2. *SHAPING A HEALTHIER FUTURE*: A STRATEGY FOR EFFECTIVE HEALTHCARE IN THE 1990S: A REVIEW OF PROCESS, CONTENT AND IMPLEMENTATION

Introduction

In the early 1990s the Irish health system was still very much in a *maintenance* phase following the constraint and curtailment which characterised the system throughout the public expenditure crises of the 1980s. By the time Mr Brendan Howlin T.D. was appointed Minister for Health in 1993 there was an emerging view in the Department of Health that it would be necessary to clarify an agenda for health service *development* if the system was to be brought forward from the difficulties of the previous decade. On entering office, the Minister for Health and his political adviser Dr. Tim Collins placed a high priority on the production and publication of a strategy which would be used to shape health service development in subsequent years. In mid-1993 a confluence of opinion therefore emerged whereby the political and civil service leadership within the Department of Health shared the view that a clear statement of strategy was an essential starting point for the specification of a broad agenda for health service development through the 1990s.

Outline of the Health Strategy

Shaping a healthier future

The 1994 Health Strategy is divided into two distinct parts:

- Chapters 1-5 (the "white" pages) are concerned with the health system framework, policy issues and approach to strategic development;
- The Four-Year Action Plan 1994-1997 (the "blue" pages) where the specific targets and objectives for each service area are presented.

This two pronged approach to Strategy presentation facilitated clarity by ensuring that the essence of the proposals for strategic development was clearly differentiated from the specifics of the Action Plan. While recognising that the document needed to advance beyond the inspirational to the specific, the integration of strategy with targets could potentially be confusing for the reader. The presentation of strategy and targets in two different parts of the one document fulfilled the objective of concretising the strategic aims of the process while at the same time ensuring that the detail did not cloud the overall vision being proposed. To facilitate an appreciation for the main areas covered in the 1994 Health Strategy document, the structure of the report is summarised in Box 1.

Box 1
Structure of the 1994 Health Strategy *Shaping a healthier future*

Chapter One

Starting Points (p.7-12)
Overview of system together with exploration of underlying principles.

Chapter Two

The Services (p.15-27)
Concepts guiding service development outlined; three main causes of premature mortality targeted for action.

Chapter Three

The Framework (p.29-37)
Underlying organisational structures reviewed and reconsidered.

Chapter Four

The Participants (p.39-41)
User satisfaction and human resource issues considered.

Chapter Five

The Next Steps (p.43-45)
Proposals for implementation and consultation on the strategy.

Four-Year Action Plan 1994-1997 (p.47-75)
Introduction
Health Promotion
General practitioner services
Dental services
Women's health
Family planning
Children's health
Childcare and family support services
Travellers' health
Addressing drug misuse
Food and medicine control
Acute hospital services
HIV/AIDS patients
Ill and dependent elderly
Palliative care
People with mental illness
People with mental handicap
People with physical or sensory handicap
The Wider Dimension

Shaping a healthier future: Health Strategy Development Process

When the decision to develop a Health Strategy was made by the Department of Health in 1993, the Secretary of the Department put together a very small team of Department officials to undertake the development of this strategy. It was made clear from the outset that the Management Advisory Committee (MAC) would be directly involved through all stages of the process. The Minister and his adviser were also committed to direct involvement in this process. What would seem to have emerged therefore was a very productive collaboration between the office of the Minister and the Secretary within the Department. All those consulted were consistent in their view that the Minister's political adviser (Dr. Tim Collins) played a particularly important role in facilitating consensus in the views and objectives forthcoming from different perspectives within the Department and the wider political system.

When the decision was taken to proceed with the development of a Health Strategy, a very short time frame was envisaged. When the process began in earnest in late 1993, it is estimated that the document took approximately 6-9 months to finalise. Given such a short time frame, it was therefore not envisaged that any extensive consultation process would be undertaken; rather, a top-down approach to strategy development from within the Department of Health was adopted. It is interesting that the direct precedent of the 1994 Health Strategy, **Health – The Wider Dimensions** which was published in 1986 was also produced by an internal Department of Health team with very limited external consultation. To provide some background to the decision to proceed with the development of the 1994 Health Strategy as primarily an internal Department of Health undertaking, a number of factors regarding the context in which this decision was made are worth noting:

- The 1994 Health Strategy was considered an innovative undertaking for a government department at the time as it pre-dated such initiatives as the Strategic Management Initiative (SMI) and the production of similar strategy statements by other government departments which have subsequently become more commonplace;
- The culture of consultation and partnership which currently prevails for public service initiatives can be traced back to the mid-late 1990s' with the implementation of the SMI and successive programmes for government; these initiatives generally post-dated the 1994 Health Strategy;
- Prior to 1993-94 a number of very important policy documents had been published by the Department of Health relating to, for example, the general medical services, the psychiatric services, the elderly and the Commission on Health Funding. In each case, an extensive consultation process had been undertaken. The Report of the Commission on Health Funding in 1989, in particular, involved an extensive review of the structure and functioning of the health system with all parties to the process represented. The 1994 Health Strategy was therefore considered an opportunity to build on the consultation process that had been undertaken in each of these sectoral areas and integrate the views and priorities for development of the health services at the national level.

It is important to note, however, that while a formal consultation process was not launched in preparation for the development of the 1994 Health Strategy, there was substantial informal contact with a number of groups, chiefly the Health Board Chief Executive Officers. While there were a number of plenary meetings involving the CEOs during which draft proposals for the Strategy were discussed, there was also very regular contact with two of the Health Board CEOs who were considered to be representative of the group. This ensured that in addition to providing an opportunity for input to the Strategy, albeit at an informal level, the CEOs were also being given an opportunity to assess proposals prior to the finalisation of the document. In this way the support of the CEOs, which would be crucial to the success of any Strategy, was ensured.

It would also seem that there was informal contact between Department of Health officials and a number of other key groups with regard to some of the proposals being put forward in the document. The discussions with any of the groups representing health service providers, in particular, for the purpose of this report did not generate any substantial criticism of this approach as they seem to hold the view that the final vision portrayed was reasonably representative of the issues and proposals which had been the substance of discussions with the Department over this time period. Where informal consultation was required and pursued, this ensured that the final package would not meet resistance from any of the sources essential to the advancement of the Strategy when finally launched.

It would seem that the involvement of external expertise was limited to a number of meetings with a small number of British and Welsh experts. A similar exercise in strategy development had been undertaken in Wales around the same time so a number of meetings were held with experts who had been involved through the Welsh Health Planning Office and reports suggest that these sources were very

helpful. The World Health Organisation's (WHO) *Health for All* initiative was, of course, being actively pursued over this period and was an obvious reference point for the development of any health strategy at the national level.

It is interesting to note that internal consultation within the Department of Health was also very limited. While Units were asked to outline targets and objectives for inclusion in the Four-Year Action Plan, the detailed discussions on the policy end of the document were generally limited to the MAC and the small team directly involved in Strategy preparation. It seems, however, that there were a number of meetings of the Principal Officers Forum during which different versions of the document were presented for information.

A number of plenary meetings incorporating all involved with the Strategy development including the MAC and the Minster for Health and his adviser provided opportunities for a very thorough examination of the proposals from a range of perspectives as they were being developed. The information available suggests that the Minister was committed to substantial involvement with the production of this Strategy which meant that the political acceptability was addressed throughout the development process. The direct involvement of the Minister, the MAC and the CEOs, at a more informal level, throughout the Strategy development process ensured that those with administrative, executive and political responsibility for putting the proposals in place were all committed to the final package when *Shaping a healthier future* was eventually published.

The launch of *Shaping a healthier future* in April 1994 was accompanied by one of the most sophisticated and successful communications campaigns undertaken by the Department of Health up to that time. With the publication of this Strategy, an explicit decision had been taken that a so called "cascading" approach would be adopted to dissemination whereby the information would be relayed through all sectors of the health system. The publicity material which accompanied the core Strategy document, including a concise summary and a video, were professionally produced to a high standard. On the day of the launch, senior Department of Health officials met with key groups from the health services to present an outline of the Strategy. In the weeks which followed, officials from the Department and the Health Boards met with groups throughout the health system to ensure that the essential messages of the Strategy were relayed in some sort of standardised manner. It is interesting in speaking with individuals who were involved in any capacity in these presentations as they can recall the experience very immediately which would suggest some effectiveness for this technique. This substantial investment in a professional and extensive communications process ensured that health service staff at all levels felt valued because of the effort taken to inform them of this Strategy and they, in turn, took ownership of the Health Strategy as presented.

***Shaping a healthier future*: Health Strategy Content**

In the opening chapter of *Shaping a healthier future*, it is proposed that "the main theme of the Health Strategy is the reorientation of the system towards improving the effectiveness of the health and personal social services by reshaping the way that services are planned and delivered" (Department of Health, 1994, p.9). To achieve this objective, it was proposed that the Health Strategy would be underpinned by a number of key principles: **equity**, **quality of service** and **accountability**.

In recognising that "achieving equity in the healthcare system will involve not only ensuring fairness, but also being seen to be fair" (p.10), the Strategy proposes that the achievement of greater equity will involve:

- Implementing uniform rules for eligibility and charges for services across the country.
- Measures to reduce waiting-times for those availing of public services.
- Giving special attention to certain disadvantaged groups.

In proposing that "the services must meet the highest possible quality standards within the resources that are available" (p.11), the Strategy recognised two dimensions to this process. Firstly, the technical quality of the service must be ensured and secondly, the importance of the consumer's perception of the quality of the service must be readily acknowledged.

The specification of the principle of accountability took account of a number of dimensions which could be inter-related. Adequate and appropriate arrangements to ensure legal and financial accountability are essential elements of any health system. In addition, the issue of clinical accountability which is specific to the health system requires that the decision makers and service providers are accountable to their clients.

A general conclusion that may be drawn from the consultations undertaken for the production of this report would suggest that the health system still has a considerable way to go in the advancement of these principles. With specific reference to **equity**, while recognising that progress has been made in the clarification of some eligibility issues, the majority view forthcoming was that equity probably constitutes the most challenging issue currently for the Irish health system. This would apply to equity in the broadest sense, incorporating equity of access, equity of experience and specifically geographical equity. While the waiting lists have become the most concrete manifestation of equity problems in the health services, the growing belief that patients with health insurance have a fast track option which is unrelated to medical need is cause for ever increasing concern about the fate of public patients in need to medical care, whether of an urgent or elective nature. A more comprehensive discussion of the fundamental issues arising with regard to socio-economic inequalities in health specifically is presented by Layte and Nolan in Section IV.

It is acknowledged that following the publication of the 1994 Health Strategy the awareness of the importance of "the pursuit of excellence" has occupied a more central function within the health system, particularly with regard to service delivery. The very limited progress towards the implementation of any standardised measures or controls at the system level is, however, readily acknowledged. While there have been innovations at the individual practitioner, specialist or institutional level, a comprehensive and integrated approach to quality assessment, monitoring and enforcement has not yet been developed within the health system. While acknowledging the production of the Patient's Charter, the failure to implement any type of system-wide approach concerned with the consumers perceptions of quality issues and responsiveness to consumer concerns about quality must be recognised and addressed.

The substantial progress made in the improvement of financial accountability within the health system was generally welcomed by the individuals and groups consulted. In particular, the Health Amendment legislation (1996) is considered a particularly powerful instrument of enforcement of improved accountability. There was also, however, a general consensus that progress towards the application of clinical accountability, in particular, was almost non-existent. While there may be isolated examples of some innovations in particular specialities or departments, and the recently established Quality Forum is to be welcomed, the lack of any system-level advancement in applications in this area is considered particularly problematic.

Shaping a healthier future places considerable emphasis on the proposal that "the concepts of **health gain** and **social gain**, allied to greatly improved data collection and analysis, will be used to focus the prevention, treatment and care services more clearly on improvements in health status or the quality of life" (p.16). It is interesting that while commentators generally seemed to welcome this proposal, they tended to view the use of these concepts as more "philosophical than operational". While any attempt to define, measure and apply the concepts of health and social gain in quantitative terms will inevitably cause considerable difficulties, the more "ideological" interpretation seemed to be quite successfully portrayed through the communications strategy accompanying the 1994 Strategy. As a result, the adoption of these concepts as "guiding lights" for health system development was broadly welcomed by those working in the health services, as well as the consumers.

It is particularly interesting that many commentators expressed the view that the concept of "social gain" has been particularly helpful is assisting developments in such areas as continuing care and the development of services for the intellectually disabled because it provided a reference point against which advancements could be proposed and supported. It is certainly the case that the major areas of development within the health system since 1994, whether at regional or national level, have been framed within the concepts of health and social gain. While acknowledging the general view that the adoption of these concepts has provided a positive "philosophical" platform for health system development, the difficulties with specification of the concepts and, consequently, problems with measuring progress towards achievement must also be recognised. Against this background, the application of any type of performance measurement techniques would therefore be hugely problematic.

The 1994 Health Strategy adopted a disease-based approach by prioritising the three foremost causes of premature mortality, i.e. **cardiovascular disease**, **cancer** and **accidents**. For cardiovascular disease and cancer, specific strategies have now been produced by the Department of Health and Children and constitute the basis for policy making and service provision with regard to prevention, diagnosis and treatment. The level of accidental death continues to pose enormous problems not just for the health services but for Irish society. It is generally recognised that any improvement in this area will require a renewed commitment to inter-sectoral Cupertino if risk reduction is to be achieved.

Shaping a healthier future: Health Strategy Implementation

The issue of implementation is addressed in the most limited fashion in the 1994 Strategy and essentially involves noting the development of the Four-Year Action Plan, targets and objectives which "must now be translated into more detailed targets and programmes at national and at regional level and, where appropriate, beyond" (p44). The approach adopted by the Strategy was to invite consultation following publication. It was then expected that each Health Board would develop a detailed plan outlining proposals to implement the Strategy within the region of responsibility. While Health Boards did furnish plans for the implementation of the Strategy, the extent to which these plans provided the basis for ongoing evaluation of progress implementation is open to question.

What is generally recognised and welcomed by the relevant commentators, however, is the practice of preparing business plans and service plans which has been successfully implemented both within the Department of Health and Children and throughout the Health Boards and health service agencies. It has been suggested that these plans provide very valuable tools for monitoring progress towards the implementation of policy objectives at the national and regional level.

It must be recognised, however, that a widely held view forthcoming from many of those consulted for this study was that the absence of any detailed plans for implementation, monitoring and evaluation was a weakness of the 1994 Strategy. In reporting this opinion, it is also important to note that the development of the 1994 Strategy was based on the understanding that these functions were appropriate to the Health Boards charged with implementation and that any attempt to tie these authorities into such a rigid planning framework would have been inappropriate. While respecting the autonomy of the Health Boards, it does, however, seem reasonable to assume that the presentation of a sectoral level strategy would address the challenges of implementation, monitoring and evaluation at a more advanced level. An additional barrier to the development of these initiatives arises due to the inadequacies of the information and management systems currently prevailing in the health system. While the importance of substantial development in these areas was clearly recognised as being important to the achievement of the targets and objectives put forward in *Shaping a healthier future*, the level of development to date is generally considered to fall far short of what is required for the application of the tools and techniques necessary for the implementation of effective monitoring and evaluation initiatives.

Conclusion

The 1994 Health Strategy was the first of its kind and represented a novel and unique initiative aimed at setting a broadly based agenda for the development of the Irish health system over a defined time period. The resulting Strategy was testimony to the successful collaboration between the political and civil service leadership in the Department of Health and the small but highly skilled team with responsibility for crafting the final document. *Shaping a healthier future* was generally welcomed throughout the health system which was a considerable achievement in an environment still suffering from the cutbacks and constraint of the previous decade. Commentators were generally of the view that the 1994 Strategy has stood the test of time well and provided a useful and constructive platform for much of the development within the health services since the mid-1990s.

With regard to the process applied to the development of the 1994 Health Strategy, a number of factors contributing to a successful outcome were identified including:

- Full commitment from the Minister, the Secretary and the MAC, and the CEOs.
- A small core group of Department officials had responsibility for drawing up the Strategy with full involvement of the MAC and "hands on" involvement from the Minister and his adviser.
- Internal and external consultation was limited but informal consultation pursued with key groups of decisions makers as required.
- Clearly defined and limited time frame.
- Extensive and effective communications strategy accompanied Strategy launch facilitating broadly based "ownership" of proposals and objectives.

While recognising the achievements of the 1994 Strategy, it would have to be considered more of a beginning than an end point. The decision to revisit this Strategy is therefore welcomed in the context of the ongoing rapid pace of development of the health services within an expanding economy and a growing and ageing population base. In looking towards the development of a new Health Strategy, commentators were therefore generally of the view that, far from considering the 1994 principles of equity, quality of care and accountability accomplished, it would be expected that these principles would continue to feature prominently in the 2001 Strategy which would also be expected to place greater emphasis on implementation, performance measurement, evaluation and delivery.