently, the seven workstreams include:

Programme Coordination

The implementation plan will consider the **programme design, management, and central coordination** of the overall RHA implementation. This will include designing the programme timeline and monitoring progress as well as managing, escalating, and mitigating key decisions and risks. Ways of measuring impact and implementation in the short, medium, and long term will also be considered as part of this workstream.

Corporate and Clinical Governance and Accountability

The implementation plan will review **organisation design** in order to reform the organisational, clinical and corporate governance and accountability lines. This will consider the complex health and social care system that includes multiple care delivery organisations and seek to reduce existing management layers, creating a flatter structure to support responsive decision-making on the ground. It will also place a greater focus on health outcomes measurement as a

mechanism for assessing performance through the Health Systems Performance Assessment (HSPA) Framework[8] in the long term.

Population-Based Resource Allocation

The completion of **population-based profiling** and the design of the **resource allocation model** to determine how resources are allocated to each RHA will be key. The implementation plan will examine the current allocation of resources to each RHA including budget, staff, and infrastructure and will produce reports on these in the current year.

Finance

The implementation plan will review the current **budgeting and financial management process and detail new processes** to set up RHAs as operational delivery units to enable service planning and funding. In order to **enable population-based approaches**, new financial reporting structures are required, as well as ensuring that financial management systems are fit for purpose. In this regard, the rollout of the Integrated Financial Management System is takes into account the move to RHAs. In addition to population-based funding, activity-based funding will also be progressed to facilitate services provided nationally and between regions.

Digital and Capital Infrastructure

The implementation plan will ensure alignment with the refreshing of the eHealth strategy. The move to RHAs is being coordinated with the introduction of strategic frameworks for the evaluation of current and future **capital infrastructure and IT requirements**.

People and Development

The implementation plan will **assess and plan for what and where our current and future staffing needs** and associated **training requirements** are as we transition to RHAs. This will involve new and improved ways of working and new reporting structures, with HR and industrial relations issues being taken into consideration.

Change, Communications and Culture

It will be crucial to **communicate the high-level vision** and specific benefits of Regional Health Areas to all stakeholders involved, so that their views contribute to a shared sense of destination and understanding of why these changes are crucial to strengthening and supporting our health and social care services, staff, and service users. The detailed design phase and implementation planning will itself benefit from stakeholder engagement and this will be an important and ongoing feature of the move to RHAs. The implementation plan will set out the required **change management approach** and **stakeholder engagements** and will focus in particular on establishing relationships with local leadership and supporting the transition to RHAs. This will include workshops with Hospital Groups, Community Healthcare Organisations, Community Healthcare Networks, the Voluntary Dialogue Forum, patients, and other stakeholders following the Government decision among other planned engagements.

In light of the transfer of policy and funding responsibility for specialised community-based disability services from the Department of Health to the Department of Children, Equality,

[8] The purpose of the Health System Performance Assessment (HSPA) framework is to provide a reliable framework for assessing the performance of the health system as a whole with measurable and quantifiable outcomes-based indicators which can be linked to relevant health policies and strategies (including Sláintecare).
Department of Health (2021) *Health System Performance Assessment (HSPA) Framework*. Available at: www.gov.ie/en/publication/6660a-health-system-performance-assessment-hspa-framework/

Disability, Integration and Youth (DCEDIY), DCEDIY will also be represented on the RHA Implementation Team to ensure the inclusion and alignment of disability services regionally.

Rationale for Change

The implementation of the six RHAs is required to provide geographic alignment between community and acute services and to enable an appropriately devolved operational service delivery framework.

This framework will be capable of providing greater clarity of clinical and corporate governance. It will also enable a health and social care service that is capable of being planned around the needs of the populations of the six RHAs.

At present, the public system's health and social care is largely provided through seven Hospital Groups, and nine Community Healthcare Organisations (CHOs). These delivery systems do not overlap in terms of management, geographies, clinical oversight, or budgets. They are independent delivery structures, which operate separately.

The current clinical and corporate governance systems inhibit the transparent delivery of integrated care that is planned and funded in line with identified population needs. Population-based planning is currently impracticable, clinical governance between care settings is unclear, budget transparency is not possible, and diverse corporate, IT and management systems provide bureaucratic blocks to a more seamless patient experience.

This means that decisions are made along organisational lines, as opposed to in line with population requirement[9]. In terms of direct impact on patients, this can lead to a gap in service when transitioning from acute to community services (or vice versa). It also means that services offered in their localities are not always planned and funded in a way that takes evidence of the needs of their communities into account.

Restructuring health delivery structures along regional lines will help to address this problem. It will allow for the streamlining of multiple corporate and clinical governance lines, provide one budget per regional population, and allow for a joined-up integrated care service with six regional management systems, as opposed to the sixteen that are currently in place.

National Centre and National Services

It is important to acknowledge that implementation of the regions is envisaged to take place within the context of a strong, lean, national centre and that the Sláintecare approach is based on "devolved responsibility for the provision of services in accordance with national policy" [10].

It is proposed that the HSE strategic national centre would support regional care delivery. It is envisaged that the HSE centre would continue to serve as a focal point for providing certain services across the country, particularly those services where it is determined that it would not be efficient to devolve them to RHAs, as, for example, in the case of highly specialised services.

The HSE would also serve a national coordination function as well as a focal point for ensuring the implementation of national health policy. The HSE would also have a role in ensuring consistency in the services provided. This should be achieved via the use of nationally set standardised quality and safety guidelines and audits.

[9] Government of Ireland (June 2021) *Sláintecare Implementation Strategy & Action Plan 2021 — 2023.* Available at: https://www.gov.ie/en/publication/6996b-slaintecare-implementation-strategy-and-action-plan-2021-2023/

[10] House of the Oireachtas (May 2017) *Oireachtas Committee on the Future of Healthcare – Sláintecare Report, page 84.* Available at: https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf

The implementation of RHAs must strike the right balance of regional autonomy and national consistency. This is vital to ensure that there is equity within, and between, regions and that patients can access the high-quality services regardless of the region in which they reside.

The need for this balance has been further reinforced by our national experience during the COVID-19 pandemic, where the HSE served a key role in coordinating and delivering the national response. The nationally consistent approach taken during the pandemic shows the value of continuing to have a strong, lean, national centre. This can be complemented by regional entities that deliver services closer to people's homes and in line with local population needs.

Corporate Governance and Accountability

There have been many revisions of our health and social care system. Many legacy structures or remnants of previous structures still exist. This adds to the complexity of identifying lines of accountability and enabling swift and effective decision-making. In its current form, the health and social care system's delivery structures can be difficult to navigate. There are multiple management layers in the current structure and substantial duplication of administrative effort, for example, with different accounting, information, and IT systems. Corporate governance lines are not always clear and transparent. For example, Hospital Group boards did not have a direct line of accountability to the HSE Board and community care services are managed separately to hospital care services. These disconnects lead to frequent blockages in patient referrals for diagnostics and in patient referrals to care in a more appropriate setting

Reducing the distance from the health service planner/decision maker to the frontline is key. Establishing RHAs must not add layers of additional bureaucracy or administration to the health and social care system.

A single budget per region, with one management structure per region, would enable accountable and transparent corporate governance and provide a clearer population-based framework to inform service planning and performance assessment on a regional basis.

Clinical Governance

Clinical governance is recognised as an important component of ensuring the quality and safety of health and social care in Ireland and many core elements of clinical governance exist in our health and social care services. Clinical governance can be defined as:

> *the set of relationships and responsibilities established by a health service organisation between its state or territory department of health (for the public sector), governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes [....] It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, integrated, high quality and continuously improving.*[11]

[11] Australian Commission on Safety and Quality in Healthcare (2017): *National Model Clinical Governance Framework, page1-2*, Available at: https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Model-Clinical-Governance-Framework.pdf

The Sláintecare Report stresses that "a clinical governance framework should ensure that the highest level of authority for the organisation has a clear line of accountability down to the individual patient. This requires that structures and processes be in place to achieve this" .[12]

Clinical governance has evolved in Ireland in an unstructured fashion. There is a lack of legislative underpinning and clarity in relation to authority, responsibilities, and accountabilities across and between health service management and senior clinical leaders.

The absence of evolved clinical governance structures in many community services– and the complexity of those clinical governance structures with GPs within the constraints of the current contract – will be considered within the context of the introduction of RHAs.

A key objective of regionalisation involves facilitating clarity and linkage of clinical governance pathways between the community and acute sectors, ensuring that clinical governance is clear at points where a patient's care transitions between primary, community and acute care settings.

Population-Based Planning

In parallel with the demographic pressures emerging across the country, there is evidence of geographic differences in health and social care needs[13]. Historically, decisions on what health and social care services are to be provided, and the allocation of budgets on an annual basis, have been decided based upon proposals from hospital institutions or community settings, rather than being decided based on a strategic analysis of a regional population's need.

A population-based approach to service planning and funding will provide a model of funding and service delivery aligned with identified population needs for health and social care.

Without this approach, it will remain a challenge to deliver a proactive, population-focused service delivery centred on key outcomes for identified groups/defined populations. Population-based service planning and delivery provides the basis for a more responsive and coordinated approach, supporting improvements of patients' experiences of care. Population-based funding allocates resources according to identified populations' need for healthcare, promoting equity in access to services. It can create a greater degree of certainty in health spending.

Ability to Make Innovative, Timely Locally-Driven Decisions

Most often, local service providers have the most comprehensive knowledge of the current needs of the populations they serve. Increased decision-making closer to the ground can lead to innovations in service delivery through experimentation and adaptation to local conditions.[14] This was particularly evident in the response of locally-planned projects to COVID-19 where such projects pivoted and adapted their services in line with the immediate needs and concerns of their patients.[15]

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[12] House of the Oireachtas (May 2017) *Oireachtas Committee on the Future of Healthcare – Sláintecare Report.* Available at: https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/committee_on_the_future_of_healthcare/reports/2017/2017-05-30_slaintecare-report_en.pdf

[13] Smith et al. (2019) *Geographic Profile of Healthcare Needs and Non-Acute Healthcare Supply in Ireland*. ESRI.ie. Available at: https://www.esri.ie/pubs/RS90.pdf

[14] Saltman, RB., Bankauskaite, V., Vrangbaek, K., (Eds). (2007) *Decentralization in health care (European Observatory on Health Systems and Policy).* euro.who.int. Available at: http://www.euro.who.int/__data/assets/pdf_file/0004/98275/E89891.pdf http://www.euro.who.int/__data/assets/pdf_file/0004/98275/E89891.pdf

[15] Department of Health (October 2021) *Sláintecare In Action.* Available at: https://www.gov.ie/en/publication/ca8a1d-slaintecare-in-action/

While the pre-2005 Health Board system provided local flexibility and responsiveness, there were issues of significant duplication and variability from region to region. There was a limited ability to ensure joined-up strategy and common standards, which the creation of the HSE and the HSE Board has begun to address.

RHAs will aim to facilitate a patient-centric, community-first model of service delivery where:

- community services are patients' first port of call over an acute setting;
- health and social care professionals are supported to treat patients effectively in the lowest acuity settings possible; and
- community-based health and social care professionals have access to specialist advice where necessary.

The ability to make timely, locally-driven decisions in each region will enable health and social care professionals to ensure that care can be provided at the lowest level of complexity.

Integrated care

Currently, the HSE structures divide governance and funding along acute and community sector lines. The governance divide between acute and community services is a significant barrier to implementing integrated acute and community care, leading to a fragmented experience of care for patients.

While structural changes alone will not ensure the delivery of seamless integrated care, regionalisation will provide a single management structure at regional level with responsibility across community and acute care, with an overall budget per region and with a better information base to support population-based decision-making at the local level.

Allocative Efficiency

As argued by The King's Fund (2013, p. 5):[16]

> *the ability to look at overall expenditure for defined populations and user groups and to use budgets flexibly is one of the hallmarks of integrated care. This is important in enabling commissioners and integrated or multidisciplinary teams to allocate resources efficiently and ensure that needs are met in the most appropriate and cost-effective way.*

Population-based resource allocation by region is funding allocation that better understands and matches demand, which will in turn provide greater predictability in health care expenditure.

The integration of funding and decision-making in community and acute care can lead to allocative efficiency.[17]

[16] Ham, C. & Walsh, N. (March 2013) *Making integrated care happen at scale and pace.* The King's Fund. Available at: https://www.kingsfund.org.uk/publications/making-integrated-care-happen-scale-and-pace

[17] World Health Organization (2017) *How to make sense of health system efficiency comparisons?* https://www.euro.who.int/__data/assets/pdf_file/0005/362912/policy-brief-27-eng.pdf
Allocative efficiency can be used to scrutinize either the choice of outputs or the choice of inputs. On the output side, it examines whether limited resources are directed towards producing the 'correct' mix of health care outputs.

Objectives

The vision of the RHAs is to facilitate comprehensive integrated, person-led, community-first health and social care through the alignment of acute and community-based services. This includes aligning corporate and clinical governance, within a strong national context, and aims to enable better performance assessment of the health service. RHAs will support population-based service planning, the integration of community and acute care, and will empower local decision-making.

RHAs will enable an alignment of services where:

- patients and staff feel safe, supported, and well-informed at all points in their care journey;
- care is provided as close to home as possible; and
- health and social care services are planned and funded around the needs of the population.

RHAs involve the full alignment and better integration of health and social care services within each specific region. This is a key component of how the HSE will organise and deliver integrated health and social care services into the future.

The objectives of regionalisation are aligned with Sláintecare's overall aims and objectives and are intended to be achievable within three years of RHA implementation:

- Increase the integration of community and acute Services
- Improve corporate governance and accountability
- Improve clinical governance
- Introduce a population-based approach to service planning

Corporate Governance and Accountability

The DoH, the HSE, and RHAs will have a streamlined, clear and shared understanding of the roles and responsibilities of the corporate governance structures governing our health service. This will be observed via published corporate governance structures and a streamlined performance assessment process. This will also result in greater predictability of health budget expenditure and more defined health outcomes linked to health expenditure. This will support the HSE Board in carrying out their oversight responsibilities to ensure efficiency, effectiveness, and equity in the health and social care system.

Clinical Governance

Clinical governance structures will be clearly defined and supportive of safe, effective, and high-quality care. Waiting lists targets will be examined on a person-centred basis by multi-disciplinary teams within each region to support effective service delivery and coordination across the various clinical settings. This can be supported by the adoption of measures such as early warning systems and clinical handover protocols at patients' transitions of care.

Population-Based Approach to Service Planning

The DoH, the HSE, and RHAs will have an agreed, articulated process to service planning that can be applied to the unique needs of each region, within a national context. This process will have defined roles and responsibilities for the regional and national administrative entities. This process will incorporate population needs into service planning and will also inform the

development and implementation of a population-based resource allocation model for funding across regional and national services. A population-based approach to resource allocation will promote equity in access to health services between, and within, regions by distributing resources according to population need.

Integration of Community and Acute Services

Models of care and referral pathways will be integrated among hospital, community, and social care sectors within the same geographical area. We will be able to observe increased communication and interaction between the community and hospital sectors. Patients will experience more continuity of care when moving from sector to sector. The integration of services will be actively progressed and evaluated as part of the Health Systems Performance Assessment (HSPA) Framework[18] via metrics such as readmission rates, waiting times, and patient experience scores at transitions of care.

[18] The purpose of the Health System Performance Assessment (HSPA) framework is to provide a reliable framework for assessing the performance of the health system as a whole with measurable and quantifiable outcomes-based indicators which can be linked to relevant health policies and strategies (including Sláintecare).
Department of Health (2021) *Health System Performance Assessment (HSPA) Framework*. Available at: www.gov.ie/en/publication/6660a-health-system-performance-assessment-hspa-framework/

Demand Analysis

When considering the implementation of RHAs as new healthcare delivery structures, it is necessary to understand the current and future trajectory of demand for health and social care within the Irish population. It is also important to consider the likely role that the reform will have in enabling increased primary and community care activity, which will in turn impact on demand. What follows is an overview of available evidence on the current trajectory of demand and expenditure of the Irish healthcare system, and a note on the impact that increased primary and community care activity can have on demand as well as the associated expenditure.

Projected Demand and Expenditure – No Policy Change Scenario

Through the Joint Research Programme in Healthcare Reform with the DoH, the ESRI has projected medium-term demand and current expenditure for acute hospital services, primary, community, and long-term care under the current health system structure[19,20,21]. Compared with 2015 levels, demand is projected to increase across effectively all health and social care sectors out to 2030, with largest increases in services for older people (e.g. nursing home residents and home care support)[22]. These projections reflect the impact of a growing and ageing population on healthcare demand. Compared with 2018 levels, by 2035, the population is projected to increase by 920,000 and the population aged 65 or older will grow from being one in seven in 2018, to being one in five in 2035. As morbidity tends to increase at older ages, these demographic changes will put more pressure on our health and social care services.

As a result of this growth in demand due to a growing and ageing population and in addition to increasing costs of care delivery, significant increases in expenditure will be required to fund public acute hospital care and to invest in primary, community, and long-term care. The ESRI project nominal expenditure requirement for:

- Public acute hospital care of between €10.8bn and €14.4bn by 2035, compared to expenditure of €5.9bn in 2018. This implies an expenditure increase of between 3.6% and 5.4% on average per annum;
- Public and private general practice of between €1.6bn and €2bn in 2035. This implies a 2.9% - 4.5% average annual expenditure increase;
- Public and private long-term residential care of between €3.8bn and €5.7bn in 2035. This implies a 4.3% - 6.9% average annual expenditure increase;
- Public and private home support of between €1.2bn and €3.0bn in 2035. This implies a 4.4% - 10.4% average annual increase. Likely increases in demand following the establishment of a statutory home support scheme is the key driver of projected expenditure growth.

[19] Wren, M.-A., Keegan, C., Walsh, B., Bergin, A., Eighan, J., Brick, A., Connolly, S., Watson, D., & Banks,J. (2017) *Projections of demand for healthcare in Ireland, 2015-2030. First report from the HIPPOCRATES model.* (Research series no. 67). Economic and Social Research Institute.
[20] Keegan C., Brick A., Bergin A., Wren M-A., Henry E., Whyte R. (2020) *Projections of expenditure for public hospitals in Ireland, 2018-2035, based on the HIPPOCRATES model.* ESRI Research Series No. 117.
[21] Walsh B., Keegan C., Brick A., Connolly S., Bergin A., Wren M-A., Lyons S., Hill L., Smith S. (2020) *Projections of expenditure for primary, community and long-term care in Ireland, 2019-2035, based on the HIPPOCRATES model.* ESRI Research Series No. 126.
[22] Wren, M.A., C. Keegan, B. Walsh, A. Bergin, J. Eighan, A. Brick, S. Connolly, D. Watson and J. Banks (2017) *Projections of Demand for Healthcare in Ireland, 2015-2030. First Report from the Hippocrates Model.* ESRI Research Series No. 67. Economic and Social Research Institute Dublin.

Addressing Inefficiencies and Inequity with Improved Community Service Provision

The implementation of RHAs provides the basis for geographically aligning community and hospital services to enable integrated care and for increasing the provision of care in the community by allowing for a population-based approach to service planning and resource allocation.

Inefficiencies in the current system are evident. The ESRI[23] shows that expenditure savings could be made if avoidable hospitalisations for certain conditions, where there is strong evidence for cost-effective community treatment or prevention, were reduced. ESRI research[24] also indicates that increased supply of community care for older people in the form of home care and long-term residential care services can reduce hospital length of stay. The intention is that this expansion of community care - which has been prioritised over recent years - will be able to be more effectively deployed when operated in alignment with acute care under regional management structures. Increasing home care support supply to realise unmet demand would likely lead to an increase in expenditure, but an increase in supply could also enable substitution of long-term care in favour of home care support, realising savings for long-term residential care expenditure[25].

Research[26] shows that unmet demand for primary healthcare services in Ireland exists, relating in part to cost issues from out-of-pocket payments for GP care as well as geographical inequalities in the supply of non-acute healthcare. ESRI research[27] shows that large inequalities exist in the supply of non-acute healthcare services, which is likely attributable in part to differences in population growth across areas of the country[28]. The health service's capacity to address these inequalities will be improved through the introduction of a population-based resource allocation model that distributes funding to meet the needs of the population.

Greater supply of healthcare tends to lead to increased demand[29] and the introduction of universal GP care would likely lead to an increase in demand and public expenditure. However, there is also evidence indicating that improved access to GP care has the potential to reduce hospital admissions of avoidable conditions[30]. In addition, and most importantly, a greater supply of primary healthcare and community care services is associated with better health outcomes[31, 32].

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[23] Keegan C., Brick A., Bergin A., Wren M-A., Henry E., Whyte R. (2020) *Projections of expenditure for public hospitals in Ireland, 2018-2035, based on the HIPPOCRATES model.* ESRI Research Series No. 117.

[24] Walsh, B., M.-A. Wren, S. Smith, S. Lyons, J. Eighan and E. Morgenroth (2019) *An Analysis of the Effects on Irish Hospital Care of the Supply of Care Inside and Outside the Hospital.* ESRI Research Series No. 91.

[25] Walsh B., Keegan C., Brick A., Connolly S., Bergin A., Wren M-A., Lyons S., Hill L., Smith S. (2020) *Projections of expenditure for primary, community and long-term care in Ireland, 2019-2035, based on the HIPPOCRATES model.* ESRI Research Series No. 126.

[26] Wren, M.A., C. Keegan, B. Walsh, A. Bergin, J. Eighan, A. Brick, S. Connolly, D. Watson and J. Banks (2017) *Projections of Demand for Healthcare in Ireland, 2015-2030. First Report from the Hippocrates Model.* ESRI Research Series No. 67. Economic and Social Research Institute Dublin.

[27] Smith S., Walsh B., Wren M-A., Barron S., Morgenroth E., Eighan J. & Lyons S. (2019) *Geographical profile of healthcare needs and non-acute healthcare supply in Ireland.* ESRI Research Series No. 90.

[28] See supporting documentation for more detail.

[29] The *King's Fund (2013) Improving the allocation of health resources in England: How to decide who gets what.*

[30] *Nolan N. (2009) Eligibility for Free Primary Care and Avoidable Hospitalisations in Ireland.* ERSI Working Paper No. 296.

[31] OECD (2020) *Realising the Potential of Primary Health Care: Chapter 3 - More effective and patient-centred care*. Available at: https://bit.ly/3GIKgen

[32] See supporting documentation for more detail.

Decentralisation and Health Care System Performance

In what is considered a highly explored area, recent analysis carried out by OECD economists found that, with moderate decentralisation, public spending in health care is lower, while life expectancy is higher, when compared with more centralised systems. However, they also found that in highly decentralised systems, public spending is higher and life expectancy is lower than moderately decentralised systems. In fact, the worst cost and quality outcomes are observed in health care systems that are 'excessively' decentralised. It is argued that this finding of a 'an interlocking U-shaped relationship' (or 'fish-shaped' relationship) with respect to health care expenditure and life expectancy also helps to understand recent reforms of OECD health systems, which have often reverted towards more moderate degrees of administrative decentralisation[33].

This supports the theory that decentralisation may allow for health systems to better target regional needs, while fostering good competition[34]. However, at the same time, taken too far, it can lead to fragmentation and excessively high costs[35]. It is important to note that, in this analysis, Ireland was found to be one of the most centralised health care systems in the OECD.

[33] Dougherty, Sean & Lorenzoni, Luca & Marino, Alberto & Murtin, Fabrice. (2021). *The impact of decentralisation on the performance of health care systems: a non-linear relationship.* The European Journal of Health Economics. https://doi.org/10.1007/s10198-021-01390-1

[34] Oates, (1999) & Weingast (2009) in Dougherty et. al (2021)

[35] Rodden (2003) in Dougherty et al (2021)

The Selection Process: Options Development and Evaluation Criteria

Model Options Development

Different potential models of reorganisation were considered in order to meet the objectives set out thus far. Here, 'models', refer to descriptions of what new health structures would look like under different scenarios of regionalisation.

A long list of five model options was initially considered which included a Health Maintenance Organisation (HMO)[36] model, a Legislative/Separation Model, an HSE-Local Model, a Subsidiary Model, and a No Change Model. This No Change model was developed and included to make the case for change. These models were developed and refined with input from DoH officials and following conversations with clinicians, patient representatives, and HSE staff. In some instances, models were determined to be unworkable early on in the process and were not fully developed. Department of Public Reform and Expenditure officials were also consulted in the early stages of model development on the general direction of development. The models differ in terms of scale of autonomy, reporting, and delegation of functions, legal basis, and accountability, among other characteristics.

Stakeholder Interviews

Structured interviews were held with a sample of health and social system stakeholders to identify areas in need of improvement and/or optimisation that might not otherwise be apparent. Over 25 hours of informal interviews were conducted with a sample of approximately 20 patients, parents, members of the Traveller community, primary care clinicians and hospital-based Allied Health Professionals (AHPs), HSE managers and community workers, trade union workers, administrative staff, and DoH staff.

Inputs received from the interviews were used to map user journeys and record experiences of the current health and social care system under a number of key headings:

- Clinical Governance
- Corporate Governance and Accountability
- Integration of Care
- Population-Based Service Planning/Funding Allocation

The main themes and recommendations of these interviews were then anonymised and collated in an effort to draw connections among the various sectors and patient experiences. Along with lessons learned from international experiences of regionalisation and of previous Irish sector reforms, these themes inform the core requirements for the implementation of RHAs.

[36] A Health Maintenance Organisation model is a type of managed care health insurance plan that features a network of healthcare providers that serve a patient population at a prepaid cost.
Falkson.S.R, Srinivasan V.N. (March 2021) *Health Maintenance Organisation.* Available at: https://www.ncbi.nlm.nih.gov/books/NBK554454/

Model Options

Model One: No Change

In this model, there is no change from current status quo, that is, the continuation of the HSE national service plans aligned with the principles set out in Sláintecare, without realigned regionalised structures, neither administrative nor legal. Community healthcare organisations and Hospital Groups continue to function with misaligned geographies and separate governance lines:

- All core functions remain with the HSE
- The HSE has its own board
- No legal change required: nine CHOs, six Hospital Groups (excluding Children's Health Ireland), and other reporting structures remain under the HSE
- CHOs and Hospital Groups are not geographically aligned

Corporate Functions

No change from current status quo. That is, there are no RHAs. The HSE currently provides all corporate functions including procurement, finance control, HR functions, ICT support, etc. The HSE is the contracting body for the national procurement of goods, services, and capital resources.

Hospital Groups and CHOs currently have no legally separate boards of their own; they do, however, have executive management teams of varying sizes, structures, and reporting lines. Hospital Groups and CHOs have wildly varied organisational structures in terms of corporate governance and the flow of accountability. Some examples of this variety can be seen in the organisational structures of the Hospital Groups' operational plans.[37]

As CHOs and Hospital Groups are not currently geographically aligned, delineation of roles, responsibilities, decision-making, and accountability across services also appear unclear and vary from organisation to organisation. Corporate governance lines are not fully transparent - there are some Hospital Group Boards in existence, for instance, which do not have a direct line of accountability to the HSE Board.

Due to the multiple management layers under the current structures, there is substantial duplication of administrative effort which results in confusing lines of governance. While the integration of certain corporate functions is making progress, legacy systems persist in others. These legacy systems cause unnecessary challenges and hinderances to core functions. 2021 saw the HSE deploying a single national integrated financial management system for example, but, prior to this, all financial reporting since 2005 has been an amalgam of financial reports from legacy health board finance systems.

Organisation and Service Planning

No change from current status quo, that is, no RHAs. The HSE currently fulfils both a planning function and an operational function. These functions are currently provided along acute/community sector lines. Some services provided by the HSE are done so on a national

[37] HSE (2019) *Operational Plans 2019*. Available at: www.hse.ie/eng/services/publications/serviceplans/service-plans-2019/operational-plans-2019/

basis, and others are provided via CHOs and Hospital Groups, which report to various divisions of the HSE.

The allocation of public funds for health is administered through the Health Vote. The DoH sets national priorities for the expenditure of Health Vote funds. The DoH and the HSE currently agree service-planning priorities and the HSE sets these out in the annual HSE National Service Plan (NSP), which is in turn approved by the DoH. The NSP describes the priorities for these funds but does not describe the specifics as to the quantum of money allocated to each priority identified. The NSP is the way the HSE gives effect to national strategies/policies and is currently delineated on an HSE divisional basis.

Further operational plans for the HSE Divisions, Hospital Groups, and CHOs are also agreed and published. Further services are provided via Service Level Agreements (SLAs) with voluntary organisations. There are limited formal networks available for the purposes of shared learning and coordination across Hospital Groups and CHOs.

In the main, the estimated existing level of service (ELS) is currently used to allocate funding for the coming year. That is, funding is allocated based on historic patterns of spending, with any additional allocation provided for under 'new development funding'. This method of funding allocation lacks agility to respond to emerging population needs in a timely, person-centred manner. Assessment as to the impact of the existing level of service funds is limited.

There are currently limited elements of population health management approaches used in the funding of services, which limits the ability of the system to link the health and social care needs to the allocation of resources annually. In addition, service planning priorities are generally agreed independently of the existing quantum of funding available. This can result in difficult negotiations as to the prioritisation of deliverables when drafting the operational plans.

Inter-Professional Networks and Information Sharing

The HSE Centre is currently responsible for the provision of training post allocations. There are examples of fora for L&D and mentorship. However, they tend to be more local in nature. The national 'Values in Action' programme works with peer-nominated staff, drawn from all grades and disciplines, to mobilise staff and empower them to create a more positive environment for themselves and improved experiences for patients and service users. Cross-professional audits are very limited. There are divisions within the HSE that provide quality assurance and quality improvement (QI) support functions.

Staff are HSE employees and cross-service/cross-facility staffing is encouraged, but there is no local hiring and no central staff bank. These factors result in an over-reliance on agency staff.

The HSE is responsible for the establishment and maintenance of national networks of facilities/professionals. Each Hospital Group currently sets standards/priorities for research/academic partnerships.

Clinical Pathways

No change from current status quo. The HSE or DoH set 'Policies, Procedures, Protocols, and Guidelines' (PPPGs) which are applied universally across the country. Relatively clear clinical governance exists within the acute hospital sector. However, this is not the case within the community sector.

The HSE sets certain clinical models of care and clinical pathways at a national level which are applied locally, for example a national model of care for cancer. At a local level, there is variation in pre-agreed clinical pathways from hospital group to hospital group or from community service to community service. Service providers currently set the majority of their own clinical models of care and clinical pathways independently of one another.

Feasibility of Implementation

System continues as is. That is, there is no current disruption but this option delays/impedes the delivery of Sláintecare commitments to regionalisation and other reforms. Future disruptions are inevitable as our current system is already under strain.

There are no restructuring or legal changes required as all core functions remain with the HSE, the HSE maintains its own Board, and the nine CHOs and six Hospital Groups remain under the HSE. There is no upfront cost associated with any transition, but this option will probably cost more in the long-run due to unsustainability and inevitable system failures.

Model Option Two: HSE-Local Model

In this model option, RHAs are set up administratively within the HSE structure, i.e. RHAs are regional divisions of the HSE:

- Six RHAs are geographically aligned regional integrated sub-divisions of the HSE which replace the nine CHOs, six Hospital Groups (plus Children's Health Ireland) and other reporting structures
- Provides regional management authority and accountability
- One population-based budget per region.
- RHAs do not have a board
- No legal change required
- The HSE remains the employer
- A strong, HSE Centre for national programmes and standards-setting

Corporate Functions

HSE Centre provides all corporate functions. That is, RHAs are divisions within HSE Centre. HSE Centre provides central procurement, central finance control, central HR functions, ICT support, etc. to facilitate the use of shared facilities and/or efficiencies at a national level.

Organisation and Service Planning

RHAs are considered divisions of the HSE. The DoH and HSE Centre determines hierarchies for corporate and clinical governance structures for RHAs/CHNs, which are applied by these structures and substructures. This may include RHA leadership teams seeking approval for budget/service design changes from the HSE Board.

The HSE sets the National Service Plan (NSP), which is drafted with a chapter/section per RHA. RHAs are responsible for implementing their respective components of the NSP.

As RHAs are divisions of the HSE and, as such, cannot enter into contracts in their own right. RHAs are not legal entities; however, RHAs and HSE Centre will participate as negotiators with voluntary sector organisations as a function of their responsibility to fulfil their element of the NSP.

The HSE Centre approves all SLAs with voluntary organisations. The Department of Health and HSE Centre approve oversight of governance arrangements of same.

RHAs as divisions of the HSE have a high degree of interaction with equivalent staff across RHAs for the purposes of shared learning and coordination. For example, RHA finance officers have a network to audit one another's work and learn from same, including efficiencies evident.

Inter-Professional Networks and Information Sharing

HSE Centre is responsible for the provision of training post allocations, national fora for L&D and mentorship, QI processes, and cross-professional audits.

As regional divisions of the HSE Centre, cross-service/cross-facility training and networking will be supported and encouraged at regional level to build team approaches to population health management. While standards will be determined and set at a national level, innovation will be supported at a local level and HSE Centre will proactively develop networks to advance best practice approaches to care across all RHAs. In this scenario, access to a central staff bank could offer regions the flexibility to manage their local needs in a timely, responsive way.

Clinical Pathways

HSE Centre or the Department set Policies, Procedures, Protocols and Guidelines (PPPGs) which are applied universally across all RHAs and RHA substructures.

HSE Centre set clinical models of care and clinical pathways at a national level which are applied locally.

Feasibility of Implementation

This option presents minimal disruption to patients' care pathways, medium disruption to healthcare system staff, and the most disruption to Hospital Group Boards (as these would be stepped down).

Internal HSE restructuring/reorganisation is required and may take a number of months. No legal change is required, however. The six RHAs are geographically-aligned regional integrated sub-divisions of the HSE which replace the nine CHOs and six Hospital Groups (excluding Children's Health Ireland), which are not statutory.

It is estimated that the upfront cost of transition to this model of regionalisation will be cost-neutral as it represents a restructuring of existing staff resources. It is, however, too early to reach a concrete conclusion on costings at this early stage in the planning process.

National and regional consistency may be better facilitated within one organisation, the HSE.

Model Option Three: Separation Model

In this model, Regional Health Areas are legally separate organisations:

- Six legally sperate RHAs, relationship with the HSE largely contractual (funding/targets/outcomes, etc. set out in contracts)
- Provides regional management authority and accountability
- One population-based budget per region
- RHAs each have their own board, i.e. six RHA boards reporting into the plus one HSE
- RHAs are employers
- A strong, leaner HSE Centre for national programmes and standards-setting

Corporate Functions

RHAs are considered their own legal entities, and hence are able to provide their own corporate functions. The HSE commissions services from RHAs in this scenario, and thus HSE Centre specifies minimum requirements for core corporate functions, including the setting of terms and conditions of employment contracts. However, RHAs are afforded autonomy within this framework in line with the requirements set out in the commissioning tender.

This may facilitate the use of shared facilities and/or efficiencies at a regional level, but national needs may not be as readily facilitated in decisions around resources, facilities, procurement, etc.

Organisation and Service Planning

The HSE would commission services from the RHAs. The DoH and HSE Centre determine hierarchies for corporate and clinical governance structures for RHAs/CHNs, which are applied by these structures and substructures. This may include RHA boards seeking approval for budget/service design changes from the HSE Board.

The HSE sets the NSP, which will detail national priorities. RHAs will develop their own Regional Service Plans as part of the commissioning process. These Regional Service Plans will be required to have regard for national priority set by the Department of Health and HSE. The Department will approve commissioning agreements.

RHAs are not considered divisions of the HSE. As such, they have their own boards and have autonomy in decision-making. The only requirements for standardisation will be those imposed via commissioning agreements. These may include provisions on minimum performance measurement and core requirements for corporate functions.

RHAs have a degree of interaction with equivalent staff across RHAs for the purposes of shared learning and coordination. For example, RHA finance officers have a network to audit one another's work and learn from same, including efficiencies evident. This will be facilitated by the HSE.

Inter-Professional Networks and Information Sharing

RHAs will engage with training bodies regarding their capacity/need for training posts. RHAs will develop a suite of profession-specific and multidisciplinary L&D and mentorship programmes for RHA substructures. RHAs will set core requirements for reporting on QI and

audit processes in line with commissioning tender requirements. RHA substructures have autonomy to build upon this core set or to institute/establish additional QI/audit processes based on local need. In this scenario, cross-service/cross-facility staffing could be facilitated through such structures as an RHA staff bank.

Clinical Pathways

RHAs set their own PPPGs which are applied equally across all applicable services universally within each respective RHA. RHAs set their own clinical models of care and clinical pathways, accounting for RHA population needs. These are applied across all applicable services universally within each respective RHA.

Feasibility of Implementation

This option is most disruptive to both patients and staff. The scale of legislative changes is considerable as a number of legal changes are required to set up RHAs as independent statutory bodies. A full restructuring of the HSE is also required with the devolution of care pathways, HR functions, etc. to each RHA, which may take considerable time to complete.

There would be an increased cost associated with transitioning to this model of regionalisation due to the higher degree of autonomy and accountability within six regional boards and the increased level of salaries associated with these responsibilities. In addition, the RHAs incur additional costs from regional responsibilities such as management of resources, facilities, and procurement, which are streamlined at a national level in the HSE-Local Model.

While the HSE remains responsible for consistency across national programmes, there may be issues ensuring consistency across each of the regions via six legally separate organisations in addition to the functions and standards of the HSE Centre.

Model Selection Approach

Multi-criteria analysis (MCA) is a decision-making methodology which provides a systematic approach to making complex decisions according to pre-determined criteria and objectives. MCA is suitable for complex decision problems that involve multiple objectives and criteria.

An MCA methodology was used to first define alternative policy options to implementing RHAs comprehensively, and then to appraise the options. In the RHA MCA, two separate streams were developed simultaneously: one developing the alternative proposed models of regionalisation for consideration (as previously detailed), and the second developing the evaluation criteria, against which to consider the alternative models.

These two streams were brought together at the end of the process to inform the final recommendation on a model of regionalisation to be brought to the Minister for Health and Government for their decision. The RHA MCA panel was comprised of nominated officials from across all divisions of the Department of Health. The overall results of the MCA have been summarised and incorporated into this RHA business case which was shared with the HSE for consideration prior to finalisation of a recommendation to Government.

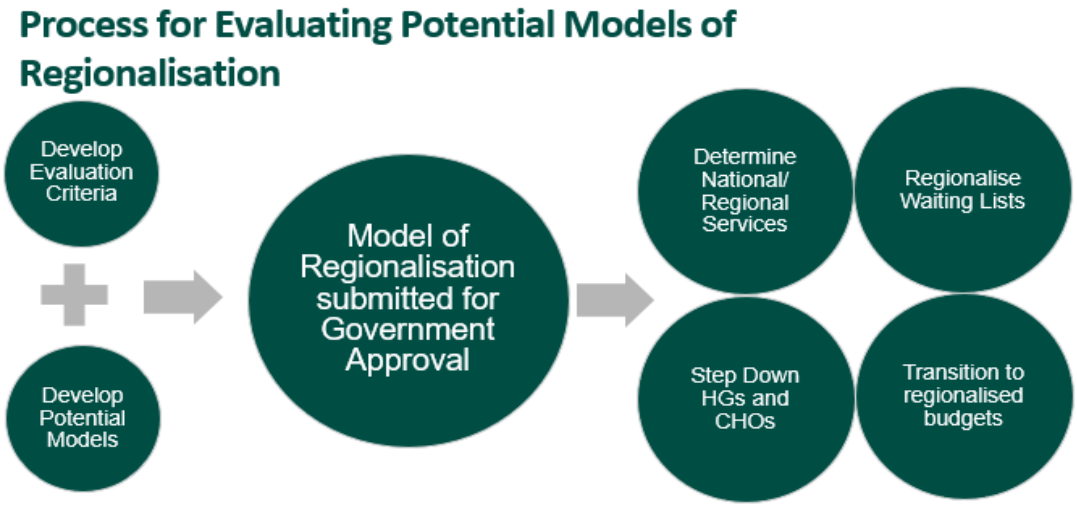

Figure 1: Process for the Evaluation of Potential Models of Reconfiguration

Evaluation Criteria

Each criterion and sub-criteria used to appraise each model align with the objectives of the reform and are listed in Annex 1. In Q2 2021, the Sláintecare Implementation Advisory Council (SIAC) supported the validation of the Evaluation Criteria developed for use within the MCA. The function of SIAC in this proofing process was to provide an advisory and challenge capacity, providing advice and testing the criteria during the development process.

Using the agreed evaluation criteria, the MCA approach allowed for a comparison of policy options via a process that provided rigour and structure to the decision-making process. This approach assessed each alternative RHA model against its ability to deliver on relevant Sláintecare objectives, including population-based planning and resource allocation, and their associated indicators from the Health System Performance Assessment (HSPA[38]) framework.

[38] Department of Health (October 2021) *Health System Performance Assessment (HSPA) Framework.* Available at: https://www.gov.ie/en/publication/6660a-health-system-performance-assessment-hspa-framework/

Value-For-Money

The value-for-money (VFM) criterion is usually incorporated into an MCA analysis to evaluate the impact of the introduction of a new investment, such as national road projects (for example, Transport Infrastructure Ireland[39]). The VFM criterion encompasses the effects on the wider economy/economic costs and on effectiveness, efficiency and equity. Efficiency and effectiveness are assessed by comparing benefits with costs, and equity can be measured by how accessible services are across society.

As this business case deals with the re-organisation of an existing system, it does not lend itself to the VFM criterion as well as other initiatives. For example, it was not possible to derive exact costings for the model options at this stage of the process. Therefore, the VFM aspects have been incorporated into the MCA analysis under other criteria where applicable. The efficiency and effectiveness aspects are covered under 'Enhanced Performance Reporting and Management of Health Outcomes' and 'Enhanced Performance Reporting and Management of Health Expenditure'. The combination of these criteria will enable better oversight and evaluation of costs relative to benefits within the health system. The 'equity' aspect of VFM is covered in the 'Population-Based Funding', 'Service Planning', and 'Integrated Service Delivery' criteria, promoting equity in access to health services within and between regions, by distributing resources according to population need. The 'economy' aspect of the VFM criteria has been assessed with regard to the models' relative cost of transition.

Appraisal of the Cost of Transition Criterion

As the model options were appraised before the detailed design and implementation stage, it was not possible to derive exact costings for them. However, it is estimated that the HSE-Local Model will be cost neutral as it represents a restructuring of existing staff resources. The Separation Model will incur a degree of increased costs related to the higher degree of accountability with six RHA boards and the level of salaries associated with these responsibilities. Under the Separation Model, the RHAs will incur additional costs from regional responsibilities such as the management of resources, facilities, and procurement, which are streamlined at a national level in the HSE-Local Model and under the No Change scenario.

As such, the models were scored separately by Department of Health IGEES officials on a scale of 0 to 3 with regard to the estimated relative cost of transition, where 3 = no cost, 2 = relatively lower cost, 1 = relatively higher cost, and 0 = substantially higher cost. The No Change Model and the HSE-Local Model were each scored with a 3. The Separation Model was scored with a 2.

Appraisal of the Legislative Changes Criterion

A detailed breakdown of the potential legislative changes for each model option was not included in the business case documentation or to the MCA panel members. As such, the models were scored separately by Department of Health officials with knowledge of relevant legislation between 0 to 3 with regard to the scale of legislative change required, where 3 = no legislative changes required, 2 = minor legislative changes required, 1 = many legislative changes required, and 0 = large-scale legislative changes required. As the Separation Model would require the introduction of primary legislation, its legislative programme would be the

[39] Transport Infrastructure Ireland (October 2016) *Project Appraisal Guidelines for National Roads Unit 7.0 – Multi Criteria Analysis. PE-PAG-02031*. Available at: https://www.tiipublications.ie/library/PE-PAG-02031-01.pdf

most intensive. No primary legislation is required for the HSE-Local Model or No Change Model. The No Change Model and the HSE-Local Model were each scored with a 3. The Separation Model was scored with a 1.

MCA Panel Appraisal

The completion of the MCA process found that no model outperformed all other models across all sub-criteria. It emerged that the No Change Model scored most poorly overall against the Evaluation Criteria, only outperforming the other two models in the Feasibility of Implementation criteria category. The HSE-Local Model and the Separation Model performed similarly in the first three criteria categories – (1) Corporate Governance, (2) Clinical Governance, and (3) Population-Based Funding, Service Planning and Integrated Service Delivery – clearly outperforming the No Change Model, but with the HSE-Local Model performing slightly better than the Separation Model. The HSE-Local Model performed substantially better than the Separation Model in the Feasibility of Implementation criteria category.

Delivery Strategy for the Business Case – Next Steps

While the Government decision of July 2019 set a definitive direction of travel, this business case clarifies the next steps needed to fully implement Regional Health Areas and seeks to inform the imminent decision on which model of regionalisation to develop at this juncture. The scale of change required to give life to the new regional arrangements – and the associated further changes that will be required to the HSE Centre and to the Department itself – is very significant. It will require careful and comprehensive planning and implementation if the desired objectives from regionalisation are to be fully achieved and the current operations at regional or national level are not destabilised during the transition process.

In line with newly established governance structures for Sláintecare implementation, the Department of Health and the HSE will build on the work set out in this business case and have begun to progress the development and implementation of a clear plan for regionalisation with input from the RHA Advisory Group. The Sláintecare Programme Board and HSE Board will play central roles in terms of oversight of the planning and implementation of RHAs and the stepping down of CHOs and Hospital Groups.

An implementation plan will be now developed on the agreed model of reorganisation as approved by Government. This implementation plan will take its lead from both the Sláintecare principles and the Sláintecare Implementation Strategy. These include communication, stakeholder engagement, and a focus on timely delivery that minimises disruption to services and direct costs. The objectives as detailed in this document will be the parameters by which RHA implementation will be evaluated.

RHA Implementation Team

Careful consideration will need to be given to the respective roles and responsibilities of the HSE Corporate Centre and of DoH in an RHA context, ensuring appropriateness and clarity, and avoiding duplication and overlap. Nominated leads have been appointed from the HSE and the DoH to a joint RHA Implementation Team. This team will coordinate the various workstreams and key dependencies for the successful and comprehensive implementation of RHAs, bringing additional DoH Management Board members and HSE Executive Management Team members in for key actions as appropriate. International expertise on healthcare design and re-organisation will also be included on the team.

In light of the transfer of policy and funding responsibility for specialised community-based disability services from the Department of Health to the Department of Children, Equality, Disability, Integration and Youth (DCEDIY), DCEDIY will also be represented on the RHA Implementation Team to ensure the inclusion and alignment of disability services regionally.

Building on collaborative work done between the Department of Health and the HSE on the programme plan to date[40], further granularity will ensure that it incorporates a level of detail required to guide the successful design, planning, and implementation of Regional Health Areas. A detailed implementation plan will be developed in partnership with the HSE and other key stakeholders in 2022. This includes building out a work programme which includes of roles/responsibilities, core user requirements, target timelines with quarterly deadlines, and a sequencing of actions under a number of key enabling workstreams.

[40] EY (May 2020) *Considering international best practice to support the implementation of Regional Health Areas (RHAs)*

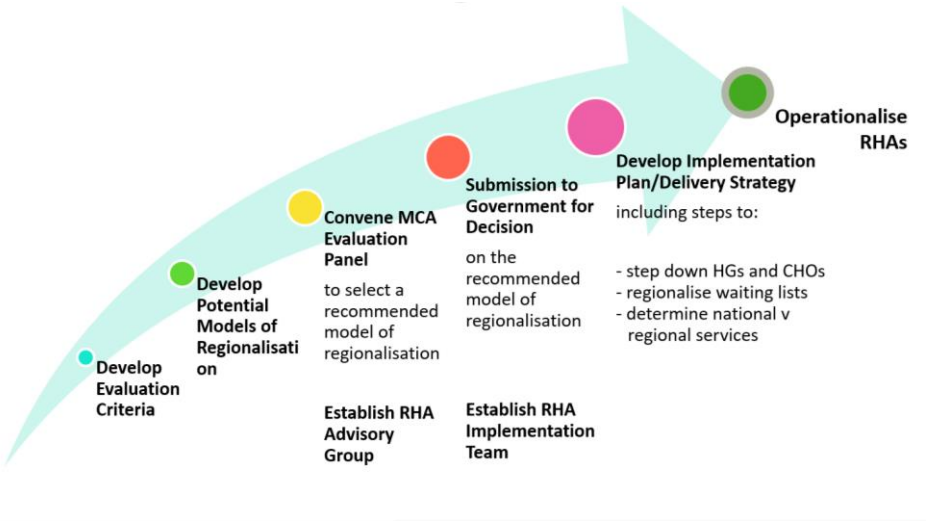

Figure *1*: Sequence of decision gates for the implementation of Regional Health Areas (RHAs)

RHA Implementation Plan

A detailed implementation plan will now be developed based on the agreed model of reorganisation as approved by Government and **is due for publication in Q4 2022**. This implementation plan will be centred around a number of interdependent workstreams. Currently, the seven workstreams include:

Programme Coordination

The implementation plan will consider the **programme design, management, and central coordination** of the overall RHA implementation. This will include designing the programme timeline and monitoring progress as well as managing, escalating, and mitigating key decisions and risks. Methods of measuring impact and implementation in the short, medium, and long term will also be considered as part of this workstream.

Corporate and Clinical Governance and Accountability

The implementation plan will review **organisation design** to reform the organisational, clinical and corporate governance and accountability lines in line with RHA implementation. This will consider the complex health and social care system that includes multiple care delivery organisations and seek to reduce existing management layers, creating a flatter structure to support responsive decision-making on the ground. It will also place a greater focus on health outcomes measurement as a mechanism for assessing performance through the HSPA Framework in the long term.

Population-Based Resource Allocation

The completion of **population-based profiling** and the design of the **resource allocation model** to determine how resources are allocated to each RHA will be key. The implementation plan will examine the current allocation of resources to each RHA including budget, staff, and infrastructure and will produce reports on these in the current year.

Finance

The implementation plan will review the current **budgeting and financial management process and detail new processes** to set up RHAs as operational delivery units to enable service planning and funding. In order to **enable population-based approaches**, new financial reporting structures are required, as well as ensuring that financial management systems are fit for purpose. In this regard, the rollout of the Integrated Financial Management System is takes into account the move to RHAs. In addition to population-based funding, activity-based funding will also be progressed to facilitate services provided nationally and between regions.

Digital and Capital Infrastructure

The implementation plan will ensure alignment with the refreshing of the eHealth strategy. The move to Regional Health Areas is being coordinated with the introduction of strategic frameworks for the evaluation of current and future **capital infrastructure and IT requirements**.

People & Development

The implementation plan will **assess and plan for what and where our current and future staffing needs** and associated **training requirements** are as we transition to RHAs. This will involve new and improved ways of working and new reporting structures, with HR and industrial relations issues being taken into consideration.

Change, Communications and Culture

It will be crucial to **communicate the high-level vision** and specific benefits of Regional Health Areas to all stakeholders involved, so that their views contribute to a shared sense of destination and understanding of why these changes are crucial to strengthening and supporting our health and social care services, staff, and service users. The implementation planning will itself benefit from stakeholder engagement and this will be an important and ongoing feature of the move to RHAs. The implementation plan will set out the required **change-management approach** and **stakeholder engagements** focusing in particular on establishing relationships with local leadership and supporting the transition to Regional Health Areas. This will include workshops with Hospital Groups, community healthcare organisations, community healthcare networks, the Voluntary Dialogue Forum, patients, and other stakeholders following the Government decision among other planned engagements.

In light of the transfer of policy and funding responsibility for specialised community-based disability services from the Department of Health to the Department of Children, Equality, Disability, Integration and Youth (DCEDIY), DCEDIY will also be represented on the RHA implementation team to ensure the inclusion and alignment of disability services regionally.

Risk Management

The 'Programme Coordination' workstream will manage the iterative process for systematically identifying, analysing, and responding to risk factors in order to support better decision-making through understanding the risks and their potential impact. A robust risk management process will be critical to the success of this large scale change programme. This will be included as part of the detailed design phase.

Risks that could have an impact on the strategic, project and/or operational objectives have been considered and will be actively managed throughout the project cycle, including:

- Strategic risks that relate to the highest level of objectives of the reform;
- Project risks that relate to the achievement and delivery of the project objectives and outcomes (development and implementation of the RHAs); and
- Operational risks that relate to the day-to-day delivery of activities, operational business plans and objectives.

Risk monitoring and reporting is being managed by the RHA implementation team. The risk register remains a live document throughout the life of the project with risks updated as required. Any risks requiring escalation will be brought to the attention of the nominated workstream leads and a decision will be made if the risk should be brought to the attention of the DoH Management Board, HSE Board, or Sláintecare Programme Board.

Monitoring and Evaluation Plan

The business case sets out the monitoring and the long-term economic evaluation plan which will consider the estimated impact of the reform against stated objectives and costs.

Monitoring

Monitoring the impact of the reform will use indicators selected from the Health System Performance Assessment (HSPA)[41] framework. This is a new overarching tool for assessing the performance of the health system with measurable and quantifiable indicators (e.g. patient-reported experiences, patient-reported outcomes, staff experiences, and equity by population groups or by geography) which can be linked to the RHAs. The indicators are grouped into sub-domains which form four clusters: outcomes, outputs, processes, and structures (see figure 3). The HSPA framework also includes three cross-cutting domains that can be applied across all clusters: equity, efficiency, and resilience. Baseline performance will be documented in detail at national and regional levels in 2022 using the HSPA framework.

Although data on indicators is generally available, there are some limitations (for example. manual collection and entry, multiple health systems). These limitations of the health information system highlight the need to invest in and strengthen the data architecture. Additional work will be required to deliver on indicators that are not readily available, and at a sufficiently granular level. As this reform is centred around the overall structure of the health service, measuring the performance of the health service as a whole is required to assess the impact of the reform.

The introduction of the HSPA framework offers an opportunity for capability building as well as for modernisation. Reporting through the HSPA framework will allow a move away from system/administrative reporting to a reporting framework that provides a better understanding of population needs and how the system is responding to these needs. Moreover, the regionalisation of reporting will allow for a more granular understanding of population needs and how these differ across the regions.

It is also proposed that a review of the reform will take place to assess its success against its stated objectives. This progress will be considered 12-18 months post-implementation to fine-tune the process of implementation as necessary.

[41] Department of Health (October 2021) *Health System Performance Assessment (HSPA) Framework.* Available at: https://www.gov.ie/en/publication/6660a-health-system-performance-assessment-hspa-framework/

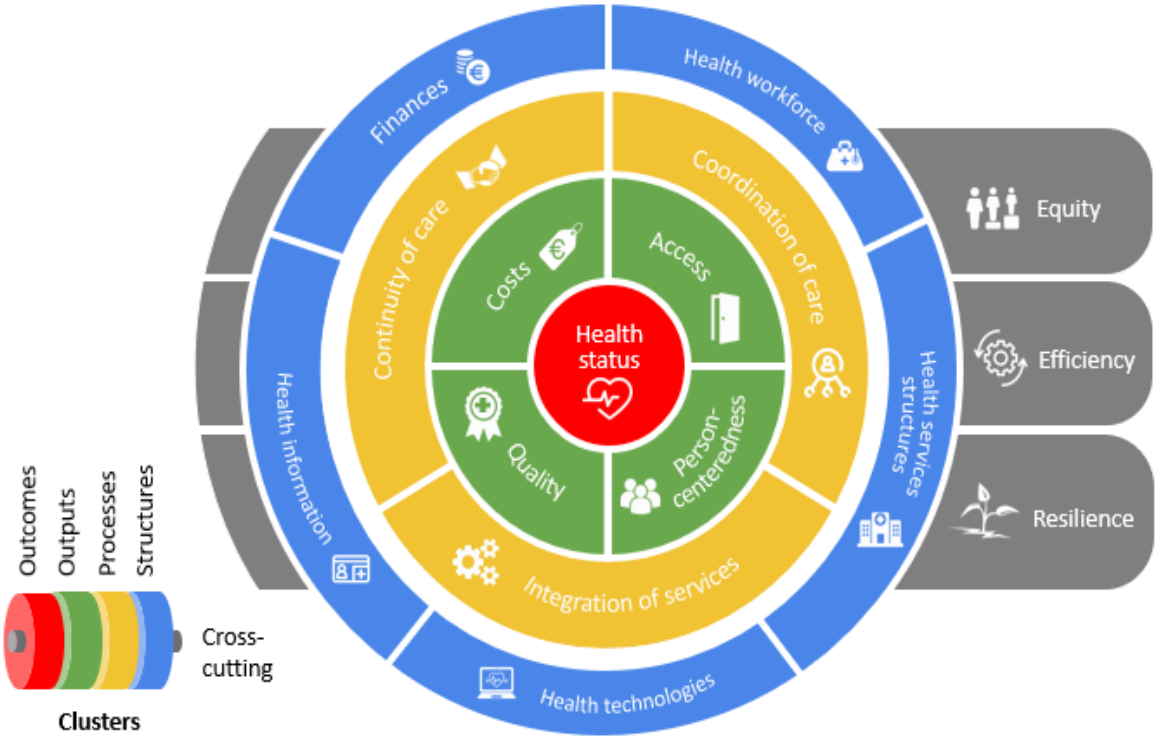

Figure 3: HSPA Framework – Outcomes, Outputs, Processes, and Structures

Evaluation

The economic evaluation will estimate the impact of the reform by considering HSPA framework indicators against costs. In designing the monitoring and evaluation plan, it is important to consider the wider Sláintecare Reform Programme that the current business case forms part of, and the interdependencies between this business case and wider system changes. With regard to evaluating the longer-term economic impact, projections from the ESRI and Department of Health Joint Research Programme in Healthcare Reform will give the current long-term trajectory of acute and non-acute expenditure in a baseline scenario. This will be used to evaluate how the reform has impacted on the baseline trajectory.

The timing of the evaluation is an important aspect as it can influence the accuracy of any findings[42]. In general, an evaluation should allow enough time from implementation to allow the project to be fully operational and for data to be readily available[43]. The timing of international evaluations of health system regionalisation reforms varies. Findings from the HRB evidence review (2019) indicate that three to five years after the reform was introduced is a common time frame for impact evaluation studies[44]. Quigley et al. (2019) conclude that the majority of the studies did not have sufficient follow-up time to capture the full impact of healthcare reforms. They further highlight that some impacts might only be identified in a longer-term perspective. However, including a very long follow-up period could also pose challenges in identifying the specific impacts from a specific regionalisation reform, where the

[42] HRB Evidence Review (2019) *Regional health organisations. An evidence review.* Available at: https://bit.ly/2Z1dWlA

[43] Butler M. (2002) Evaluation in the Irish Health Sector. Dublin, Ireland: Institute of Public Administration. CPMR Discussion Paper No. 21.

[44] HRB Evidence Review (2019) *Regional health organisations. An evidence review.* Available at: https://bit.ly/2Z1dWlA

health systems are undergoing several rounds of changes and reforms[45]. On this basis, the evaluation will take place no earlier than five years post implementation.

Ways of measuring impact and implementation in the shorter term will also be considered as part of the Programme Coordination workstream.

Conclusion

This business case recommends **establishing RHAs internally within the HSE.** Doing so provides a means to improve clinical and corporate governance, enable population-based health service planning, and facilitate the integration of acute and community care. This option is considered the most feasible, least disruptive option to delivering on comprehensive reform of health service structures.

The case for changing our current structure was overwhelmingly made. With this result in hand, the time is now to progress with the implementation of geo-aligned regional structures in line with Sláintecare objectives.

[45] HRB Evidence Review (2019) *Regional health organisations. An evidence review*. Available at: https://bit.ly/2Z1dWlA

Annex 1: Evaluation Criteria

Table 1: Evaluation Criteria

Evaluation Criteria	Sub-Criteria	Assessing the ability of the model to facilitate
1. Corporate Governance	Clear Corporate Governance and Oversight	Clear corporate governance structures, oversight, and responsibility for the safe care of a population. Administration is streamlined and coherent, minimising the risk of duplication of administrative efforts.
	Clear Lines of Accountability	Clearly defined roles and responsibilities that are attributable to positions with unambiguous accountability, e.g. identifiable decision points and decision makers. Streamlined corporate governance lines for managerial and financial decision-making.
	Locally-Driven and Responsive/Flexible Decision-Making	Appropriate response to national/local circumstances and identified population needs in service planning. Timely, locally-driven decisions are enabled, reducing bureaucratic layers and time to make decisions. Regional autonomy is provided for appropriately.
	Enhanced Performance Reporting and Management of Health Expenditure	Transparency of financial information on costs for health services and how this expenditure impacts health service outputs and health outcomes.
2. Clinical Governance	Enhanced Performance Reporting and Management of Health Outcomes	Transparency and visibility of performance management process and health outcomes (e.g. mortality, morbidity, safety of care, readmission rates, patient experience, patient need, and effectiveness of care) and how those outcomes impact health service structures or expenditure.
	Clarity in Care Pathways	Clearly defined care pathways, spanning acute and community-based services, that are designed to provide care as close to people's homes as appropriate. These care pathways have clearly defined decision points and processes for patients' transitions of care from one service/sector to another.
	Person-Centredness	Care that is people focused and promotes patient self-management. Empowers and facilitates active involvement of patients in their own care and treatment.
	Clear Clinical Governance and Oversight	Clinical governance structures that are clearly defined and describe the roles and responsibilities for the provision of safe care for a population. Clear multidisciplinary governance structures.

Evaluation Criteria	Sub-Criteria	Assessing the ability of the model to facilitate
3.Population-Based Funding, Service Planning, and Integrated Service Delivery	Population Health Management Approach	An evidence-based population health management approach (including population profiling and health needs assessment). This approach informs policy decision-making, service planning and equitable, needs-based resource allocation for defined regional populations and national services.
	National and Regional Integrated Service Planning	Long-term integrated service planning for geographically-aligned acute and community-based services. Service planning based on the current and projected needs of defined populations at both national and regional levels as appropriate.
	Integrated Care	Integrated care, e.g. clearly defined, end-to-end referral pathways including at transitions between acute and community care. Greater responsiveness and coordination between services, thereby supporting improvement of patients' experiences of care and outcomes.
	Pooled Budget (one budget per region), using population-based resource allocation	Budget and resource allocation on a needs basis for defined populations, using population-based resource allocation. A single budget per region, covering hospital, community, and social care services.
4. Feasibility of Implementation	Disruption	The extent to which the model causes disruption within the health and social care service delivery.
	Duration of Restructuring Phase	Models are assessed with regard to the length of time required to restructure, i.e. the duration of the transition.
	Sláintecare Reforms	The implementation of key Sláintecare initiatives including the elimination of waiting lists, the introduction of universal healthcare, and transition of care to the lowest acuity environment.
	Legislation Changes Required	Scale of legislative changes should be considered, if changes are required.
	Cost of Transition	Models are assessed with regard to their relative cost of transition.
	National Consistency	Nationally consistent approaches and interoperability in both corporate and clinical functions where required (e.g. clinical programmes, interoperable ICT systems/data collection systems).

An Roinn Sláinte
Department of Health

Bloc 1, Plaza Míseach, 50-58 Sráid Bhagóid Íochtarach, Baile Átha Cliath, D02 XW14
Block 1, Miesian Plaza, 50-58 Lower Baggot Street, Dublin, D02 XW14

@RoinnSlainte
www.health.gov.ie