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HEALTH TECHNOLOGY ASSESSMENT IN IRELAND

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Abstract

Ireland's health system is primarily funded from general taxation and is publicly provided, although private health care retains a considerable role. It is a unique structure, a mixture of universal health service free at the point of consumption and a fee-based private system where individuals subscribe to private health insurance that covers some of their medical expenses. The recent history of the Irish health services saw consolidation of existing services and an expansion into new areas to adapt to changing practices and needs. There has also been a drive to extract maximum efficiency so as to maintain the volume and quality of patient services at a time of very tight financial constraints. Introduction of new health technologies continued to accelerate. New technologies tended to spread rapidly before systematic appraisal of their costs and benefits. When the state is involved in funding the public hospital system, acceptance of new technology is a matter for discussion between agencies and the Department of Health and Children. Decisions about spending annual "development funding" have generally not been based on careful assessment of proposals for new technology. In 1995, a healthcare reform put new Public Health Departments in Health Boards in a prime position in Ireland's health services organization. These departments now emphasize evidence-based medicine. While Ireland does not have a national health technology assessment (HTA) program, there are plans to form an advisory group on HTA in 1998. HTA is seen as a significant element of future health policy in Ireland.

Keywords: Technology assessment, biomedical, Delivery of health care, Ireland

The Republic of Ireland lies in the Atlantic Ocean, separated from Great Britain by the Irish Sea to the east and bounded to the northeast by Northern Ireland. There are four provinces (Table 1). The capital of Ireland, Dublin, has a population in excess of 1 million. Other major population centers are Cork, Limerick, Galway, and Waterford.

Ireland is a sovereign independent democratic republic. Its parliament exercises jurisdiction in 26 of the 32 counties on the island of Ireland. The *Oireachtas* or National Parliament consists of a House of Representatives (*Dáil Éireann*) and the Senate (*Seanad Éireann*). The *Dáil* has 166 members and is elected by adult suffrage on the single transferable vote system, which involves constituencies of three, four, or five members. Each elector numbers his or her preferences in order. The system is often called proportional representation and facilitates representation by smaller political parties that might not, in other systems, be able to send members to parliament.

The 60 members of the Senate are made up of three groups: a) 11 nominated by the Prime Minister (*Taoiseach*); b) elected by panels of cultural, professional democratic interests; and c) elected by graduates of the universities.

Table 1. Four Provinces of Ireland

	Area in hectares	Population
Leinster	1,963,335	1,860,037
Munster	2,412,738	1,008,443
Connaught	1,712,172	422,909
(Part of) Ulster	801,211	232,012
Total	6,889,456	3,523,401

Elected local authorities comprise 27 county councils, five county borough corporations, and six borough corporations, along with 49 urban district councils and 26 boards of town commissioners. All members of these authorities are elected under a system of proportional representation, with elections taking place every 5 years. Local authorities perform a range of services in the areas of housing, roads, environment, sanitation, and general local services.

HEALTH SERVICES

In 1970, health services were removed from the jurisdiction of local authorities. Responsibility for health services was transferred to eight newly created regional health boards. The population served by these boards ranges from 200,000 to 1.2 million, with annual budgets ranging from IRE £86 million to IRE £340 million. Board members include elected local representatives, ministerial nominees, and delegates from consumer and health professional organizations.

The health board structure is essentially built around three core programs: general hospitals, psychiatric hospitals, and community care programs.

The general hospital program may incorporate regional, general, or community and district hospitals. Regional hospitals are located in large population centers and provide a comprehensive range of services. General or county hospitals have consultant-staffed units for provision of services to the immediate catchment area. District hospitals contain small units staffed on a part-time basis by general practitioners.

Psychiatric hospitals have changed following a major review of psychiatric services in 1984. Care of the mentally ill has been reoriented away from large psychiatric hospitals to include more care in acute general hospitals and in the wider community. Health boards enter into agreements with a wide range of voluntary organizations, particularly those caring for the mentally handicapped, for the provision of designated services.

The community care program within the health board has three components: community protection, community welfare, and community health. Responsibilities for community protection include the prevention of infectious diseases, food hygiene, child health examinations, and health education.

Public voluntary hospitals have remained outside the health board system established in 1971. Many of these hospitals have traditionally been run by religious orders, and some function as teaching hospitals. Alternatively, public voluntary hospitals may be incorporated by charter or statute and work under lay boards of governors. The greatest concentration of these hospitals is in Dublin. In this paper "health agencies" means health boards or voluntary bodies that have their own independent boards.

The Department of Health, formed in 1947, was renamed the Department of Health and Children in 1997.

PRIVATE HEALTH FUNDING

Until 1996 private health insurance was provided only by the Voluntary Health Insurance (VHI) Board and various occupational health schemes. The VHI is currently the main provider of health insurance services in Ireland. Following enactment of the Health Insurance Act in 1994, British United Provident Association (BUPA), a private health insurance provider, has entered the market. Voluntary premiums paid by individuals for health insurance are currently tax-deductible at the standard tax rate. Private insurance reimburses members directly for allowable expenses incurred for outpatient services and has some contracts with providers, including hospitals and doctors, for direct payment arrangements. Private insurance covers mainly hospital expenditures. Visits to general practitioners (GPs) are also covered, but the threshold for reimbursement is relatively high so that nearly all GP visits are paid for entirely by the patient. Privately insured patients also pay the entire cost of prescribed medicines up to a ceiling, beyond which the government covers the balance.

Private insurance is provided through a series of plans with different levels of entitlement. The state-funded system for the poorest third does not function on a fee-based system. For those in category 1 (medical card), the doctor is paid a fixed fee per patient per year. Doctors have to meet the pharmaceutical costs of their patients from a budget and can keep a proportion of savings relative to the budget, giving an incentive to restrain the growth of costs. Such a system makes the Irish public system resemble a private health management organization in the United States or a budget-holding doctor in the United Kingdom state system. However, unlike in those systems, the GP does not purchase hospital care for patients out of a budget and thereby limits competitive pressures on hospitals.

An additional peculiarity of the Irish system is that both public and private services may be secured from the same providers. A majority of general practitioners and hospital consultants provide services to both public and private patients, pharmacists serve the public and private sectors, and the major public hospitals have both public and private beds. Indeed, almost half of the private hospital beds are in publicly funded hospitals. In addition, depending on the nature of their contracts, hospital consultants may practice in both public and private hospitals. This mix of public and private services, which facilitates complementary roles rather than conflicting ones, is widely regarded as one of the strengths of the Irish health system.

THE HEALTHCARE SYSTEM

The health system in Ireland is primarily funded from general taxation and is publicly provided, although private health care retains a considerable role. It is a unique structure, a mixture of universal health service free at the point of consumption and a fee-based private system where individuals subscribe to private health insurance that covers (some of) their medical expenses. Primary level care is funded by the state for around 40% of the people at the lower end of the economic scale and for whom free primary healthcare services are provided. Since 1991, all income groups have been provided with free hospital care.

Public health expenditure in 2000 will amount to IRE £4,200 million, or 5.9% of the gross domestic product (GDP). Private health expenditure was estimated at a further IRE £800 million, or approximately 2% of the GDP. It is important to note that in Ireland the Department of Health and Children also has responsibility for services such as social work, adoption, childcare, etc. This fact must be taken into account when comparing Irish health expenditure with that of other countries. A strategy for health care in the 1990s, published in 1994, sought to enhance the health and quality of life of the population by focusing on the key principles of equity, quality of service, and accountability.

The financial system was reformed in the 1980s. Recently, legislation in regard to voluntary health insurance was changed to take into account European Union (EU) directives. For many years, the government-owned voluntary health insurance company was the sole provider of voluntary health insurance in Ireland. Reform of the law has allowed BUPA to enter the Irish market, and other international private health insurance corporations will likely do so in the coming years. It is important to remember that the Irish market for voluntary or private health insurance is very large on a per-capita basis, with almost 40% of the population having private health insurance.

Rapid growth in health expenditures during the 1970s was followed by government cuts in real expenditures in the 1980s. In 1987, as part of a general reduction in government spending, health funding was reduced significantly. In response to public concerns, the government appointed a Commission on Health Funding in June 1987, whose September 1989 report made a number of proposals for major reforms, some of which were put into effect in 1991 (1).

All patients in Ireland can choose their general practitioner, but whereas private patients may choose doctors at will, public patients (the 40% at the lower economic scale who receive free coverage) must register with a GP who participates in the public system. Patients must also apply to the health board for a change of doctor. GPs generally act as gatekeepers and usually work on their own rather than in group practices.

Generally speaking, Irish GPs have higher hospital referral rates than their counterparts in the United Kingdom, possibly because of the preponderance of single physician practices. In the last 5 years, the Department of Health and Children has been trying to provide GPs with more staff and space. However, it is difficult for the department to ensure that each practice is adequately supplied with back-up facilities. In general practices covering sparsely populated rural areas, GPs are allowed to dispense their own drugs.

Eligibility

Eligibility for health services can be broadly divided in Ireland between two categories. Category 1 consists of adults and their dependents who are judged to be unable to arrange GP services without undue hardship. This represents about 37% of the population, who are all eligible for a full range of publicly funded health services free of charge. Health boards may issue medical cards, based on means testing. Chronic illnesses are also taken into account.

People in category 1 are entitled to the following services:

- GP services;
- Prescribed drugs and medicines;
- All inpatient public hospital services in public wards (including consultant services);
- All outpatient public hospital services (including consultant services);
- Dental, ophthalmic, and aural services and appliances; and
- Maternity and infant care service (including the services of a family doctor during pregnancy and family doctor services for mother and baby for up to 6 weeks after the birth).

Category 2 comprises all remaining adults, or about 63% of the population. Though eligible for publicly funded health services, they are not eligible for free GP services or prescribed medicines. In cases of chronic illnesses, however, arrangements are made to pay pharmaceutical bills above a certain level. People in category 2 are entitled to:

- All inpatient public hospital services in public wards (including consultant services) subject to certain modest charges;

- Outpatient public hospital services (including consultant services) subject to certain modest charges but *excluding* dental and routine ophthalmic and aural services; however, the latter exclusion does not apply in the case of referrals from a child health clinic or a school health examination;
- Maternity and infant care service;
- A refund of expenditure on prescribed drugs and medicines over IRE £42 per month for an individual family; and
- Free drugs and medicines for the treatment of illnesses specified under the Long-Term Illness Scheme.

Although both category 1 and category 2 patients are eligible for free hospital services, many choose to use private hospital services provided either by the state or by private hospitals. There is a small charge for outpatients on their first visit, and a small inpatient charge. Health boards have discretion to provide services free of charge in cases of hardship to people who are not normally eligible for particular services.

Strengths and Weaknesses

Irish health services are recognized internationally as high in quality. Well-qualified, committed, and caring staff is trained to the best international standards. A strong voluntary sector provides an integral part of the public system without forgoing the benefits of independence and flexibility. A mix of public and private services facilitates complementary roles.

However, many services are not sufficiently focused on specific goals or targets, making it difficult to assess their effectiveness. Information to support a more focused approach is frequently unavailable or else underutilized. Insufficient attention has been paid to tackling the main causes of premature mortality in Ireland, which has a lower life expectancy than the EU average. There are long waiting times for certain services and inadequate linkages between complementary services (i.e., hospitals, GPs, and other community services). Community-based services are not yet developed to the extent that they can appropriately complement and substitute for institutional care or provide adequately for those in the community who are dependent on support. Organizational and management structures, in place for nearly a quarter of a century, need to be updated to provide for more effective decision making and accountability.

MECHANISMS FOR CONTROLLING HEALTH TECHNOLOGY: RECENT POLICY REPORTS AND PAPERS

The recent history of the Irish health services reflects a period of consolidation of existing services and expansion in new areas to adapt to changing practices in treatment and care and to meet changing needs. The period has also been marked by a drive to extract maximum efficiency so that the volume and quality of patient services can be maintained at the greatest level possible at a time of very tight financial constraints.

The health strategy "Shaping a Healthier Future" (4) says that the demand for health care and personal social services is certain to increase rapidly (as is the cost), due to an aging population. Health spending in Ireland may well increase rapidly in response to growing demands. In the late 1980s, when public spending was perceived to have grown too large relative to the capacity of the economy to support it, spending adjustments and their effects were dramatic. The strategy analyzes the challenges and opportunities ahead and sets out a planned approach to deal with them, taking into account the inevitable limitation in resources.

"Shaping a Healthier Future" must be seen in the context of studies of the overall system and reports on individual services in the last few years. Among the key influences were "Health: The Wider Dimensions" (2), published by the Department of Health and Children in 1989, as well as specific reports on public health, GP services, acute hospital services, mental and physical handicaps, mental illness, the elderly, child care, and many other areas. Publication of these studies and reports has been followed by wide consultation with interested groups in relation to their respective implications. Development of the strategy, particularly in relation to health promotion and disease prevention, has also taken into account the themes and targets of the World Health Organization's Health for All program, and the potential for strengthening EU cooperation following the inclusion of such responsibilities in the Maastricht Treaty. Studies and consultation processes have provided comprehensive analyses of the Irish health service and options for development and reform, drawn together in the health strategy and the Four-Year Action Plan.

Regulation of Pharmaceuticals and Medical Equipment

Pharmaceuticals and medical equipment are regulated for safety and efficacy according to the EU programs for this purpose.

Location and Control of Production

The 1970 Health Act gave *Comhairle na nOspidéal* (the Hospital Council) power to control and regulate medical consultants. Since the introduction of medical technology is almost always driven by the medical practitioner, this council has a major role in deciding the location of technologies and controlling the producers. For instance, a major hospital cannot initiate a coronary artery bypass graft (CABG) program or a transplantation program without Comhairle's approval. Comhairle also decides the type of medical/surgical practices that take place in general, regional, and university hospitals.

Comhairle has also been a very significant player in limiting the range of services provided by hospitals. As a result, a hospital has an agreed range of specialties, with additional specialties only included if Comhairle and the Department of Health and Children agree to that location. This has meant that the unplanned spread of technologies has not been a major problem for the Irish health sector. Within hospitals, however, individual clinicians will seek to introduce technologies in their own areas.

Payments, Budgets, and Fee Setting

In 1989 the government introduced a system of capitation payments for GPs to replace the old fee-per-item service. This arrangement was introduced for medical cardholders (category 1 patients) to overcome the perceived problems in the fee-per-item method, which was thought to encourage overvisiting, overprescribing, and overmedicalization for minor illnesses, a perception that was supported by evidence of higher rates of consultation among cardholders. The new payment arrangement introduces capitation weighted by: a) age of patient (divided into five bands); b) gender; and c) distance from the patient's home, with allowances for after hours and specified services. GPs have been given superannuation arrangements and various form-of-leave payments in return for their contractual arrangements under the capitation system.

In 1987, as part of the rationalization of hospital services and in order to raise funds, charges were introduced for the first outpatient visit (£10) *and* for inpatient treatment (per day, for public beds). The general hospital service was rationalized in 1987, with a 25% reduction in the number of acute hospital beds and a significant reduction in the number of hospitals.

Ireland's expenditure on health and personal social services in recent years has averaged about 9% of the gross national product (GNP). About 2% of that has been privately financed,

whether through voluntary health insurance or out-of-pocket expenditure; the publicly-financed element has averaged about 7% of the GNP. International comparisons compiled by the Organization for Economic Cooperation and Development (OECD) (3) exclude some elements of Irish health expenditure (such as the cost of income maintenance schemes) not included in other countries, and refer to the share of gross domestic product (GDP) rather than of GNP. On this standardized basis, health expenditure accounts for about 8% of Ireland's GDP (3). However, Ireland's per capita GDP is at the lower end of the range. Consequently, the amount of money spent on health care per person in Ireland, although it represents a major commitment of national resources, is considerably lower than in other EU countries where comparative studies have been made. Ireland has succeeded in developing many services, particularly in acute care hospitals, which are recognized as being on a par with those in considerably more affluent countries.

Streamlining Services

Acute hospital service has been streamlined to meet changing needs, resulting in the closure of some older hospitals and transferral of their services to more modern facilities. The advent of day surgery and reduction in lengths of stay due to improved technology have made hospital service much more efficient and effective. The quality of service has been improved and the level of activity, in terms of the number of patients treated, has been maintained. Significant progress has been made in developing a network of community-based services to provide an alternative to institutional care.

Setting Priorities

One of the health strategy's central themes is that decisions on priorities and the allocation of resources will be made in a more open and objective way and will draw on detailed information and analysis of needs, costs, and outcomes, while acknowledging that priority setting can never be entirely objective. The strategy accepts that it is possible to measure the health gain deriving from cardiac surgery and from joint replacements. It may be possible to measure the social gain deriving from better support services for parents of mentally handicapped children living in the community. However, it is difficult for these quite different benefits to be ranked in determining where extra resources are to be made available.

The Commission on Health Funding pointed out the tendency for such choices to be made in an arbitrary way, mainly in the interests of those groups able to exert the most influence on the resource allocation process (1). This is very much in conflict with the principle of equity, which is the foundation stone of the Irish health strategy.

The health strategy states that decisions on priorities must continue to be taken by the government. However, it accepts that the decision-making process would benefit from a system of identifying and informing the public's preferences in general among alternative priorities. The strategy is clear that it is ultimately a matter for the Irish people to decide whether it is possible to develop any method for seeking a broadly based national consensus on Irish priorities.

This is a difficult challenge. Clear answers will not be easily found. However, any progress that can be made toward discussing healthcare priorities at a national level will, at the very least, provide some assistance to the decision-making process. The strategy will attempt to reorient the decision-making process to include more open and explicit choice mechanisms, which not only take into account detailed information and analysis but also reflect public preferences where possible. The Department of Health and Children is committed to initiating detailed research into possible approaches to identify public preferences among competing priorities.

Following the creation of the state, legislative initiatives, particularly the Health Service Act of 1947, were concerned with controls over food hygiene and infectious diseases. In

the 1950s, maternity and child medical services were expanded; in the 1960s, legislation focused on fluoridation of public water supplies and controls on drug distribution. In the 1970s and 1980s, organization, management, and financing of the health service system, together with issues relating to health education and promotion, were priorities. In the 1990s, a restructuring of some elements of the healthcare system was very much on the agenda. The 1994 Health Insurance Act introduced competition into the market for private health insurance.

Performance and Costs: Health Outcomes

The overall health of the Irish population has improved considerably over the past 40 years. Although life expectancy is still low, the risk of dying before age 70 is very similar to that in other countries. Life expectancy at birth has increased substantially but is still below that of most EU countries. Since 1950 it has increased by 11 years for women and by 8 years for men. In 1991, life expectancy at birth was 71.2 years for men and 77.7 years for women. When compared with other EU countries, life expectancy for men ranked ninth and for women ranked 11th out of 12. At age 40, Irish women have a life expectancy of 39.0 years, the lowest in the EU (where the average is 40.8 years).

There has been a substantial reduction in infant mortality since the late 1940s. In 1947, the rate was 68 per 1,000; it dropped to 19.5 in 1970, with a further reduction to a low of 5.9 in 1993. Childhood vaccination programs have had a major impact on communicable diseases. The death rate from strokes has almost halved since 1972, and there has also been a significant reduction in deaths from heart disease. Mortality from road traffic accidents, other accidents, and poisoning has shown a welcome drop in recent years. Maternal mortality has declined 15-fold in recent decades, from 31 per 100,000 live and still births in 1970 to 2 per 100,000 in 1992. The overall death rate was 8.9 per 1,000 in 1991. Heart disease and cancer each accounted for approximately one-quarter of all deaths in Ireland in 1992.

Health Expenditure

Ireland is among the few countries that has experienced a reduction in the share of GDP devoted to health in the period from 1980 to 1993, with a drop of about 23%. The growth in the volume of resources devoted to health care by the public sector in Ireland has been well controlled. Over the past 16 years, the volume of gross noncapital public health expenditure (i.e., before the deduction of income from public bed charges and private treatment in public hospitals) has experienced three distinct phases. It declined by 2% between 1980 and 1984, and again by 6% in the four subsequent years. Spending then grew between 1988–96, rising by 16%, an annual volume rate of 2% that was equivalent to the annual increase in health service employment in the same period. As a result, the fall in gross public resources devoted to health in the 1980s has been reversed, and gross expenditure is now some 10% higher than in 1980. The level of net public expenditure is no higher though, due to the increase in charges and private treatment.

With the volume of public spending remaining practically stable throughout the 1980s, gross health expenditure as a percentage of GNP showed a general downward trend from a high of 8.1% in 1980 to 6.8% in 1989. Health expenditure as a proportion of GNP generally increased to 7.6% in 1993, the highest level reported for this decade. Since then, the economy has grown at an exceptionally fast rate, so that the share of GNP devoted to health expenditure fell to 6.8% in 1996, the lowest level since 1980.

The major increase in health expenditure in the 1990s was in the community care program, not in the core general hospital program. This development follows the trend of the 1980s, when despite constant overall health expenditure the community care program grew in size.

The Health Research Board

The Health Research Board (HRB) was established on January 1, 1987, following the amalgamation of the Medical Research Council and the Medico-Social Research Board. Its functions are: a) to promote, assist, commission, or conduct medical, health, and health services research and such epidemiological research as may appropriately be carried out at the national level; b) to assist and support other health agencies in promoting or conducting epidemiological research; c) to act as liaison and to cooperate with other research bodies in Ireland or elsewhere in promoting, commissioning, or conducting relevant research; and d) to undertake such other cognate functions as may be determined from time to time by the Minister for Health and Children.

The HRB's 1997 allocation was IRE £3.8 million. In their submission of estimates for 1997, the HRB sought a base funding of IRE £3.4 million in order to begin to reach the IRE £5 million per annum target recommended by the Science and Technology Innovation Advisory Council (STIAC) report, mentioned in the White Paper on Science, Technology, and Innovation. In addition, the HRB received IRE £200,000 for hepatitis C research in 1997.

Following international peer assessment, five new research units were established that address areas of significant social and economic importance: Suicide Research, Diabetic Nephropathy, Early Arthritis, Gene Therapy for Cancer, and Retinopathies Research and Therapy. Five research units established in 1991 successfully completed their programs in 1996: Schizophrenia, Alzheimer Disease, Opportunistic Infection in AIDS, Leukemia/Aplastic Anemia, and Pharmaco-epidemiology and Medicines Evaluation.

New research studies on some of the key areas relating to hepatitis C virus infection were initiated. One large-scale project grant for health services research was awarded for a study on "Analysis and Mapping of Small Area Variation in Health Outcomes." In addition, the HRB commissioned Dr. David Parkin, University of Newcastle-upon-Tyne, to undertake "A Review of the Training and Teaching of Health Services Research in Ireland."

Some 59 new research project grants were awarded, which will provide employment opportunities for some of the brightest and best young graduates in Ireland. From a very high-quality field, eight postdoctoral research fellowship awards were made. As part of the Irish Presidency of the European Union, the HRB, in conjunction with the Department of Health and Children, hosted a meeting of the EU-Biomedical and Health Research Programme Committee in Dublin in November 1996.

Three Irish-led research consortia were awarded research contracts under the second call of the EU-BIOMED-2 research program. In addition, 12 Irish research groups will be participants in other successful consortia. Recently the HRB embarked on a matching funds arrangement with the Wellcome Trust for additional research.

HEALTH TECHNOLOGY ASSESSMENT

The term "medical technology" is often associated with equipment, but its true meaning embraces all methods of providing treatment to patients. Recent developments in high technology medicine, all of which have been extremely costly, include diagnostic machines such as magnetic resonance imaging equipment, chemotherapeutic drugs, and highly skilled minimally invasive surgical techniques such as laparoscopic surgery.

The introduction of new medical technologies into the health services in Ireland and in other countries continues to accelerate. There has been a general tendency in Ireland for new technologies to spread rapidly before there has been any systematic appraisal of their costs and benefits. This spread arises from the understandable desire of doctors and patients to make use of any developments that offer the prospect of better and more effective care. As part of the health strategy, a formal system of technology assessment will be introduced.

An advisory committee will be appointed to consider what type of assessment system is best suited to a small country.

Ireland does not have a health technology assessment (HTA) agency. Where the state is involved in funding the public hospital system, acceptance of new technology is a matter for discussion between agencies and the Department of Health and Children. Generally speaking, a set amount of funding, called "development funding," is available to the health sector each year. The Department of Health and Children divides funds among agencies. The amount of money available is governed by the additional amount available for improvements in the health sector. Each service (hospital, primary care, mental health, etc.) bids for development funding.

Agencies assess the need for service improvements in terms of the needs of the population they serve, through discussions with administrative, medical, nursing, and paramedical personnel. These discussions are usually concerned with improvements in patient care and identification of gaps in existing service. Each agency must set priorities, since all requests will not be funded. Bids for service improvements are evaluated carefully because the agency will have to defend its decisions and requests in discussions with the Department of Health and Children.

Agencies then present their bids for service improvements to the Department of Health and Children, which examines the top priorities to ensure that they are in line with the National Health Strategy. Financial restrictions dictate that only the top priority service improvements are normally funded. While no formal HTA takes place, results of trials and available literature supporting the bid are presented. The department makes the final decision on what service improvements will receive funding for the year.

The Department of Health and Children may carry out special studies on a national basis, as has been done with cardiac surgery, liver transplantation, and cancer services. The department identifies the national interest in carrying out these studies, which take into account the current state of the technology, publications on trials, and information on health outcomes. A multidisciplinary team, assembled by the department to assess the project, reports to the department secretary, and the minister makes the final decision.

RECENT DEVELOPMENTS AND FUTURE PLANS

In 1995, following a major review of public health arrangements, the Minister for Health and Children implemented the Hickey Report, which put new Public Health Departments in Health Boards in a prime position in Ireland's health services organization. Public Health Departments have since emphasized evidence-based medicine. Directors of Public Health are increasingly using the evidence available on certain technologies in planning future health services, an approach that increasingly affects decision making at the local level. More precise costing arrangements introduced by the Department of Health and Children now allow more precise cost analyses to be made. The next step is to assess certain medical procedures to quantify their health outcomes.

Health technology assessment is seen as a very significant element of future health policy in Ireland in the coming years, and the setting up of an agency to advise on HTA is being considered.

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