Interview: Tony Oâ??Brien â?? Director General, Health Service Executive (HSE), Ireland

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Tony Oâ??Brien, Director General of the Irish Health Service Executive (HSE), highlights the reforms instituted in the past few years, key challenges faced, his thoughts on the sustainability of the Irish healthcare system, and his commitment to making it fit for the needs of its patients.

The Health Service Executive (HSE) was meant to be abolished in 2014, a year after you were appointed interim chief executive. What reforms have been implemented since then?

Although I was appointed at a time when the governmentâ??s clear policy was to abolish the HSE, I was not interested in being distracted by that. There is always going to be a national health service â?? a successor body to HSE. My priority was to set out the configuration of this service in ways that made sense, regardless of the existence of the specific entity of HSE.

The focus has been to break down the health delivery system into manageable parts rather than having a large, singular system. On the acute side, we established seven hospital groups, on an administrative basis, to realign their services in a way that support quality outcomes and volume. Each of them also has an academic focus to facilitate strong education and research linkages with our third-level sector, thereby providing greater opportunities for research and innovation.

On the non-acute side, we created nine community health organizations. It is important to note that the Irish healthcare system is broader than what â??healthcareâ?? typically means; it includes social care: long-term elderly care, care for people with physical and intellectual disabilities, and a wide variety of support services, including some unexpected things like civil marriage, for instance. They are also geographically contiguous. Having nine of them instead of a single national entity means our health functions can be of an appropriate, relatable human scale.

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We also now have a singular national ambulance service based from a single national operation center. Finally, many of our programs are based on eligibility. We have standardized our process for testing eligibility for means-tested health services.

Ultimately, we wanted a flatter organizational structure. We sought to standardize the systems that affect citizens while allowing for customization. There will now be 96 healthcare networks within the nine community health organizations to provide for appropriate clinical leadership on a comprehensible scale, each catering to populations of between 40,000 to 70,000 people. This will make our health service more responsive to local needs.

What were the key challenges?

The economic implosion in 2009 was a critical one. Not only was there a significant increase in demand for health services, public funding for healthcare decreased drastically. For instance, the health service saw, in 2012, a 15 percent reduction in staffing, with 5 percent of that happening on a single day, a result of incentivized exit programs.

This had a host of implications. The exit program was designed to eliminate the highest paid staff, which meant that along with their departures went experience and institutional knowledge. The remainder had to do not only more work but work at a higher management level, serving more patients â?? while also getting paid a lot less, because the entire public sector had had their pay cut between 2009 and 2012. This made for quite a demoralized workforce.

Another challenge for us is the fact that despite being a small country, we are quite geographically dispersed. Ireland does not, like many other countries, have densely populated urban areas and very sparsely populated rural areas. We have very dense urban areas, with half the population living in metropolitan Dublin, and the other half fairly evenly distributed in rural areas. This creates challenges related to the configuration of services, which we try to address in our population planning and capacity building.

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More recently, a key development has been the successful negotiation of the new pricing agreement with the Irish Pharmaceutical Healthcare Association (IPHA). How significant is this for the Irish healthcare system?

Historically, Irish consumers, including the state, have paid disproportionately more for some of their pharma products than some other European countries, for a variety of reasons. Additionally, our population is growing and aging, while our life expectancy is growing ahead of the EU-15. The reality is, within Ireland, we will have more people, living longer, with more chronic disease and needs. It was clear that, if we had continued paying at the original rate, our rate of increase in expenditure would have been totally unaffordable.

It is imperative that Irish people continue to have access to new pharmaceutical developments and innovations at reasonable, affordable and sustainable prices. In recent years, we have introduced reference pricing, and now, through negotiated agreements with IPHA, substantial price reductions. Those negotiations have been conducted by both sides with vigor, to the extent that at one point, HSE had actually considered exercising our power (voted on by Parliament) to set mandatory prices without negotiation, as a last resort if negotiations failed.

As it is, I am happy that an agreement has been reached, which will grant the industry a degree of certainty, give us stability, and access to new innovations to patients. That said, this agreement does not actually cut our expenditure, only the growth rate each year â?? we will still have to pay more each year!

This is the second of such agreements between HSE and IPHA, and hopefully just another one in a series that will enable us to have a stable and sustainable relationship with the pharma sector, which is an important part of our economy. Much of the innovation and the manufacturing for the global pharma industry occur here, so a good relationship is a win-win situation.

This tension between unsustainably increasing healthcare budgets and the safeguard of access to innovative medicines is a debate in the rest of Europe as well. How confident are you that Ireland will be able to continue to grant access to the latest innovative drugs?

It depends entirely on the success of our economy: the HSE spends one out of every four tax euros. We pick up costs in excess of the first EUR 144 spent per month to families outside of our means-tested schemes, so there is a huge amount of expenditure on healthcare from the private and public purses. There is also a small but vibrant private healthcare sector. Our ability as a society to fund healthcare is inextricably linked to our economic fortunes.

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I believe there is also a very serious risk that healthcare itself may be fundamentally unsustainable, even with vibrant, double-digit growth â?? which not many countries will have. The old paradigm of healthcare, defined in the 1950s as â??absence of illnessâ?? predates modern medicine, and certainly the era of pharmacological advances in which we are now. Healthcare and social care are now about leading functional lives with multiple chronic diseases. This means that we have a high cost-dependency on healthcare. Long-term care in nursing homes, multiple admissions to acute hospital settings, new biologics drugs â?? all these are enormously expensive. We could effectively spend our entire economy on healthcare.

There will always have to be significant, meaningful dialogue with the pharma sector about what products we can afford. This entails approval and decision-making processes from our side, which will appear too slow from some perspectives, but are necessary to our ability to safeguard patient interests and fund healthcare sustainably.

Minister for Health Simon Harris has plans to reform the Irish healthcare system, transitioning from its current two-tier system to a single-tier one, moving away from the ability to pay to need, but the idea of universal health insurance has been shelved for now due to its costs. What does this mean for Ireland?

An over-focus on the issue of universal health insurance can be a distraction as all healthcare is paid for somehow. The fundamental question is: do we want single-tier access to healthcare? Do we want healthcare provided on the basis of need rather than individual economic circumstance? This is a critical question.

Parliament has established an all-party committee whose function is to determine the kind of a healthcare system Ireland should have ten years from now. Previously, any sort of long-term healthcare planning had been derailed by the short-term nature of political term cycles, which is not unusual. This new process, however, is designed to produce a consensus view. Ten years is a reasonable horizon because meaningful change takes time.

The important thing is that we agree, as a nation, on what we want, and we empower our healthcare system to change itself into that. Now, realistically, we might not be able to have everything we decide we want, but at least once we have decided what it is that we want, we can figure out how much of it we can afford. Then, and only then, does the question of universal health insurance become relevant.

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One critical area of concern I would like to emphasize is social care. This is a pretty common debate now in Europe, given that we are aging and we have needs outside of the mainstream health system, are we going to provide home care and assistance packages on a demand-led basis? If we do not, there will be people who could otherwise receive care at home that are in hospitals, so this is absolutely a central part of that discussion. There is an old sterile argument, often described as â??false economicsâ?•, that money is actually saved when you move patients from hospital to home, but this is not true. A new patient moves in, and in reality, a patient delayed from discharge is cheaper for the hospital to care for than a new patient that will need a whole battery of new tests, procedures and other services. This means we will have a whole set of new costs for new cohorts of patients arising from the community, which we now need to meet to allow the acute system to do what it is supposed to do.

We already have a number of projects on the range of pharma interventions and medication delivery systems for the home setting, and we just need to decide what priority and funding to attach to them.

Another challenge is the ability to recruit and retain talent, both managerial and technical, away from other attractive destinations like Australia, Canada and the UK. How is HSE dealing with this?

Healthcare personnel are the most important resource the system has. This was another focus for me: invest in peopleâ??s abilities to lead. I did not want administrators, I wanted managers and leaders. We have been fortunate to have had support from the pharmaceutical sector. For instance,

we have developed master classes with sponsorship from companies like Novartis and Janssen.

This is important because our staff are also very poachable. We do lose a lot of the staff that we train to other jurisdictions like the UK, the Middle East and Australia, and we are continuously recruiting staff. Unless we are able to provide the type of motivating environment that will encourage those staff to stay with us, it will be a never-ending cycle of recruitment. A constant churn of staff is not good for the care environment.

It is also very important that, within the Irish society, healthcare professionals are valued for their work. We cannot have our staff battered for the shortcomings of the system without at least equal recognition and praise of their commitment and work.

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The HSE has historically not been very popular. How do you address this problem of public perception?

It was created to be unpopular â?? and often described as a â??heat shieldâ?• for the political system. The decision to create the HSE was announced in July 2003 and it came into legal existence on 1 January 2005, before it had a chief executive and before its predecessor bodies had been wound up. Insufficient time had been given to set out the institutional culture, systems and strategy â?? for instance, on how it could leverage its single-payer status to obtain cost savings. Broad undertakings were given to the trade unions that no one would lose their jobs. The pace at which this all happened I have likened to a high-speed road crash.

Through this lack of vision, HSE inevitably became a very centralized, disempowering organization â?? the exact opposite of the one that I am trying to create. This is why the community health organizations and the hospital groups are so important because they more closely align HSE with its patients and workers.

I am trying to promulgate the four values of â??care, compassion, trust and learningâ?? throughout the system. These are good practices already present in the delivery system, and I want to universalize them so that people will be able to see those values clearly in practice in the Irish healthcare system.

Minister of Health Simon Harris has said â??we all know the health service has problems â?¦ but there are also a lot of things going wellâ?•. Looking beyond these criticisms, what are the strengths of the Irish healthcare system?

It is a fine line: to recognize the shortcomings of the healthcare system while also praising its achievements.

As an example, at the beginning of my term, we were measuring hospital waiting lists out beyond four years. Now they are between a year and 18 months â?? which is still terrible but represents a significant improvement. We have made significant progress in a number of areas like the shift from in-patient treatment to day care treatment. We have a much bigger focus on health and wellbeing, promulgated under the â??Healthy Irelandâ?? strategy. We are also investing heavily in e-Health technology, and on this, we have brought in Richard Corbridge from the NHS to work with us as Chief Information Officer. Our national cancer control program has also been a success, which would not have been possible with eleven regional health authorities.

The Irish healthcare system as a whole has very strong foundation, proven by its remarkable resilience during the years of extraordinary austerity. Health cuts for many countries mean that they will not get as much of an increase in funding the next year as hoped for. Here in Ireland, we have seen billions of expenditure extracted from the Irish healthcare system. Not only is it still standing, it has improved in a number of ways while doing more with less. We have a whole range of services available now that did not exist before the recession.

What is your final message to our audience?

> The Irish health system has a very bright future, especially because it recognizes â?? and is ready to meet â?? the challenges that it faces

Across a number of fronts, I am seeking to make the health services of Ireland more fit for the needs of the population. There is much to be proud of in the healthcare system but it does not yet fully meet population needs. That said, I want to ensure that the healthcare system and its staff are appropriately praised for what they can do, while acknowledging that we need to be better empowered to do more.

We have facilitated this with RTE, the Irish national broadcaster, on a television program called Keeping Ireland Alive, which follows the journeys of individual patients on a single day, to showcase the full complexity of healthcare delivery in Ireland.

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