Trinity College Dublin
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Health Regions: Getting governance right

A case study of the design and implementation of new decentralised health regions in Ireland, 2018-2023

Prof Sara Burke, Dr Carlos Bruen, Dr Sarah Parker, Dr Rikke Siersbaek, Luisne Mac Conghail & Dr Katharine Schulmann

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Key reform context & component: Decentralised Health Regions

Context

- Mixed, fragmented system of public-private financing and delivery
- Only European country without universal healthcare system
- *Sláintecare* 10-year programme of healthcare reform in 2018 – overarching aim of universal healthcare

Rationale for decentralising health services to six region

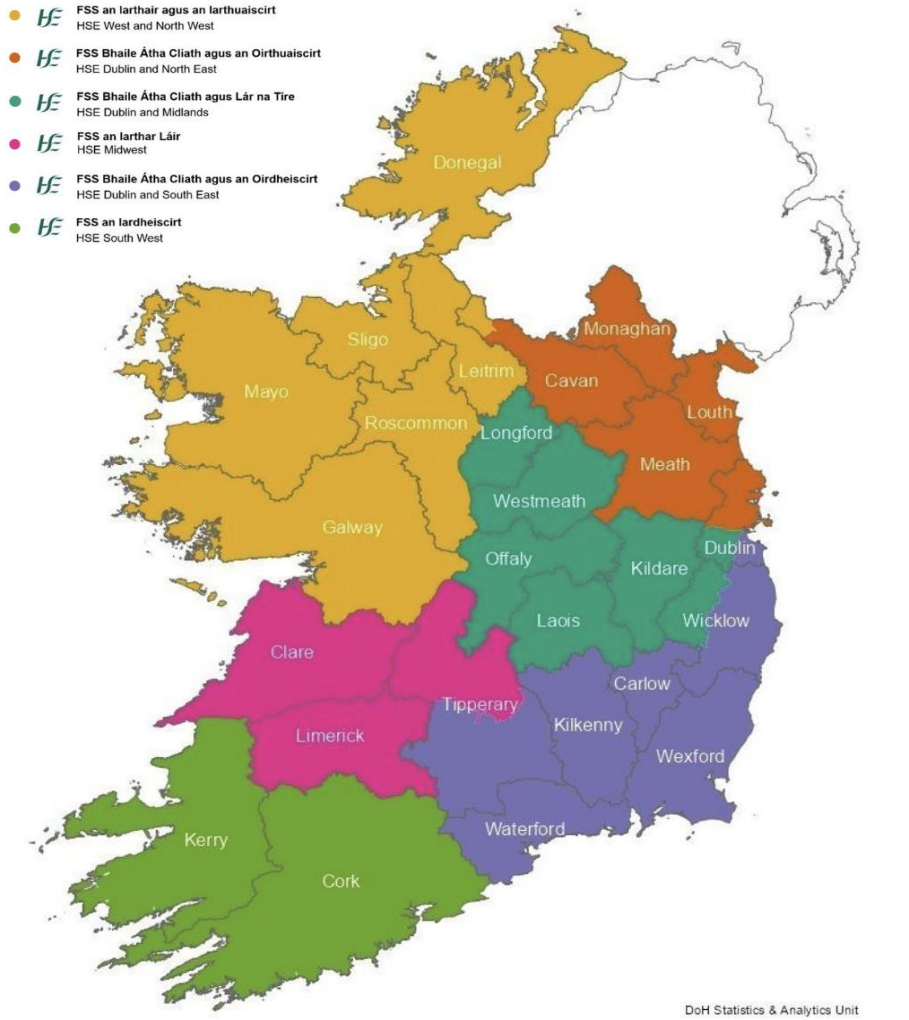
i. Integration of care

ii. Clinical Governance

iii. Corporate Governance and Accountability

iv. Population-Based Approach to Service Planning

Map of HSE Health Regions and County Boundaries[4]



Draws on research we did in 2003

- To use governance of the design and implementation of the regions as focus of our policy analysis
- To inform design and implementation of the Health Regions
- To shed light on broader Sláintecare reforms through a governance lens
- To contribute to international academic research on centralisation/ decentralisation

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RESEARCH Open Access

The role of governance in shaping health system reform: a case study of the design and implementation of new health regions in Ireland, 2018–2023

Katharine Schulmann[1*], Carlos Bruen[1], Sarah Parker[1], Rikke Siersbaek[2], Luisne Mac Conghail[1] and Sara Burke[1]

Abstract

Background Effective governance arrangements are central to the successful functioning of health systems. While the significance of governance as a concept is acknowledged within health systems research, its interplay with health system reform initiatives remains underexplored in the literature. This study focuses on the development of new regional health structures in Ireland in the period 2018–2023, one part of a broader health system reform programme aimed at greater universalism, in order to scrutinise how aspects of governance impact on the reform process, from policy design through to implementation.

Methods This qualitative, multi-method study draws on document analysis of official documents relevant to the reform process, as well as twelve semi-structured interviews with key informants from across the health sector. Interviews were analysed according to thematic analysis methodology. Conceiving governance as comprising five domains (Transparency, Accountability, Participation, Integrity, Capacity) the research uses the TAPIC framework for health governance as a conceptual starting point and as initial, deductive analytic categories for data analysis.

Results The analysis reveals important lessons for policymakers across the five TAPIC domains of governance. These include deficiencies in accountability arrangements, poor transparency within the system and vis-à-vis external stakeholders and the public, and periods during which a lack of clarity in terms of roles and responsibilities for various process and key decisions related to the reform were identified. Inadequate resourcing of implementation capacity, competing policy visions and changing decision-making arrangements, among others, were found to have originated in and continuously reproduced a lack of trust between key institutional actors. The findings highlight how these challenges can be addressed through strengthening governance arrangements and processes. Importantly, the research reveals the interwoven nature of the five TAPIC dimensions of governance and the need to engage with the complexity and relationality of health system reform processes.

Conclusions Large scale health system reform is a complex process and its governance presents distinct challenges and opportunities for stakeholders. To understand and be able to address these, and to move beyond formulaic

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Sláintecare.
Right Care. Right Place. Right Time.

Addressing Health Inequalities – towards Universal Healthcare

Sláintecare.
Right Care. Right Place. Right Time.

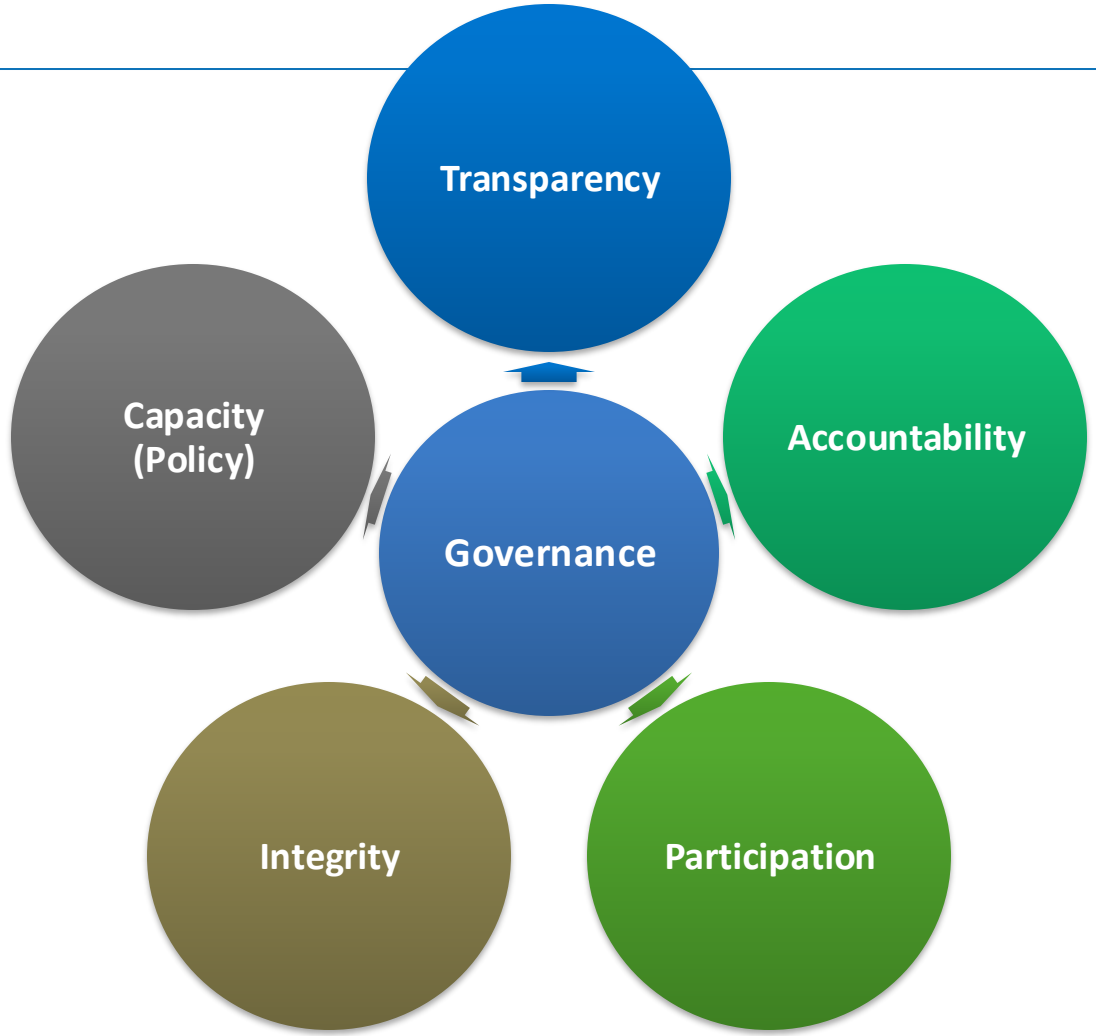
Improving Safe, Timely Access to Care, and Promoting Health & Wellbeing

Methodology

- Qualitative multi-method approach to explore how aspects of governance have shaped the design and implementation of the HSE Health Regions (2018-2023)
- Two methods employed, enabling the triangulation of information:
    1. **Document analysis**: Systematic examination of policy documents, government reports, white papers, and official statements between 2018 and 2023
    2. **Key informant interviews**: 12 semi-structured interviews conducted with policymakers and health system leaders between Nov 2022 and Aug 2023
- Thematic analysis of data, applying deductive/inductive coding

Analytic Lens – TAPIC Governance Framework

- Views governance as a core function for strengthening health systems
- Governance as comprised of five dimensions
- Governance enablers/barriers to design and implementation interact with other factors (resource/financial constraints, disease outbreaks etc)



(Greer et al, 2016; 2018; 2019)

Transparency Reporting/ performance assessment, information	• **Lack of information** sharing by those directly involved in design of Health Regions, **poor communication at times between key stakeholders** • **Status of the design and implementation** of the Health Regions **unclear** to stakeholders not directly involved in policy/design • **Reporting and monitoring of implementation inadequate/ineffective** for accountability purposes
Accountability Decisions explained, mandated, can be sanctioned	• Formally, DoH and HSE leadership are accountable to the Minister; in practice, **no evidence of a system of reward/sanction to hold senior leadership accountable** for decisions taken and for meeting/missing implementation targets • Absence of a **culture of accountability especially in terms of operationalizing policy/change (REOs)** • Despite possessing significant influence on health sector decision-making, **DPER/DEPNDR is not part of the health system accountability structure**
Participation Forums, consultations, advisory committees	• Efforts to **engage relevant stakeholders** perceived as **lacklustre and a box-ticking exercise**, **outsourced to consultancies** • **COVID-19** played a significant role in **limiting stakeholder engagement** • Future engagement and participation deemed **crucial to ensure buy-in and ownership of the reform process** at all levels and across the new regional structures (HR, IHA, CHN, GPs, Section 38 & 39s, broader health sector)
Integrity Allocation of roles/ responsibilities, clear formal rules, stability	• **Clarity around the aims** of the decentralisation reform and **shared vision** for the **Health Regions lacking** in early reform phases • **Blurring of roles, responsibilities and processes** (notably DoH and HSE) for implementation of the reform, coupled with conflicting visions for the design of the Health Regions • Status and structure of Regions finalised towards the end of data gathering and analysis
Capacity (Policy) Technical, financial and analytical resources	• **Adequate policy formulation capacity evident** in the system • **Implementation capacity** (know-how to translate policy design into practice) and required resources **inadequate** for designing, planning and implementing a complex programme of reform

Conclusions

- Deficiencies in the governance of the Health Regions design and implementation process across all five, interrelated TAPIC domains
- 'Conflict at the Centre': Tensions in the relationship between key institutional partners, DoH and HSE; influential DPER/DPENDR outside of formal health governance system
- Competing visions for the Health Regions and what the reform will accomplish
- Blurred division of responsibilities across *policy design, design of the implementation,* and *operationalisation* of the implementation processes
    - Allocating sufficient resources and (skilled) capacity to operationalising implementation is key
- Enhanced trust and communication between/across different system levels is needed to achieve the promise of the decentralisation reform
- How will we know if the regions are working, what do we measure?

Regions' governance – Sláintecare implementation

- Good progress on charges, most new services universal, free at point of delivery
- New public-only consultants' contracts
- Emphasis on public health and new ways of working although dangers of reverting to type
- Striving to deliver integrated care on frontline, ECC, new regions
- Greater coherence at the top in terms of HSE & DoH & last minister's political priority for UHC
- Clarity on what's in the regions, what's not
- New minister, getting the governance right…..

Any questions and thank you for listening

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