RESEARCH ARTICLE

Understanding service reorganisation in the Irish health & social care system from 1998 to 2020: lessons for reform and transformation [version 1; peer review: awaiting peer review]

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Abstract

Background: Given policy drives for integrated care and other reforms requiring service reorganisation this study analyses service reorganisation in the Irish health and social care system from 1998 to 2020 with the aim of identifying lessons for reform implementation and system learning generally.

Methods: A mixed-method, co-designed study of three distinct datasets through in a policy document analysis, a thematic analysis of interviews with elite respondents, and a formal review of the international literature, sets the Irish reorganisation story in the context of services and system reorganisation elsewhere. This approach is apt given the complexity involved.

Results: We find repeated policy declarations for forms of integrated care from the early 1990s in Ireland. These have not resulted in effective change across the system due to political, organisational and implementation failures. We identify poor clarity and commitment to policy and process, weak change management and resourcing, and reluctance from within the system to change established ways of working, cultures and allegiances. Given its narrative approach and identification of key lessons, this study is of use to policy makers, researchers and practitioners, clinical and managerial. It forms part of a bigger project of evidence building for the implementation of Sláintecare, Ireland's 10-year health system reform programme.

Conclusions: The paper captures important lessons for regionalisation of services delivery and other reorganisations in service-based systems more generally. We find evidence of a negative policy/implementation/practice cycle repeatedly missing opportunities for reform. Learning to break this cycle is essential for implementing Sláintecare and other complex reorganisational health reforms generally.

Keywords
Reorganisation, health systems, services reform, decentralisation, integrated care
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**Introduction**

This aim of this study is to describe the phases, processes and outcomes of service reorganisation in the Irish health and social care system from 1998 to 2020 to identify useful implementation insights for on-going Sláintecare implementation, general health reform, and system learning. The study was co-designed with policy makers and implementers of Ireland’s 10 year health system reform programme, Sláintecare (Houses of the Oireachtas, 2017) as part of the HRB funded project ‘Health system foundations for Sláintecare implementation in 2020 and beyond – co-producing a Sláintecare Living Implementation Framework with Evaluation: Learning from the Irish health system’s response to COVID-19’ (Burke et al., 2020).

The study captures myriad challenges in organising care at macro, meso and micro levels (Braithwaite et al., 2019). Given path dependencies, we offer a rich description of the implementation difficulties of reorganising care for health system reform, particularly relating to regionalisation and decentralisation of care. As the narrative, or story of change is important in this context we take account of local issues, roles, politics, time and other contextual factors. Whilst the development story of the Irish care system can be rooted to the founding of the State in 1922 (Barrington, 1987; Burke et al., 2018; Wren, 2003) this study focuses on the period from 1998 to 2020 to reflect recent population health trends, health reform policies and implementation processes relating to service reorganisation, including professional and political perspectives.

The following research question and sub-questions generated a structure for the study:

**What and how can we learn from service reorganisation in the Irish Health and Social Care System from 1998 to 2020?**

This core question was operationalised through five sub-questions:

1. What distinct service reorganisations can be identified from 1998 to 2020?
2. What was the focus and language of each service reorganisation; what mechanisms were understood to drive reorganisation in each case; what outcomes can be identified?
3. What change processes were undertaken for implementation, and with what effect?
4. What can we learn for current design and implementation work on Regional Health Areas?
5. How can we embed this learning more broadly for on-going system reform?

Four theoretical lenses guided the analysis. A complex adaptive systems lens frames reorganisation as non-linear, dynamic, emergent process (e.g. McDaniel et al., 2013; Mitleton-Kelly, 2003) for which success should be read from a critical policy analysis perspective (e.g. Greenhalgh & Papoutsi, 2018). Attention to context (Meier & Dopson, 2019) highlights the myriad elements of the ‘local’ as important implementation factors that cannot be ignored given the history, fragmented nature, and lack of administrative coherence across the Irish system (Houses of the Oireachtas, 2017). Understanding the contextual factors influencing or determining outcomes reflects an appropriate degree of complexity given the scope of the study (Meier & Dopson, 2019).

Finally, an organisational learning lens takes account of the collective nature of system discourse and learning (e.g. Davies & Nutley, 2000). From this perspective, relevant factors include gaps in knowledge translation and sharing, bounded rationalities and silos, the relevance and impact of situated meanings, and the ways in which access to knowledge and understanding empowers groups for implementation (Bhatt, 2000).

Service reorganisation is understood here as structural changes to the design, governance, management and resource allocation patterns of service delivery. Whilst service reorganisation is often focussed on centralisation/decentralisation or regionalisation, it is not limited to this as it also references changes to services design and delivery in general. Service delivery models and practices are influenced by, and shape experiences of, care and work, systems management, and outcomes relating to access, equity, safety and quality; in best case scenarios they are designed to improve patient care and outcomes (World Health Organization, 2007). Service delivery is also inherently linked to other core system functions such as workforce and information management, medical products and technologies, financing, governance and leadership (ibid).

**Methods**

Once the scope, approach and research questions were agreed through a co-design process with the knowledge-users and researchers, three distinct data generation and analysis processes were followed in a mixed-method, concurrent research process (Creswell & Zhang, 2009).

Dataset one comprised 38 policy, strategy and planning documents including the 16 Health Service Executive (HSE) National Service Plans (NSPs) from 2005 to 2020. Potential documents were named and included if they articulated, informed or operationalised Irish reorganisation policy and implementation between 1990 and 2020. Inclusion was agreed by the research team and knowledge users to ensure relevance and no important omissions.

Documents were collected from relevant databases, websites and internal sources, screened and content analysed using a matrix of key terms generated from initial scoping of the literature to identify common reorganisation drivers. These were design intent, change mechanisms, mention of specific resources for change, implementation strategy or plan, intervention evaluation, governance, workforce planning and integrated care. The analysis was conducted by mapping the contents of documents onto an MS Excel spreadsheet using a range of column headings, i.e. title, author, year, resource type and
structural focus. Documents were also qualitatively reviewed for content on design intent, change mechanisms etc. as per reorganisation drivers noted above, with summary details included under spreadsheet column headings. After content analysis was completed, documents were read for context using secondary sources (e.g. Burke, 2009; Drumm, 2011; Kelly, 2007; McDaid et al., 2009; Smith & Normand, 2011; Wren, 2003; Wren & Tussing, 2006) to include relevant commentary on reorganisation and structural change in the Irish system. The 16 NSPs were analysed for content to see if reorganisations outlined in policy documents translated into operations planning, funding allocation or reporting of outcomes.

On a parallel track and constituting Database 2, ten interviews with elite respondents were conducted, transcribed and qualitatively analysed to identify key themes. Respondents were purposefully recruited based on the following criteria: insider knowledge of service reorganisation initiatives during the study period, inclusion of relevant political, policy development and operational perspectives, addressing early, mid and later reorganisation phases over the study period.

All respondents were approached by email from the lead researcher (SBa) and asked to participate and no-one declined. In advance of interview, every respondent received a participant information leaflet and consent form. Consent was signed either in person before the interview or by digital signature in advance when interviews were conducted online. Two interviews were conducted face to face, and the other eight conducted online due to the restrictions of the COVID-19 Pandemic. One researcher (SBa) conducted 7 interviews, MS conducted two interviews, and SBu one interview. In all cases, only the respondent and the interviewer were present, and interviews lasted from 40–60 minutes. In some cases, transcripts were returned to respondents. All semi-structured interviews were guided using the same interview protocol designed through initial literature scoping and discussion with the research team. Interviews were recorded using the Otter.ai software (https://otter.ai/), cleaned for clarity and anonymity, and coded using the interview protocol to focus on phases of reorganisation, their design intent, the change management steps taken for implementation, and discussion of lessons to learn on reflection. Several key themes identified through analysis of these data are reported below in the findings section.

Finally, a rapid review of peer-reviewed literature on reorganisation in health and social care systems generated dataset three. After initial scoping, a search was conducted in late February 2020 using the following search terms: system reform, health service reorganisation, social care service reorganisation, change management, implementation, regionalisation, integrated care, and policy analysis. The databases searched were ASSIA (20/02/20), ABI/INFORM Global (24/02/20), CINAHL Complete (EBSCO) (21/02/20) and PubMed (24/02/20). Searches rendered 918 citations, of which 7 were duplicates and removed. 604 citations were excluded through a first screen based on titles alone. 254 citations were excluded through a second screen based on title and abstract review. The full text of 53 papers were assessed by two reviewers (SB, MS), of which 26 were excluded for the following reasons:

- Did not relate to structural reform (9)
- Focussed on a single or specific change e.g. financing, health insurance (8)
- Focussed on one health or social care sector only (3)
- Not from a comparable system or country to Ireland (2)
- Theoretical or conceptual only (2)
- A population health or methodological focus only (2)

This resulted in 27 papers initially included for content analysis and identification of key themes as reported below in the results section. Given the very broad scope of one paper (O’Neill et al., 2012) it was subsequently excluded from full analysis due to time constraints.

Bias was managed through the co-production process, i.e. iteration of research design, development, discussion and dissemination phases through which knowledge-users interrogated findings for resonance and validity. Interviews were coded by three different researchers (SBa, MS, SBu) and emerging themes discussed at research team meetings.

Secondary datasets (one and three) were generated in positive desktop conditions, and the interview dataset (two) generated through an open invitation process, using a participant information leaflet and consent forms signed in advance of interview by all respondents. The study was conducted under ethical approval granted by the Research Ethics Committee of the Centre for Health Policy and Management and Centre for Global Health at Trinity College Dublin (1/2019/04E) as part of the Foundations for Sláintecare Implementation Project (HRB-APA-2019-012 Burke et al., 2020).

Given the co-productive nature of the research design for strong applicability, a draft report was completed and reviewed with knowledge-users. Insights from discussion of the early draft are reflected in the final study.

### Results

Results generated through analysis of the three distinct datasets create an overall perspective discussed in the broader context of health and social care reform at the end of this paper. The paper closes with conclusions and recommendations for implementation of reorganisational change.

**Dataset one: documentary analysis of 38 policy and strategy documents**

The 38 policy, planning and strategy documents collected and analysed in order to identify discrete phases and content of reorganisation in the Irish health and social care services from 1998 to 2020 are listed in full in Table 1 below.
<table>
<thead>
<tr>
<th>No</th>
<th>Document Name</th>
<th>Source</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990s</td>
<td>Department of Health</td>
<td>1994</td>
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<tr>
<td>2</td>
<td>Health (ERHA) Act 1999</td>
<td>Houses of Oireachtas</td>
<td>1999</td>
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<tr>
<td>3</td>
<td>Quality and Fairness: A Health System for You Health Strategy</td>
<td>Department of Health and Children</td>
<td>2001</td>
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<td>5</td>
<td>Audit of Structures and Functions in the Health System (The Prospectus Report)</td>
<td>Department of Health and Children</td>
<td>2003</td>
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<tr>
<td>8</td>
<td>The Health Service Reform Programme</td>
<td>Department of Health and Children</td>
<td>2003</td>
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<tr>
<td>9</td>
<td>Health Act 2004</td>
<td>Houses of Oireachtas</td>
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<td>10</td>
<td>Transformation Programme 2007-2010</td>
<td>Health Service Executive</td>
<td>2006</td>
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<tr>
<td>11</td>
<td>Organising to Deliver Integrated Care (The McKinsey Report)</td>
<td>Health Service Executive</td>
<td>2008</td>
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<td>12</td>
<td>Integrated Services Programme: Emerging Service Delivery Model (internal presentation, not available online)</td>
<td>Health Service Executive</td>
<td>2010</td>
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<td>14</td>
<td>The Establishment of Hospital Groups as a Transition to Independent Hospital Trusts (The Higgins Report)</td>
<td>Department of Health</td>
<td>2013</td>
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<td>15</td>
<td>Securing the Future of Smaller Hospitals: A Framework for Development</td>
<td>Department of Health/ Health Service Executive</td>
<td>2013</td>
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<tr>
<td>16</td>
<td>Memorandum to ‘All members of HSE Management Team; all Regional Directors of Operation; all ISA managers’ by Tony O’Brien, 12th May 2013</td>
<td>Health Service Executive</td>
<td>2013</td>
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<tr>
<td>17</td>
<td>Health Services Executive (Governance) Act 2013</td>
<td>Houses of Oireachtas</td>
<td>2013</td>
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<td>20</td>
<td>Sláintecare Implementation Strategy</td>
<td>Department of Health</td>
<td>2018</td>
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<td>21</td>
<td>Sláintecare Action Plan 2019</td>
<td>Department of Health</td>
<td>2019</td>
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<td>22</td>
<td>Health Services Executive (Governance) Act 2019</td>
<td>Houses of Oireachtas</td>
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<td>23</td>
<td>HSE National Service Plan 2005</td>
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<td>HSE National Service Plan 2006</td>
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<td>HSE National Service Plan 2012</td>
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Documentary analysis evidences unspecified goals and lack of clear understanding of reorganisation; the ‘what’ (the intended change) and the ‘how’ of reorganisation (approaches to and means of achieving change) are confused. As an example, scant reference to workforce planning is symptomatic of the lack of a clear and comprehensive approach. Given its importance, as a key mechanism for delivering change and as an essential health system building block, its low focus in the documents is surprising. Consideration of workforce planning is clearer in the NSPs; however, this focus is erratic. While the Hanly Report concerns workforce directly (Department of Health and Children, 2003d), it focuses narrowly on consultant staffing in the hospital sector following the European Working Time Directive and not its role in reorganisation per se.

Outcomes, when highlighted seem haphazard and focussed predominantly on structural design. Whilst similar objectives of reform are listed across the documents, i.e. improved governance and accountability, service integration, financial sustainability, improved efficiency and planning of services, improved patient experience and outcomes, there is little reference to earlier reforms and policies, or evaluation of progress made. It is unclear how the whole system can be transformed by specific strategies, or how changed structures will improve service delivery. The unclear purpose and understanding of change mechanisms seems to contribute to poor system learning limiting improvements in service delivery over the years.

Analysis of the 16 NSPs shows that language of regionalisation (as a form of reorganisation) almost disappears from 2014 to 2018, but re-emerges post 2017 with the publication of the Sláintecare Report. The NSPs evidence a story of constant HSE reorganisation – as transformation (2007–2008), reconfiguration (2009–2012), or as directorates (2012–2016) and although operational in nature, the absence of a language of reorganisational drivers here given the significant structural transformations undertaken is surprising.

Across all documents, a considerable focus on governance was identified, and despite terminological variation and inconsistencies, integrated care was identified as a consistent focus of reorganisation policy over the study period.

In summary, analysis of the policy, planning and strategy documents reviewed highlights a health and social care system caught in a series of organisational reform false starts, a pattern of repeating phases of a) policy intent and planning that b) remain substantively unimplemented. This pattern suggests that various ‘plot twists’, political, practical or cultural, have shifted the system from its strategic intent towards other, less design-focussed ends. The story of these phases is presented in narrative format in the sections below, and further analysed to understand implementation barriers and opportunities through analysis of respondent interviews in dataset two.

Quality and Fairness
On reorganisational terms prior to the publication of Quality and Fairness: A Health System for You-Health Strategy in 2001 (Department of Health and Children, 2001b), the only major health service organisational change since 1970 was the establishment of the Eastern Regional Health Authority (ERHA) in 1999 (Houses of the Oireachtas, 1999). The ERHA was established as the agency with overall responsibility to plan, arrange for and oversee health and personal social services for the one and a half million people who lived in Dublin, Kildare, Wicklow and those from outside the Eastern Region who would come to Dublin for treatment. The ERHA was ‘responsible for ensuring that the services provided [were] closely coordinated around the individual patient, even though they may be provided by different agencies’ (ibid). The early emphasis on person-centred care is evident.

Quality and Fairness was important, as it was the only national health policy between 1994 and 2018. As such, it set the policy direction for the decade to follow. It was closely aligned with increased investment and expansion of primary care services as detailed in the Primary Care Strategy.
(Department of Health and Children, 2001a) published within weeks of *Quality and Fairness*. Importantly, the policy committed to ‘an independent audit of functions and structures in the health system’ making it a pillar document for reorganisation. In the run up to 2001, the Health Boards were considered unfit for purpose and the documentation reviewed reflects this shift towards organising services under a unified national body with a more consistent approach to planning, governance and service delivery, as evident in the formation of the ERHA in 1999.

To this end, three reports were commissioned by the Department of Health and Children known, respectively, as the Hanly, Prospectus and Brennan reports (Department of Health and Children, 2003a; Department of Health and Children, 2003b; Department of Health and Children, 2003d). The 2001 strategies noted above and these three commissioned reports argue for a dedicated change management approach including an implementation strategy, resources for change, and evaluation of change. However, there is little reference to the implementation of these recommendations in subsequent departmental or HSE publications. The three commissioned reports were published in conjunction with the *Health Service Reform Programme* (Department of Health and Children, 2003c) in June 2003 by the then health minister Micheál Martin. This document specified the plan to abolish the health boards and establish the HSE as ‘the first ever body charged with managing the health service as a single entity’ (ibid.). With the exception of the 12-page *Health Service Reform Programme*, there is little evidence in the public domain of the strategic planning that would be expected in light of these documents prior to the formation of the HSE or its evaluation thereafter.

The emergence of the HSE and Integrated Service Areas (ISAs)

The establishment of the HSE including new governance, organisation and funding structures is a turning point in the reorganisation story of the Irish system. The *Health Act 2004* establishing the HSE (Houses of the Oireachtas, 2004) introduced the most significant change to health service organisation since the foundation of the State. It removed the control of the health vote from the Department of Health and specified the objective and functions of the newly established HSE as follows:

‘To use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public… The Executive shall manage and shall deliver, or arrange to be delivered on its behalf, health and personal social services in accordance with this Act and shall… integrate the delivery of health and personal social services’ (ibid).

Initially, the HSE was made up of a National Hospital Office (NHO), a Primary, Community and Continuing Care Directorate (PCCCD) and a National Shared Services Centre as new structures (Health Service Executive, 2005a; Health Service Executive, 2007b; Health Service Executive, 2007a). Four Regional Health Offices – Dublin/Mid Leinster, Dublin North East, Western and Southern Areas – were also established. Once again, the documents linked with this phase of reorganisation have limited information on the design intent or change mechanisms to trigger and sustain the implementation of such major system changes. Apart from the *National Service Plan 2005* (Health Service Executive, 2005a) which announces a ‘major change management programme’ and some resources allocated for those changes, there is an
absence of a consistent change management approach in subsequent NSPs from 2006 and 2007 (Health Service Executive, 2005b; Health Service Executive, 2007a). Further documents outlining in more detail this reorganisation initiative and its salient factors could not be identified in the public domain.

Of importance to system-reorganisation during the early development of the HSE is the planning and delivery of ISAs. These were established on an administrative basis to deliver regionalised, integrated care (Health Service Executive, 2008; Health Service Executive, 2010c; Health Service Executive, 2010b; Health Service Executive, 2010a). The integration of the NHO and PCCCD into a single National Directorate of Integrated Service Delivery was announced in July 2008 with a deadline of September 2009 for full implementation. Notable here once again is the absence of documents detailing these processes in the public domain. Only two internal documents were located for this analysis (Health Service Executive, 2008; Health Service Executive, 2010c). As a result, information on the reorganisation design intent and presumed change mechanisms with reference to ISAs is limited; no change management approach is specified in any of the documents. This is an important finding given our identification of integrated care as a core focus of reorganisation over the last 30 years in the Irish system, and suggests the benefits of taking a closer look at the story of the ERHA, and particularly the ISAs. This is done with the analysis of Dataset 2 below.

**Future Health, HSE directorates and service silos**

The publication of *Future Health: A Strategic Framework for Reform of the Health Service 2012 – 2015* in 2012 (Department of Health, 2012) was the first major policy publication after the 2011 Election and reflects changing political and policy priorities. Following *Future Health*, reorganisation was marked by a sharp ‘reversal’ of earlier efforts to introduce integrated care. The documents evidence a separation of structures for acute and non-acute service delivery (Department of Health, 2012; Department of Health, 2013; Department of Health and Health Service Executive, 2013; Health Service Executive, 2013b; Health Service Executive, 2014a; Health Service Executive, 2014b). These separate care domains were established on an administrative basis, initially through Hospital Groups (HGs) in 2013, and subsequently with the development of Community Health Organisations (CHOs) from 2014 (Department of Health, 2013; Health Service Executive, 2014a).

The governance structure of the HSE changed with the *Health Executive (Governance) Act 2013*, through which the HSE Board was abolished and a HSE Directorate established (Houses of the Oireachtas, 2013). Aside from the plans outlined in *Future Health*, no change management focus is evident in the primary documents reviewed, although there is some emphasis on it in the NSPs from this period (Health Service Executive, 2013b; Health Service Executive, 2014b; Health Service Executive, 2015). Overall, the general design intent during this phase focuses on conceptualising a broad ecosystem design that would facilitate the political aim of introducing universal health insurance.

**Sláintecare and the reemergence of integrated care**

The publication of the *Sláintecare Report* in 2017 (Houses of the Oireachtas, 2017) signaled, for the first time in the history of the State, cross-party political consensus on a high-level, long-term plan for health reform (Burke *et al.*, 2018). The *Sláintecare* vision of ‘a universal health system accessible to all on the basis of need, free at the point of delivery (or at the lowest possible cost)’ champions integrated care clearly and is potentially a critical pivot point in the story of Irish health and social care system reorganisation.

This renewed policy pivot towards integration is evidenced in the structure of the *Sláintecare* Report, with an entire section devoted to integrated care covering all aspects of service and care provision based on the WHO building blocks approach (World Health Organization, 2007). Implementation is also a core pillar of the Report that recommends, a dedicated implementation office, transition funding, and the intention to evaluate change. The *Sláintecare Action Plan 2019* (Department of Health, 2019) follows this approach, once again seeking to integrate all health and social care, although in a considerably different form compared to the ISAs set up in 2010. Similarly, a return/repeat dynamic is evident in the re-establishment of an independent HSE Board (Department of Health, 2019; Houses of the Oireachtas, 2019). The documents analysed for this phase of reorganisation suggest growing awareness of the need for change management and a clear implementation strategy (Department of Health, 2018; Department of Health, 2019; Health Service Executive, 2018; Health Service Executive, 2019; Houses of the Oireachtas, 2017).

**The enduring nature of integrated care delivery as a reorganisation challenge**

As mentioned above, integrated care is not explicitly defined in earlier national strategies, i.e. *Quality and Fairness and Primary Care Strategy* (Department of Health and Children, 2001a; Department of Health and Children, 2001b). Nonetheless, important components, such as the focus on primary care, the integration of primary and acute services, and care at the lowest level of complexity where possible in the community are discussed. An added challenge apparent in the analysed documents indicates that integration is understood (or confused) in multiple ways. The term ‘integrated care’ refers to integrated service delivery, integrated planning and funding, integrated primary care and acute services and integrated structures. These different forms of integration do not necessarily result in integrated care for patients, and the details of implementation, or more importantly, how to evaluate integration are absent from the documents.

While there is an increasing and consistent policy focus on achieving the integration of service delivery or integrated care for patients in some form starting with the national strategies in 2001, the details of how these outcomes can be actioned are not clearly outlined. There is limited discussion
in *Future Health* (Department of Health, 2012) and a full section on integrated care in *The Healy Report* (Health Service Executive, 2014a). Nonetheless, the focus on integrated care clearly wanes from 2013 with the formation of Hospital Groups and CHOs, a shift also reflected in the NSPs from 2012 and 2013 (Health Service Executive, 2012; Health Service Executive, 2013a). Given the reemergence of integrated care as a policy and system goal with Sláintecare in 2017, the question arises as to why previous policy and planning initiatives for integration were largely unsuccessful. Our analysis of the second dataset generated for this study offers some answers as our respondents lived through these events.

**Dataset two: semi-structured interviews with 10 elite respondents**

Building on analysis of dataset one, through which reorganisation phases were identified, this second stage of data analysis confirms the initial pattern noted and supports the identification of five clear reorganisation phases, their different focuses and intent, the change management processes that accompanied them, and finally, points of reflection and learning from these rich experiences.

**Five phases of reorganisation**

There was broad agreement among respondents in identifying five phases of reorganisation in the Irish health and social care system since 1998. During the **first phase**, services delivery, organised through Health Boards established under the 1970 Health Act (Houses of the Oireachtas, 1970), entered a period of transition during the 1990s as the need for more system-wide services management and better decision making emerged. This was driven by trends in population health, including the prevalence of chronic disease and multimorbidity. This awareness gave rise to a **second phase** of early stage rationalisation and reorganisation represented by the establishment of the ERHA (Houses of the Oireachtas, 1999).

Underpinned with the new *Quality and Fairness* policy paper aimed at promoting primary care (Department of Health and Children, 2001b), and commissioned reports focused on structure and governance (Department of Health and Children, 2003a; Department of Health and Children, 2003b) a **third phase** of reorganisation was identified with the setting up of the HSE from 2004 (Houses of the Oireachtas, 2004). The HSE was designed with three main components or functions, a National Hospitals Office (NHO), a Primary Community and Continuing Care Directorate (PCCC) working across four Regional Health Organisations, and a National Shared Services Centre. The Health Information and Quality Authority (HIQA) was established in 2007 to monitor and drive performance and quality standards. The general thrust of these early phase reorganisations was towards greater rationalisation of the Irish system.

On-going development of the HSE under the **Transformation Programme** (Health Service Executive, 2006) meant structuring the delivery of services for a population-based approach through ISAs. This was a shift from the original HSE design and merged the NHO and PCCC Directorate into an integrated care model under several national director-led areas. Also of note during this and following phases is the impact of economic crisis and austerity on the system which should be taken into account when reflecting on capacity to reorganise and strategically change (Burke et al., 2014).

Several of the respondents interviewed identified a **fourth reorganisation phase** triggered by *Future Health* (Department of Health, 2012). This led to the dissolution of the HSE Board, the establishment of a National Directorate Structure reporting on service lines (Houses of the Oireachtas, 2013), Hospital Groups (Department of Health, 2013), provision for CHOIs from 2014 (Health Service Executive, 2014a), and new Mental Health Areas.

The **fifth phase** identified is the emergence of Sláintecare (Houses of the Oireachtas, 2017) and subsequent implementation and action plans (Department of Health, 2018; Department of Health, 2019; Department of Health, 2021). Considering this phase is largely unrealised in organisational terms, respondents suggest that slow implementation means it is important to address systemic challenges at an early stage of the change cycle. All five reorganisation phases identified are outlined in Table 2 below.

**The focus of reorganisation over the study period – implementation challenges**

In responding to questions about the focus of different reorganisations over the study period, respondents discussed many of the barriers that in their opinion halted implementation or delivery on design goals. These goals include creating a population-based, system-wide services delivery model that is patient-centred, integrated and clinician-led, supported by shared services with integrated systems for management of finance, data, HR, performance & risk, procurement and other functions. This also means establishing collaborative work practices between clinicians in the acute, secondary and primary care settings so that patients experience integrated care pathways. Respondents identified versions of this vision in *Quality and Fairness* (Department of Health and Children, 2001b), the ISAs circa 2008, Sláintecare (from 2017) and the new GP Contract (Department of Health et al., 2019).

Nonetheless, our respondents also report that most of these goals have not been realised due to a range of enduring implementation challenges. These include a lack of, or late, articulation of the vision driving organisational change, clarity about its purpose, its clinical rationale and pathway, absence of the systems, data and skilled management necessary, or of the commitment and mechanisms that resource, measure and incentivise the reorganisational change. Globally speaking many of the challenges root to a series of system-wide unresolved conversations, poor relationships and a lack of leadership.

**Unresolved conversations**

Some of these factors are driven by what one respondent referred to as ‘unresolved conversations’ between the Departments of Health and Finance, between the Departments and the HSE, between stakeholders from the different care domains.
Table 2. Five Phases of Services Reorganisation 1990–2020.

<table>
<thead>
<tr>
<th>5 Phases of Services Reorganisation</th>
<th>Across Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>From Health Boards to the ERHA (initial organisational reform from 1994)</td>
<td>1990s</td>
</tr>
<tr>
<td>ERHA and the drive towards a system-based model</td>
<td>1999 – 2003</td>
</tr>
<tr>
<td>Emergence &amp; development of the HSE (&amp; ISAs)</td>
<td>2004 – 2011</td>
</tr>
<tr>
<td>Directorates, HGs &amp; CHOs (Future Health)</td>
<td>2012 – 2016</td>
</tr>
<tr>
<td>Towards a system for integrated, universal care (Sláintecare)</td>
<td>2017 – 2020+</td>
</tr>
</tbody>
</table>

at all levels, and indeed among politicians and the public. As noted above, for example, the introduction of *Future Health* (Department of Health, 2012) was jarring, given the general trajectory towards integrated care. In fact the slow pace and lack of progress on *Future Health* in the view of one respondent suggests a ‘playing down of the clock’ on the part of officials who did not believe in the policy direction, despite its strengths in terms of identifying incentives to drive change (R10).

The power and trajectory of acute hospitals towards an ‘academic centres of excellence’ model is also noted as a challenge in this context – particularly given that integrated care needs various integrators including a governance model, integrated funding, data and information. Respondents see that although creating the right linkages for integrating care between voluntary hospitals and the public system is difficult, opportunities when integration was emerging in the past were missed. For example by building incrementally from the ERHA and other system-building initiatives of the time towards a national system, gains might have been made. Instead, a ‘big-bang’ approach was taken in creating the HSE as a new entity, thus starting from zero on the integration challenge. On the side of the public system in relation to integration of voluntary hospitals, there is a sense that their autonomy is a barrier, but respondents also note that the existence of a perceived negative narrative around the ‘Dublin problem’ needs to change.

Giving these findings, what might be called ‘resolving conversations’ about the direction of system reform and about how to move beyond identified implementation challenges that keep the system from realising its policy goals are needed. Without such conversations the vision and policy remains unclear or unacceptable. In this case, the system finds ways to lag and slow implementation progress. Our respondents note that this is not without negative outcomes including fatigue, and losses of momentum, people and belief.

**Relationships and leadership**

The breakdown of relatively good working relationships between GPs and consultants at local levels during the early phases of the HSE, and failures at realising a model of multidisciplinary collaboration at scale were highlighted, as were weaknesses in management at all levels and poor relationships between managers and clinicians. At a systems level the lack of follow through on systems alignment and shared services due to reticence at departmental level, and resistance to change from the unions are also seen as challenges to successful implementation. There is a need to overcome a fragmented view of the system that sets acute, primary and community care domains as silos that compete. There is a need to understand earlier, and new experiences of spanning old boundaries for patient-centred care.

Overall, respondents note an absence of leadership in tackling ‘vested interests’, and an inability to create national medical specialities due to ‘turf wars’ and established lines of professional accountability. The role of ‘political interference’ is relevant also, for example in halting the development of the ISAs just when they were ‘in danger of becoming successful’, or contributing to an overly negative narrative about the Health Boards that was simplistic in tone and substance. Underpinning these and other complex challenges is a sense that, whilst structures need to change, these changes have to meaningfully deliver services in a population-based, patient-centred, integrated, equitable and systemic way.

**Reorganisation and change management**

**Phasing implementation**

In responding to questions on change management, respondents further developed their thinking on the complex nature of phasing and implementing reorganisations. For example on the ISAs one respondent felt that implementation came too late, i.e., when Brendan Drumm became CEO of the HSE and stated that its NHO/PCCC structure was to change – it took a further two years before the new structure was outlined. There is also need for realistic understanding about the slow nature of reorganisation as structural and practical change that takes time. Noting an absence of this understanding, one respondent remembered how, ‘Brennan is on public record saying the HSE’s CEO’s view that transformation was a ten-year project just showed “the lack of ambition in this sector”’. This respondent felt this actually showed, ‘a lack of understanding in the Department of Finance’ (R10).

On a positive note, the National Cancer Control Programme was identified as a success driven by committed leadership, pacing and clear vision. It was also noted nonetheless that this programme was relatively simple in comparison to
delivery of other national clinical services, i.e. ‘We failed to do it in general surgery. We failed to do it in medicine. We failed to do it in paediatrics, and we failed to do it in maternity services’ (R01).

Clinical buy-in
Another driver of managed change is buy-in by clinicians but in the Irish context respondents talk of the lack of a clear, defined change management process, and clarity on how to achieve positive clinical outcomes; ‘If [the project] is only about the regions and structures then it will become an easy target. I think the integration processes around different groups or population cohorts is really important, so bringing clinicians into that process, that’s what COVID shows, if you have the clinicians and the politicians all focussed on the one goal then everything moves quickly … If clinicians see the change as managers creating new jobs, they become very cynical’ (R10). In other words, reorganisation for regionalised care delivery for example, should integrate with further implementation of three to four of the clinical programmes, Older People or Chronic Diseases for example. This should be in place, ‘as part of the national approach’ (R10).

People and participation in design
There is recognition that at the core of change management are people; it ‘depends on the person or groups that lead it and their capacity to deliver. You can have the implementation plans but at the end of the day it comes down to people’ (R09). From this perspective another respondent suggests the importance of ‘bringing in the people for the regions to the design process [of regionalised care delivery], have the selection and development of the leadership that’s going to run the regions as part of that whole [design] process’ from the beginning (R10).

Aligned to this view is the importance of culture, participation and courage for tough decision-making, political and otherwise – much of which our respondents considered to be lacking. A certain recurring pattern to the policy implementation cycle in the Irish context is noted, i.e. a decision for change is followed by a reorganising phase that threatens established cultures. This leads to a series of industrial relations challenges to planned changes in ways of working and established accountabilities. Often at this point delivery of change slows and the necessary lower system level appointments are not made. The outcome is a loss of momentum, a change in direction with a new government and a new policy, thus the cycle reboots. The goal and hope of Sláintecare is to overcome this negative pattern given the cross-party agreement and longer-than-political-cycle timeframe.

Whilst the obvious drivers of change such as legislation, funding and positive HR planning and management were discussed, respondents also noted how experiences of co-design and having the right people to manage the change makes a difference. For example, a distinction was made between the transition process that created the ERHA (as positive) with people on board, and the larger scale process of establishing the HSE, which did not. There is a view that the rationale underpinning the HSE was unclear from the outset. One respondent argued there was no industrial relations resistance to the HSE because ‘it didn’t make any real difference to frontline practice’ (R07). One could argue this indicates a top down, disconnected plan and delivery process. Remark- ing on the lack of alignment on the vision, another respondent felt the Brennan Report (Department of Health and Children, 2003b), whilst successful on highlighting quality and performance management, came from a ‘banking mindset’. The Prospectus Report (Department of Health and Children, 2003a), in principle informing the same reorganisation process (HSE establishment), was on the other hand more organisational and integrationist in approach. The implication being the visions of the Department of Finance and the Department of Health were different. As a result, the change management approach was ill defined and lacked ambition.

Translating clear policy into operations
Integration as an idea is clearly apparent in Irish health and social care system reorganisation from the early 1990’s, but it lacks clarity and formal process for developing strategic and operational understanding and buy-in with politicians, officials, frontline clinicians, allied health professionals and service managers. Reflecting on the ISA experience from an operational view, one respondent noted that whilst it was ‘easier to achieve the basic connections of cross-over sup- port between hospital care and community health care because there was one single point of leadership of people around the same table’ (R08), the true potential of the structure was never realised. The on-going confusion has several layers, ‘we don’t speak an integrated language yet’, nor is integration incentivised, ‘the system can’t tell us what our performance on integration is, we don’t reward integration… budgets are allocated on the basis of organisational units, not on the basis of population [need]’ (R09).

Despite initial development of ISAs, the formal structures necessary for integration of financial management, budget allocation, human resources, governance and information systems were never, and still remain, unrealised. From an organisational perspective on the ISA, ‘we were asking a lot of the bit in the middle [i.e. managers] to embrace integration when below it and above it wasn’t involved’ (R08). For example, clinical leadership whilst necessary was opportunistic and circumstantial rather than formally created, ‘x was a default clinical director in the ISA’ but ‘membership of the senior management team was not clear’ (R08). Even though posts were designed for integration, ‘the actual structure itself I don’t think ever got properly formed’ (R08). With the lack of formality and integration of systems, ISA managers had insufficient authority to make decisions particularly in terms of financial management, there was ‘no real mechanism to balance the population care demand and the budget allocation’ (R08).

Based on this analysis the rationale for reorganisation should be clear, committed to, clinically strong, supported with ena- bling systems, co-designed and agreed early on with timely roll-out and practical decision making. Once a direction is
taken, sufficient time and focus for development is needed, ‘hopefully people will be honest enough to realise that what we’ve tried in the last 15 years, and then gave up after three or four years, and tried something else, and gave that up after three or four years has just been a disaster’ (R03). It seems the delivery of necessary change has been poor due to a complex set of challenges including a lack of clear direction, engagement, buy-in and commitment from all stakeholders from the political to clinical to operational domains. Leadership and skilled management are essential for these patterns to change.

**Learning from reorganisation**
A final focus of interviews was on identifying learning opportunities in order to inform ongoing reform processes, particularly reorganisation. The period from 2011 to 2013 was particularly challenging. Many of the major changes made through the transition from Health Boards and the ERHA, to the HSE and ISAs were, as noted above, only beginning to bed-in. Subsequent structural changes (such as the dissolution of the HSE Board, the establishment of HGs and CHOIs) present as politically motivated, and disruptive of early steps towards population-based, integrated care. On the basis that integrated care is the goal, lessons relating to four linked key themes were identified from this dataset. These themes are governance, alignment and funding, culture change and new work practices, enabling systems, and finally vision, leadership and learning.

**Governance, alignment and integrated funding**
Working out the right model for structural alignment includes ensuring the different care domains are linked in a ‘right size’ regional bodies with clear authority, decision-making power, ownership and accountability. This means enabling local decision making with a simplified management structure and local opportunities for tailoring solutions (e.g. HSE ICPOP, 2018). Establishing the right governance, line management and communications for integrated care is a challenge but essential early on. This should ensure a positive power-balance between distinct care domains, local issues, organisational politics and national, broader population-health goals. Respondents argue for a change in statute for voluntary hospitals for example (given their priorities are often divorced from national goals), and the removal of private practice from public hospitals for clarity. As noted, the primary, community and continuing care sector needs prioritisation, senior clinical governance and commitment.

Integration also needs allocated funding that is ‘on message’ and incentivises specific actions for integration. Given that to date, there is ‘no real mechanism to balance the population care demand and the budget allocation’ (R08), service budgets should be designed to enable integrated care; this means increased funding for the primary, community and continuing care sectors.

Overall, a regional and integrated governance model for services delivery needs to be clear and focussed on the patient, be politically robust and take a whole-of-system approach. This no doubt requires tackling the power of ‘vested interests’ but also openness across the system to letting go of negative narratives, and developing new, more life-giving engagements, taking risks and working for fresh beginnings, renewed relationships and the emergence of a shared vision. Before this is possible, the governance structure needs to be clear and meaningful.

**Culture change and new work practices**
With an operational focus, respondents acknowledge that establishing new work practices has been a challenge. Given the findings reported above, learning will mean new collaboration between disciplines and domains (following the patient pathway), but also better relationships between clinicians and managers at local levels, between different clinical specialties, and between local and national management. For local managers, there seems to be a disconnect and breaking of trust with senior and national management, often driven by a centrist ‘results-based’ management culture that does not link back to the local context. A fundamental challenge is the delivery of 24/7 care and decision-making capacity at and across all care domain levels, delivering this means transformational engagement with unions, professional bodies and the Departments of Health and Public Expenditure and Reform.

It also means creating the space for strategy at all system levels. We may be ‘really really weak in terms of human capacity to think about these things, we spend our time responding, always in rapid response mode’ but learning suggests that ‘local entities need to have their own space to be strategic as well… there should be a shared function at [regional] level to be strategic from a service delivery perspective’ (R09). Local leadership should be enabled to make decisions so that even though, ‘we haven’t cracked integrated systems… we don’t speak an integrated language yet’ (R09), a path to doing so is created. Engaging with new ways of working, and developing a culture to do this is key.

**Ready data and enabling systems**
Throughout this study, the implication is that good design and decision-making requires the enabling of systems that provide the capacity for oversight, control, strategy and indeed understanding for leadership. Integrated, population-based care is complex and requires robust data systems, information and evidence that underpins new structures, rather than reorganisation based on what providers want per se. Strategists and managers need line of sight, the tools and technologies to make informed and, where needed, transformative decisions. The message here is that these systems, both hard and soft in nature, take time and investment to embed. Our respondents sound the cautionary note that despite reticence, principally from the Department of Finance, on this kind of investment – not making it will disable progress on Sláintecare goals.

**Vision, leadership and learning**
Leadership needs to be clinical, operational and political. Our respondents’ narrative suggests that understanding the
The ‘right’ role of politics in health is a challenge. Whilst the system needs clinical, technical and managerial skills, it also needs political leadership that is clear, innovative and willing to make change, develop new linkages, and learn from past mistakes at the policy level. Nonetheless, where respondents identify political ‘interference’ they suggest the system needs to develop and change itself. There is acknowledgment that at times the focus has been overly technical and process driven. Respondents suggest that while learning from other systems and sectors is important the courage and conviction of leadership is needed to deliver engagement, dialogue and to co-design, for the emergence of resolving conversations that can underpin and embed the vision of integrated, universal and equitable care. This also means engaging citizens in new ways.

Dataset three: peer reviewed literature (27 papers)
The full list of peer-reviewed papers included is shown in Table 3 below. They are categorised according to reform type and country.

**Table 3. Detailed reform types by year and country #27.**

<table>
<thead>
<tr>
<th>Year</th>
<th>Author</th>
<th>Reform Type</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>Casebeer &amp; Hannah</td>
<td>Regionalisation</td>
<td>Canada</td>
</tr>
<tr>
<td>1998</td>
<td>Church &amp; Barker</td>
<td>Regionalisation</td>
<td>Canada</td>
</tr>
<tr>
<td>1998</td>
<td>Saltman &amp; Figueras</td>
<td>System Reform/Policy</td>
<td>Comp. Systems</td>
</tr>
<tr>
<td>1998</td>
<td>Rummery</td>
<td>Joint Commissioning</td>
<td>UK</td>
</tr>
<tr>
<td>2002</td>
<td>Marshall et al.</td>
<td>Primary Care</td>
<td>England</td>
</tr>
<tr>
<td>2003</td>
<td>Pink &amp; Leatt</td>
<td>Health System Reform</td>
<td>Canada</td>
</tr>
<tr>
<td>2004</td>
<td>Atkinson &amp; Haran</td>
<td>Decentralisation</td>
<td>Brazil</td>
</tr>
<tr>
<td>2005</td>
<td>Davis</td>
<td>Alignment Acute/Regional</td>
<td>Canada</td>
</tr>
<tr>
<td>2005</td>
<td>Neville et al.</td>
<td>Regionalisation</td>
<td>Canada</td>
</tr>
<tr>
<td>2007</td>
<td>Touati et al.</td>
<td>Regionalisation</td>
<td>Canada</td>
</tr>
<tr>
<td>2007</td>
<td>Dickinson, Peck &amp; Davidson</td>
<td>Leadership &amp; Organisational Change</td>
<td>UK</td>
</tr>
<tr>
<td>2008</td>
<td>Arrendondo &amp; Orozco</td>
<td>Health System Reform</td>
<td>Mexico</td>
</tr>
<tr>
<td>2009</td>
<td>Chessie</td>
<td>Regionalisation</td>
<td>Canada</td>
</tr>
<tr>
<td>2009</td>
<td>Minkman, Ligthart &amp; Huijsman</td>
<td>Integrated Care</td>
<td>Netherlands</td>
</tr>
<tr>
<td>2010</td>
<td>Sheaff et al.</td>
<td>Health System Reform/Networks</td>
<td>UK</td>
</tr>
<tr>
<td>2011</td>
<td>Naccarella et al.</td>
<td>Primary Care</td>
<td>Australia</td>
</tr>
<tr>
<td>2011</td>
<td>Wakerman &amp; Humphreys</td>
<td>Primary Care</td>
<td>Australia</td>
</tr>
<tr>
<td>2012</td>
<td>O’Neill, McGregor &amp; Merkur</td>
<td>Whole System Review (HiT)</td>
<td>UK/NI</td>
</tr>
<tr>
<td>2013</td>
<td>Sorensen et al.</td>
<td>Health System Reform/Governance</td>
<td>Australia</td>
</tr>
<tr>
<td>2013</td>
<td>Smith &amp; Barnes</td>
<td>Integration Health &amp; Social Care</td>
<td>England</td>
</tr>
<tr>
<td>2014</td>
<td>Hastings et al.</td>
<td>Health System Reform/WFP</td>
<td>Canada</td>
</tr>
<tr>
<td>2014</td>
<td>Toth</td>
<td>Decentralisation</td>
<td>Italy</td>
</tr>
<tr>
<td>2014</td>
<td>Santana, Szczygiel &amp; Redondo</td>
<td>Integrated Systems</td>
<td>Portugal</td>
</tr>
<tr>
<td>2015</td>
<td>Rossi et al.</td>
<td>Primary Care</td>
<td>USA</td>
</tr>
<tr>
<td>2017</td>
<td>Loewenson &amp; Simpson</td>
<td>Primary Care</td>
<td>Comp. Systems</td>
</tr>
<tr>
<td>2017</td>
<td>Shay &amp; Mick</td>
<td>Alignment Acute/Regional</td>
<td>USA</td>
</tr>
<tr>
<td>2018</td>
<td>Cheng</td>
<td>Regionalisation</td>
<td>Canada</td>
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</tbody>
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Four studies were published in 1998; one to two studies were published most years from 2002 to 2018, except for 2014 when three studies were published. These results are noted in Figure 2 below.

Nine studies report on issues relevant to service reorganisation in Canada, making it the most referenced national system among the papers reviewed. Four papers report from the UK, three from Australia and two from the USA. One paper each reports from Portugal, the Netherlands, Italy and Brazil (five in total), respectively, whilst two studies compare systems as shown in Figure 3 below. There is a broad mix of journals included in the set, although there is an unsurprising focus on services and health system functions. A loose grouping of topics and journal types indicates six papers with an organisational change or management focus, and eight papers with a policy focus, whilst 13 papers address factors relating to services delivery including themes of integrated and primary care.

The types of reorganisation referenced include regionalisation and decentralisation (8), services integration (5), changes to primary care delivery (4), network or partnership building (2), and change, whether at a system level (3), a policy level (2) or in terms of culture, behaviours or values (2). The final paper is a whole of system review that was excluded from thematic analysis on grounds of its overly broad scope for the current study (O’Neill et al., 2012). The care domain focus across the papers is on primary and social sectors, including at the regional level, only two of the 27 papers reviewed reference the acute care domain. These results are show in Figure 4 below.

The prevalence of mechanisms of change during the study period was noted and shown in Figure 5 below. Of interest, given the focus of this study on the implementation of reorganisation, is the high prevalence of what we have classified as ‘hidden but real’ mechanisms of change. Following Lacouture et al.’s definition (2015), we understand these hidden/real mechanisms embody ‘element[s] of reasoning and reactions of agents in regard to the resources available in a given context to bring about changes through the implementation of an intervention, and evolve within an open space-time and social system of relationships’.

These are the cultural, behavioural or practical ways in which communities (patients, clinicians, managers etc.) respond to any intervention that demands change. These
‘implicit mechanisms’ highlight the importance of engagement and social participation, (Arredondo & Orozco, 2008; Chessie, 2009; Davis, 2005) of information management and attention to political culture (Atkinson & Haran, 2004; Pink & Leatt, 2003), of leadership & governance (Dickinson et al., 2007; Marshall et al., 2002; Neville et al., 2005; Touati et al., 2007), and culture change management in general (Sorensen et al., 2013).

Findings for dataset three

**Thematic Analysis**

Seven themes emerge from a content analysis of the 26 reviewed papers. Unsurprisingly given the study’s focus on reorganisation, a key theme is ‘integration, whole system approaches and scalability’. A second prevalent theme is ‘leadership and management’, which includes practices and systems. ‘Culture for change’ is an important focus in the papers, as is what we have termed ‘policy-pace and politics’. Finally, a further three themes highlight ‘framing and purpose’, ‘participation and patients’, and the ‘pressure to measure’ which includes some issues relating to cost control.

**Integration, whole system approaches and scalability**

Reorganisation for regional care delivery results in mixed outcomes under the ‘integration, whole system and scalability’ theme. Integrating and coordinating services at scale is a challenge that needs robust information systems for example, does not assure citizen engagement, and may result in higher costs (Church & Barker, 1998). New services and accountability structures are introduced (Davis, 2005; Neville et al., 2005) but success is strongly dependent on local expertise (Minkman et al., 2009). In general, at scale interventions seek to confront resource scarcity, systems for equitable funding, allocating resources effectively and delivering services efficiently (Saltman & Figueras, 1998) but changes can emerge as ‘ill-evaluated reformulations’ of the governance, financing, structural and operational functions (Santana et al., 2014). Operationalising regionalised care delivery (a reorganisation for integration) proves very challenging given the complexity of delivering ‘highly differentiated and integrated’ organisational forms (Shay & Mick, 2017). Regional Boards, for example, in seeking ‘clinico-administrative governance’...
show the need for a combined technocratic, democratic, political and cognitive approach (Touati et al., 2007) which means discovering new routes across professional and sectoral boundaries (Smith & Barnes, 2013). Regionalisation can also result in widening health system developmental gaps between regions (Toth, 2014).

**Leadership and management**

Given the critique of structural type reorganisations such as regionalisation in this literature, the more complex practices of leadership and management emerge as drivers of success. Asking a simple question, ‘does decentralisation improve health system performance?’ Atkinson & Haran find that good management, along with elements of wider political culture, leads to decentralised local health systems and not vice-versa (2004). Experience is identified as the main driver for implementing policy shifts, suggesting the importance of paying attention to the management of change (Casebeer & Hannah, 1998). There is no substitute for this form of ‘high focus work’ (Davis, 2005), which means investing in leadership, communications and proactive engagement as reported by Hastings et al. on workforce planning and change in the Canadian context (2014); a point also made in a study on regionalised citizen governance boards in Canada (Chessie, 2009).

In the context of primary care development (a key care domain represented in the literature reviewed) Loewenson & Simpson (2017) highlight a range of process-type supports and interventions for success such as early first contact and continuity, coordination of referral, multidisciplinary team approaches, investment in primary care competencies, and specific payment and incentive models. These managed interventions locate primary care as a site of innovation, where information technology and peer-to-peer learning networks support learning from practice. Leadership and interpersonal relationships are key factors (Rissi et al., 2015), as is case manager expertise (Minkman et al., 2009) and managerial activity that understands and creates effective cultural drivers (Sheaff et al., 2010).

A systemic and systematic approach is needed for optimal workforce recruitment and retention in primary care for example. Envisioned outcomes are highly dependent on good governance, leadership and management, adequate funding, infrastructure and service linkages (Wakerman & Humphreys, 2011). Such systemic approaches also mean addressing gaps that exist in the development of service benchmarks and national information systems for adequate monitoring and evaluation of health service performance (ibid).

**Culture for change**

Cultural change as a driver of reorganisation is broadly recognised in the general literature on change management (Barry et al., 2018) and highlighted in points already made above. Engaging a workforce in change is difficult and must attend to local culture (Davis, 2005). The differentiation of professional groupings from a purely structural perspective means that opportunities to broaden informal horizontal linkages are underexploited, weakening integration. Without socialisation and cultural engagement, the ambiguity of individual experiences results in contested meanings being attributed to organisational change (Dickinson et al., 2007).

Once again, in the primary care context, cultural change is understood as fundamental for new forms of clinical governance that value public accountability, display willingness to work together and learn, and an ability for self-critique and learning from mistakes (Marshall et al., 2002). An important barrier is the autonomy of practices and a perceived pressure to deliver on measurable change (ibid). The cultural focus also highlights the non-transferability of ready-made lessons from one national system to another (Saltman & Figueras, 1998) suggesting, as above, that experience and practical activity are key factors for reorganisation success (Sheaff et al., 2010). This means understanding how artefacts (such as tools and technologies) are adapted before changes to espoused values are realised, or indeed, deeper changes in underlying assumptions (ibid). Desired outcomes such as a ‘hybrid manager culture’ that bridges the gap between administrative and clinical stances on reform while possible, seem unrealised (Sorensen et al., 2013).

**Policy-pace and politics**

Reorganisational reform is often determined by politics (Arredondo & Orozco, 2008), and the timeliness of policy implementation matters. If too early in the policy process, implementation results in poor engagement and integration (Cheng, 2018; Loewenson & Simpson, 2017). Whilst political engagement is critical with the State in a ‘steering not rowing’ role (Saltman & Figueras, 1998), politicians do scapegoat management for high costs (Davis, 2005). Nonetheless, mechanisms exist for rendering positive political engagement that doesn’t hinder technical process, for example, ‘arm’s length organisations’ that effect incremental system change (Pink & Leatt, 2003) or policy cover for collaborative financial contracting (Minkman et al., 2009).

**Framing and purpose**

Along with leadership, effective management and attention to cultural and political dynamics clear framing and purpose enables reorganisational change. Clarity about the decision-making authority of new structures such as regional boards for example, and their relationships with other statutory bodies (e.g. departments of health) reduces uncertainty (Neville et al., 2005). Poor frameworks for aligning the integration of the workforce across primary care organisations and service planning agencies, compounded by the absence of data and benchmarking goals, results in poor outcomes (Naccarella et al., 2011). Provider networks need investment and the creation of conditions for inter-organisational cooperation (Minkman et al., 2009), as well as frameworks for collaborative working between decision-makers and researchers (Hastings et al., 2014), professional and sectoral bodies (Smith & Barnes, 2013). Framing and clarity of purpose is also essential for managing public expectation in relation to reorganisation goals, for example results such as
greater access to services are not necessarily assured (Davis, 2005).

**Participation and patients**

Following from the above analysis, reorganisation as a reform process requires participation from stakeholders, and a clear patient or person-centred focus (Cheng, 2018; Hastings et al., 2014). There is a balance to be struck for democratic accountability that sits well with technocratic challenge (Touati et al., 2007) which means participation with leaders (ibid), professional groupings (Dickinson et al., 2007), regional planners (Cheng, 2018), patients (Cheng, 2018; Hastings et al., 2014), and citizens more broadly (Church & Barker, 1998).

**The pressure to measure**

In this vein the ‘pressure to measure’ needs nuance given that reorganisation is a complex and generally slow process that can be right in the longer term but cannot render tangible nor easily identifiable outcomes in the short to mid-term. Cost containment exigency from government can be experienced as an unhelpful exogenous pressure (Davis, 2005; Neville et al., 2005), or a perceived deliverable that hinders the process of learning new practices for example (Marshall et al., 2002). Obviously, within this context buy-in to effective evaluation (Santana et al., 2014) and performance management (Sorensen et al., 2013) is critical so that policy directions can meet operational challenges in ways that empower more than disable.

**Discussion and Conclusions**

This research aimed to deliver an understanding of reorganisation in the Irish health and social care system over the period of 1998 to 2020, with a view to informing development of the new regions as detailed in the HSE 2020 Service Plan (Health Service Executive, 2019) and Sláintecare Action Plan 2019 (Department of Health, 2019), and subsequent planning documents (Department of Health, 2021). Beyond this immediate context, the study is also relevant for reorganisation projects more broadly, including the development of enhanced community care and its mechanisms, for example Community Health Networks, Community Specialist Teams, new care pathways and aligned management systems.

We asked five key questions to focus the enquiry. These are:

1. What distinct service reorganisations can be identified from 1998 to 2020?
2. What was the focus and language of each service reorganisation; what mechanisms were understood to drive reorganisation in each case; what outcomes can be identified?
3. What change processes were undertaken for implementation, and with what effect?
4. What can we learn for current design and implementation work on Regional Health Areas?
5. How can we embed this learning more broadly for on-going system reform?

Through generation and analysis of two nationally focussed datasets (policy documents and elite interviews), we have identified five distinct reorganisation phases during the study period. An earlier ‘Health Boards’ phase rooted in the Health Act of 1970 is also referenced as the base-point to what followed in the 1990’s.

We have described each of these phases and identified a clear underlying design intent towards population-based, integrated care and service delivery across them all. Despite this intent we find that these goals were not realised and remain the espoused policy intent in 2021. The findings highlight the absence of unified policy purpose accompanied with strong change management, implementation planning and resourcing. Data analysis also reveals how some reorganisational reforms were politically abandoned just as they were beginning to embed, whilst others were politically motivated rather than evidence-based. We have also identified that the operational system resists change, and in many ways blocks progression. The general outcome of Irish health and social care system reorganisation over the past two decades is weak or inconsistent implementation of reform initiatives.

These outcomes can be attributed, at least in part, to poor clarity about, and commitment to the reorganising mechanisms employed. This has hindered the identification and evaluation of outcomes. Where explicit mechanisms including new structures are highlighted (in policy and planning documents), their meaningfulness often gets lost in lagging implementation. Our findings indicate a failure of system learning so that effective reorganisation when needed remains elusive. Despite the evidence from the international literature that the mechanisms driving change are often implicit and ‘soft’ in nature, learning to work with meaningful engagement, participation, cultural and political nuance seems a profound challenge. Our interview respondents report that the enduring outcome of reorganisation work since 1990 in Ireland is a series of ‘unresolved conversations’ rather than an identifiable learning path.

We have highlighted many of the challenges to such a path of development and growth. These include failures, both political and operational to translate reorganisation policy plans into salient changes that make a difference. Reasons for this include an absence of political leadership and policy cover, and instances of ‘political interference’ that have disrupted the progression and focus of large-system transformation. While recognising there has been too much change at times, and missed opportunities for learning from earlier structures such as Health Boards, the ERHA and the ISAs, implementation has also been hindered by pushback from both acute and community sectors unwilling to move beyond their own perspectives to lead on reform-based change.

Our question about change processes undertaken for implementation highlights how the policy, strategy and operational documents reviewed are patchy and unclear in their articulation of plans, and commitment to implementing proposed changes. In some instances, this may have been...
for political expediency, but it may also reflect a lack of capacity in addressing the complexity of organisational change involved. Creating conditions for timely, complex connections for population-based, integrated care is a practical, on-going task of moving beyond established silos and boundaries, negative narratives and turf wars – factors our respondents believe remain in play to date. There are few quick wins, but we conclude that sustainable reorganising initiatives should be clearly underpinned with change management plans and resources, long-term, clinically robust, and based on population health evidence and evaluated outcomes where available.

In response to the challenges identified, our analysis of the peer-reviewed international literature on reorganisation highlights some important lessons for the Irish system. Whilst regionalisation is not a panacea, it can be the right architecture to deliver universal, population-based care in the right place, at the right time, at the right level of complexity, with the right team. Ensuring this happens in practice means resourcing leadership development, hands-on and skilled management, and working with local cultures. In this vein, some positive reorganisational changes are evident in Ireland; particularly those driven by the National Cancer Programme, but these successes have not translated at scale.

According to the literature, a 'right' balance of political engagement, policy progression and accountability needs to be found. There is no 'one size fits all' solution, which means the framing and clinical purpose of proposed reorganisational change, regional or otherwise, is critical. Primary and community care needs investment as sites of innovation and in the process, appropriate cover and protection from an excessive 'pressure to measure' culture is needed. The international literature highlights the importance of due process, time, balanced goals and accountabilities for building success.

In sum, our analysis suggests that new conversations are important triggers of change. Sometimes a system is shocked into different conversations and parameters. For example, we see in the COVID-19 crisis how latent systemic capacity for change, agility and adaptability emerged in the responses of swift decision-making, role changes, e-referral, and new cooperation across care domains (Burke et al., 2020). It is also evident that when political, clinical and health system leadership delivers clear vision and policy, the public highly value the system and work with it (Cullen, 2020).

Based on our findings, the co-production approach, and applying an organisational learning lens, we identify five recommendations for implementing positive reorganisation. Firstly, the clinical rationale must be clear and committed to with a vision and leadership that sustains, tackles inconsistencies and blockages with courage, and protects the system through the change process. Secondly, governance (including clinical governance in the community) and skilled management (line and change) must be addressed and resourced early but cannot become the sole focus; this should remain on positive outcomes for service-users, patients and public health. Thirdly, engaging people as participants, working with organisational cultures at local levels and creating space for strategy and planning throughout the system is the greatest driver of change and must be resourced. Fourthly, the system needs to be a system so that decision makers of all types have the data, controls, hardware, software, protocols and procedures to inform planning, evaluation, learning and progress. It is also important to ensure the scope and level of system integration is right for the governance structure agreed – whether regional or otherwise. Finally, reorganisation involves a degree of complexity that requires enlightened political engagement and orientation. Keeping the discourse true over the long-term needs skilled network builders and communicators. Success requires visionaries willing to take risks and bring people with them.

In response to our practical question about how learning from reorganisation can inform on-going system reform, we offer some positive directions. Our study indicates a health and social care system challenged by an ambiguous message that says, 'change', i.e. follow espoused policy but 'don’t change', i.e. practice stays the same. The organisational learning literature suggests responding in this case means generating a 'third space' (Elkjær, 2004; Hosking & Bass, 2002), i.e. learning a new set of parameters to deliver transformational goals. Examples of this kind of practice from within and beyond the Irish system can be explored and learnt from.

This study unpacks a story of reorganisation in the Irish health and social care system over the past thirty years and sets it in the light of the international literature. It shows how Ireland’s challenges are not unique and how we can learn from them. Analysis of interview data gives voice to many failures and challenges, but also socialises these experiences to trigger new conversations where they are needed (Nonaka & Takeuchi, 1995). Whilst Sláintecare, coupled with the COVID-19 Pandemic means shifting gears, reorganisation to sustain any positive reform emerging is inevitable. We do well to learn from previous experiences in this regard.

Data availability
Datasets one and three are made-up of secondary, publicly available materials and, although listed in tables included in this study, can be accessed if requested by email to the corresponding author, with explanation of intended use and for a study approved by a recognised ethics committee. Dataset two includes human data which although anonymised, is not publicly shared in order to protect the privacy of respondents in accordance with Trinity College Dublin guidance on Open Data and Research Data Management (https://www.tcd.ie/library/riss/research-data.php). Our respondents may be identifiable given the size of
the Irish health and social care community, and the scope of the topics under discussion. Interview transcripts can be shared if requested by email to the corresponding author if intended use is clearly explained and assured, the study is under the approval of a recognised ethics committee, and respondents’ privacy is explicitly assured under a formal agreement between all parties.

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