



Integrated Healthcare Conference:

Integrating Care for People and Communities

The Auditorium, Convention Centre Dublin
4 September, 2025. 11:45 – 13:00



Rialtas na hÉireann
Government of Ireland



Welcome & Introduction

Damien McCallion
CTTO & Deputy CEO of the HSE



Integrating Care for People and Communities

Agenda

Details	Speakers
Introduction and welcome	Damien McCallion, CTTO and Deputy CEO
Where we are on our journey towards integrated care	Damien McCallion, CTTO and Deputy CEO Tony Canavan, REO HSE West and Northwest
Best international practice in integrating care for people and communities	Sarah Reed, Senior Fellow, Nuffield Trust
Panel Discussion: Integrating care for people and communities	Anne Lawlor, Co-chair of the HSE Patient Forum Lorna Kerin, Regional Patient Service User Lead Mary McGrath, Health and Social Care Professions Regional Integration Development Lead Eileen Whelan, Regional Director of Nursing and Midwifery Dr Siobhán Ní Bhriain, Regional Lead for Medicine, HSE Dublin and Midlands Sarah Reed, Senior Fellow, Nuffield Trust
Reflections and final comments	Anne Lawlor, Co-chair of the HSE Patient Forum Damien McCallion, CTTO and Deputy CEO Tony Canavan, REO HSE West and Northwest



Where we are on our Journey Towards Integrated Care

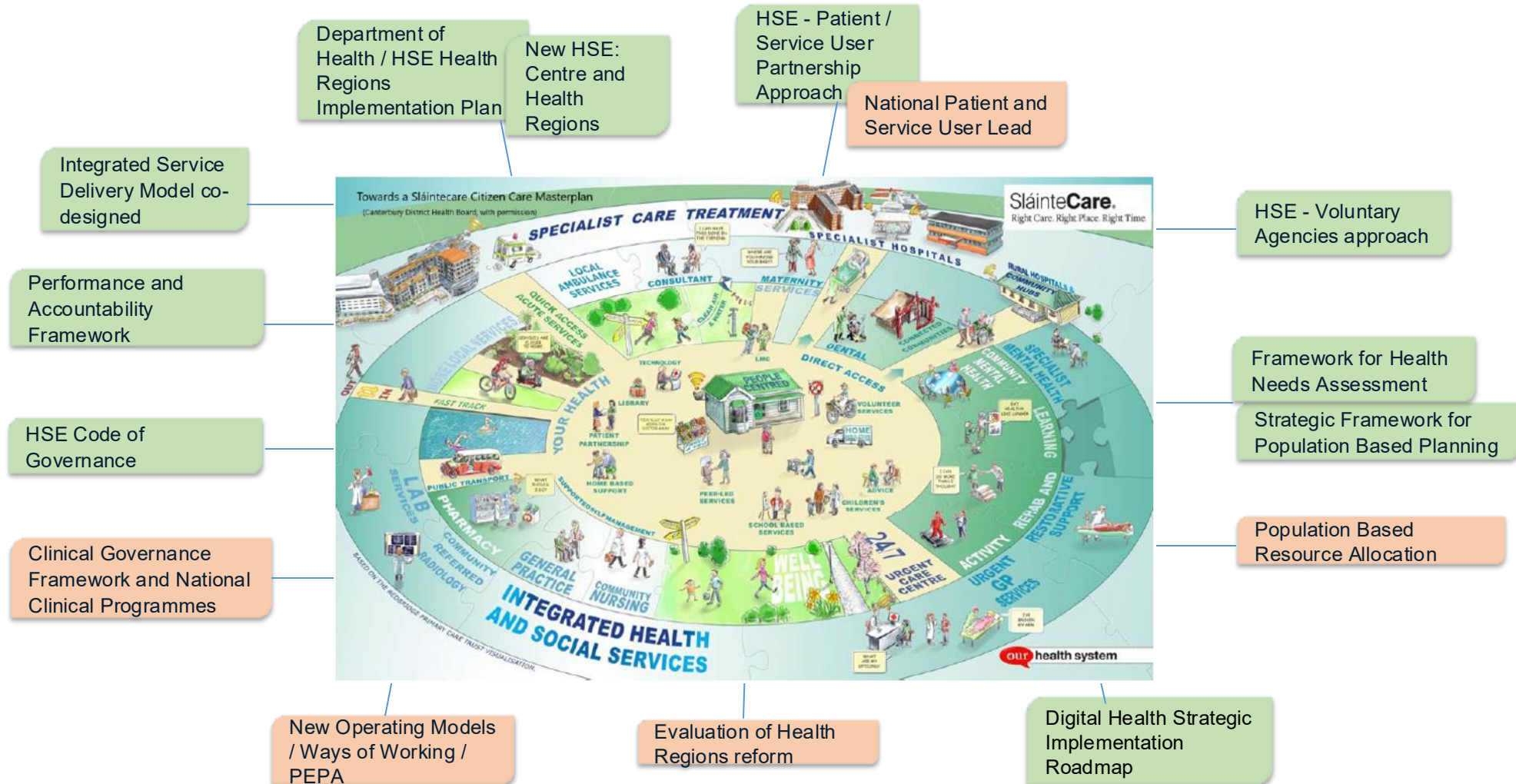
Tony Canavan, REO HSE West and Northwest
Damien McCallion, CTTO & Deputy CEO of HSE

Integrating Care for People and Communities





Delivering integrated care for people and communities requires whole system change: National Perspective

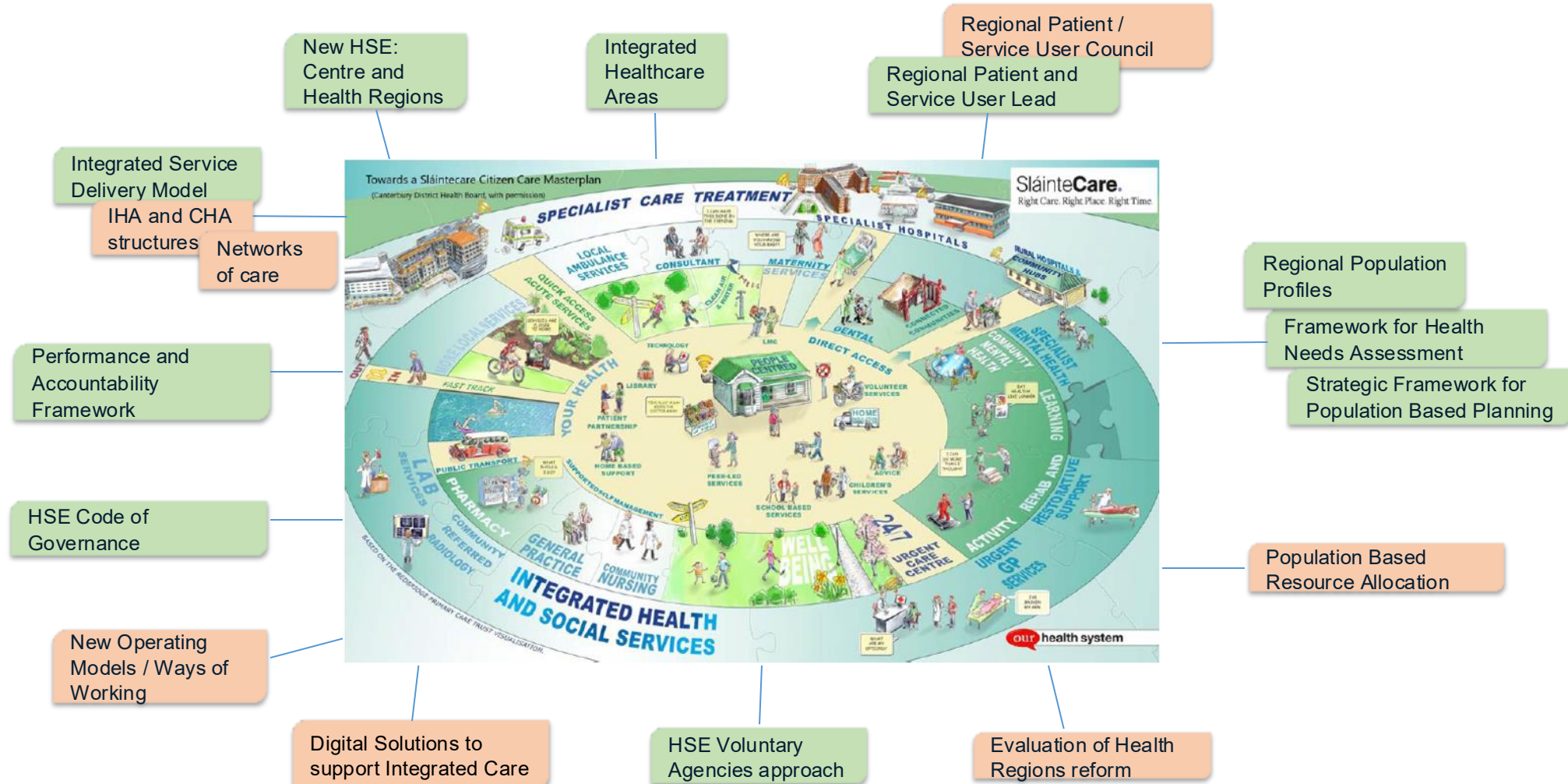


Working together towards integration:

Realising the benefits of whole system changes will require people and culture change



Delivering integrated care for people and communities requires whole system change: Regional Perspective



Working together towards integration:

Realising the benefits of whole system changes will require people and culture change



Integrating Care for People and Communities: Best international practice

Sarah Reed, Senior Fellow, Nuffield Trust



Integrating care and moving services out of hospital

International Lessons

Sarah Reed, Senior Fellow, Nuffield Trust

-
- **Context and background**
-

Decades of reform...



(1970 – 1990)

(1990-2010)

(2010-2020)

....and more to come



(2025)

- Expanding existing capacity of GP clinics, pharmacies, diagnostic centres
- Re-locating services from hospitals to communities and the home
- Boosting prevention and health promotion

Our approach

- Case study analysis to learn from attempts at reform in other countries:

Scoping review of potential case studies

Scoping discussions and shadowing with UK experts / stakeholders

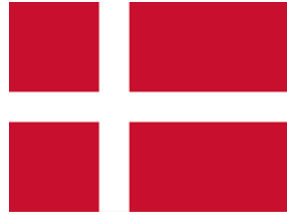
Semi-structured interviews + thematic analysis

Review of published literature to triangulate interview findings

Structured review of policy documents + thematic analysis

External review and QA with national and international experts

Why Denmark and Ireland?



- At the **start of reform** journey
- Health system widely viewed as exemplary, **more ideal conditions for shift**
- **Some common drivers for reform:** demographic challenges, relative prioritisation of acute sector, inequitable distribution of resources

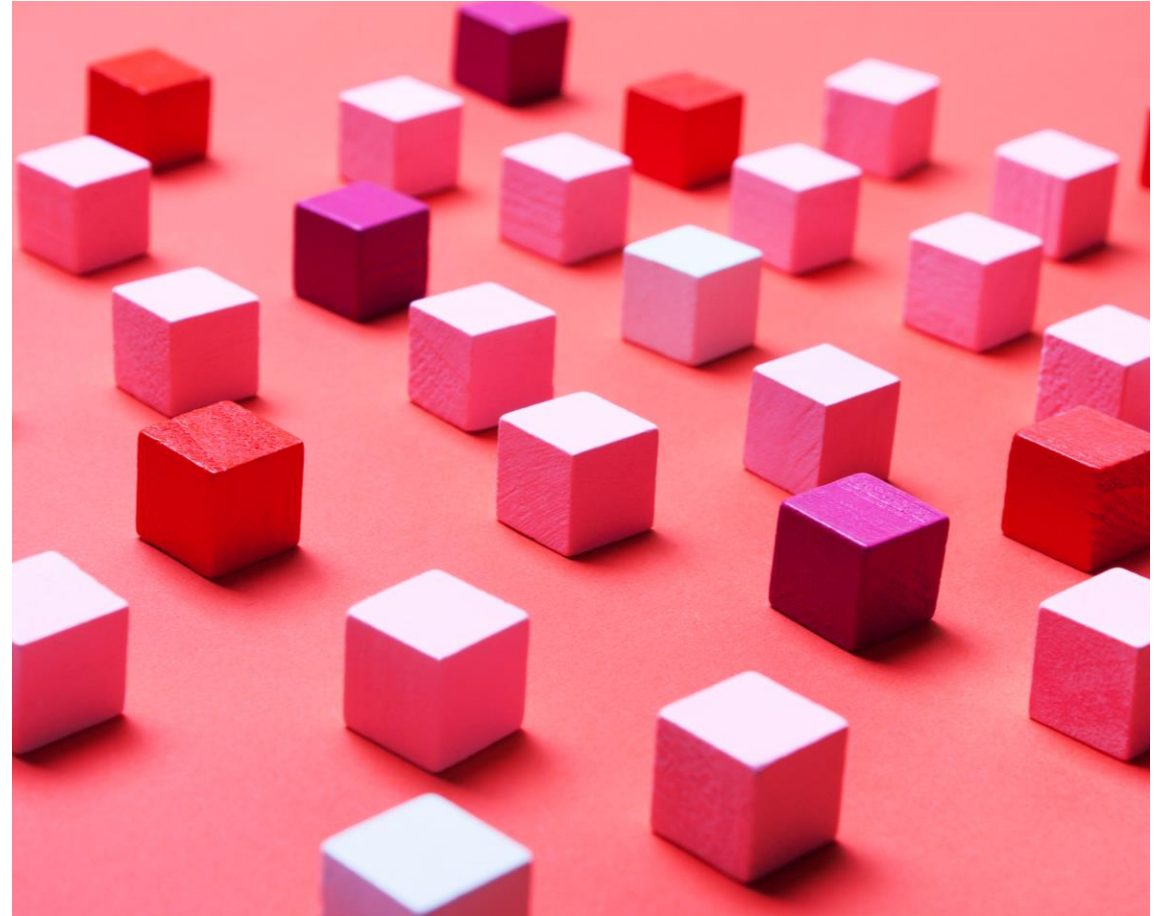


- **8+ years into reform** journey
- Entering reform from **similar place of system pressure:** e.g. long elective waits
- Some **common features of reform**, e.g. focus on neighbourhood hubs and delivery

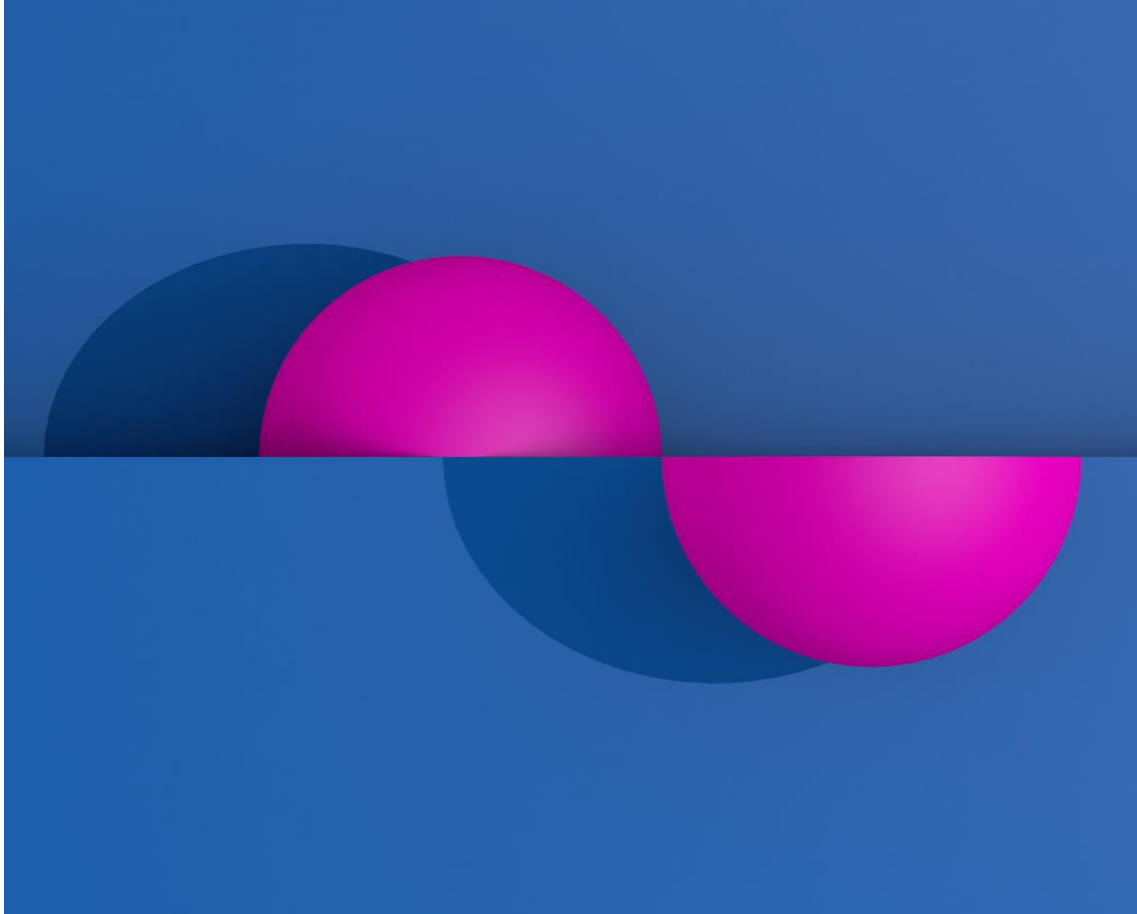
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- **International learning**
-

1. Political consensus and collaboration are precious assets for reform

- “My biggest wish for the UK in this process, and the biggest benefit that we’ve had in this process, is that there has been all-party agreement on what to do... So every new flavour of government that comes in might take a slightly different slant on things...but there’s agreement that we’ll continue to move forward with the large stuff...”
- **(National policy maker, Ireland)**



2. Disjointed policy making can derail plans



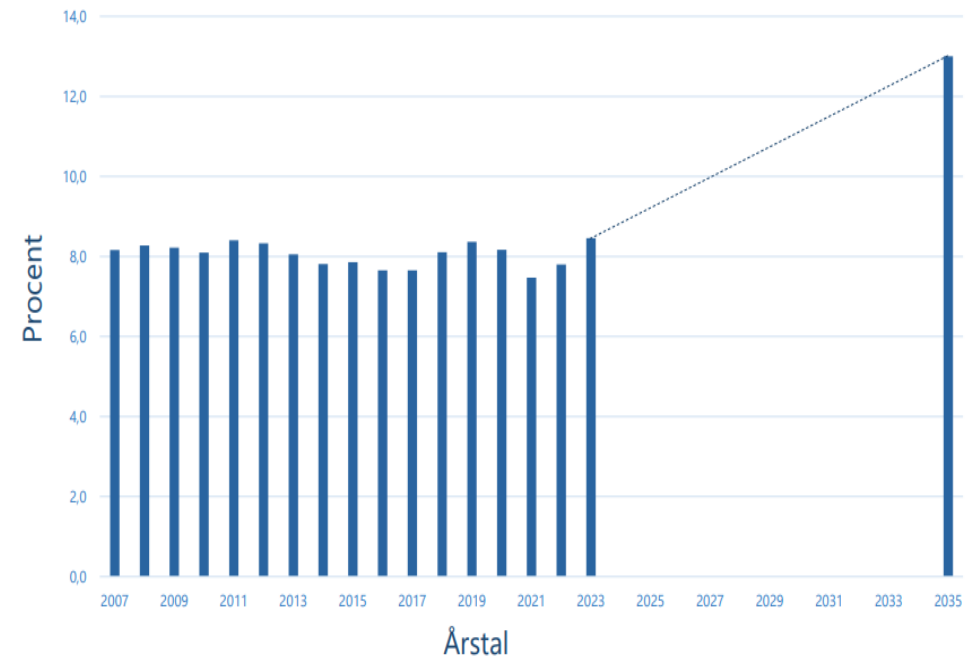
- “We had very significant upfront investment and the government kept following through on its promise of funding year on year, which made it possible to develop these new services... But now it’s stalled, which means we can’t develop much further...”
 - **(System lead, Ireland)**

3. Shifting care = building community capacity, not cutting hospitals

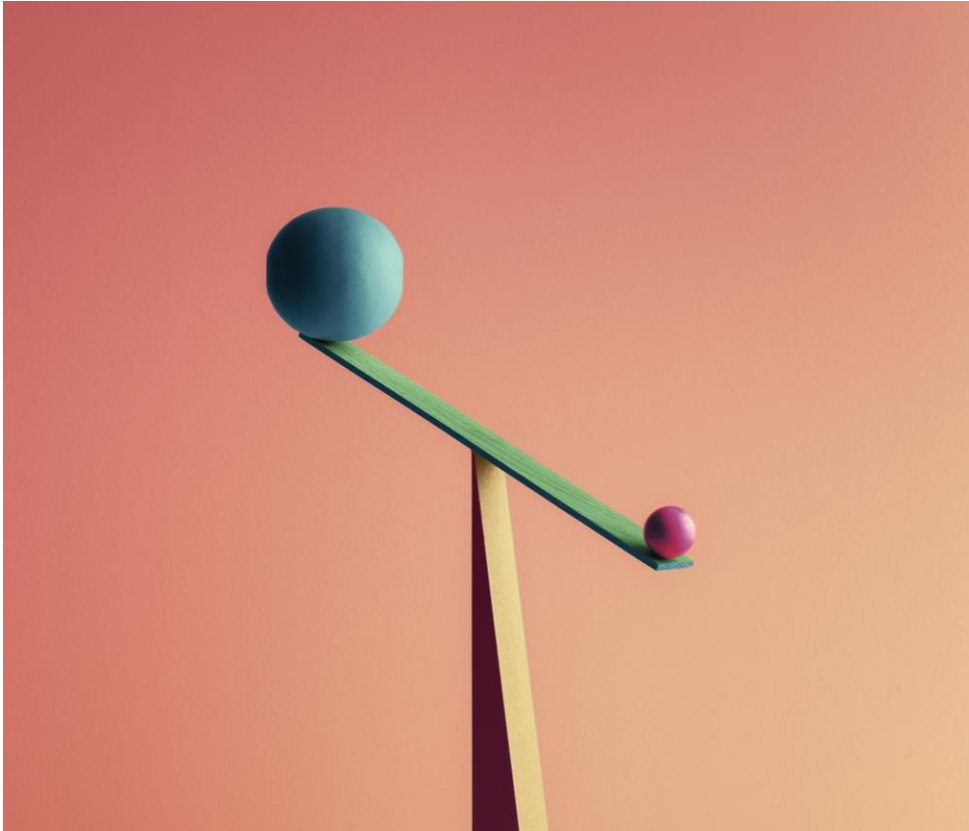
“You can’t just take resource out of the acute sector and expect the acute sector to work well... You need to invest in other services in a deliberate way that decreases demand on hospitals simultaneously”

(System lead, Ireland)

Proportion of total regional healthcare expenditure spent on general practice (2007-2035)



....but this balance can be fragile



- “If there is a huge cancer scandal or something in hospitals... sometimes it is very difficult to contain the costs of hospitals. There’s a driving force into the hospitals sector, so we really have to tame that.”
- **Municipal policy lead, Denmark**
- “The danger all the time is that as the pressure comes on with trolleys and beds again, the political system focus goes back to acutes”
- **National policymaker, Ireland**

4. Shifting care means shifting staff, not just money

“If one should say anything good about this reform, I think it is that we’re trying to use different tools to move the doctors to the areas where they are most needed.”

(Academic, Denmark)



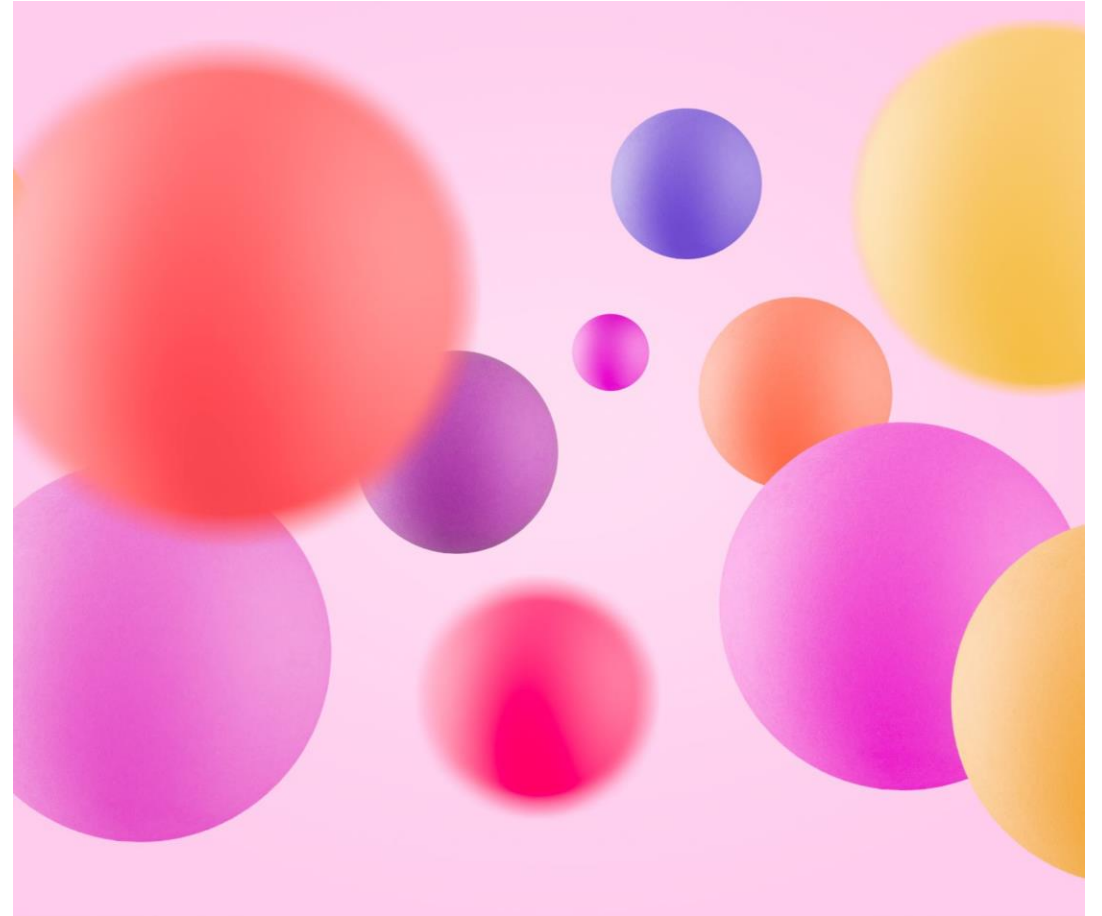
5. Managing the unintended consequences of reform

“[Hospital consultants] have admitted to rejecting more referrals out of a need to be stricter on keeping within their budget. This is totally insane because my practice is open. I cannot shut the door. If a patient doesn’t get what they need in the hospital, they come back to me and that’s stressful.”

(GP, Denmark)

“So many more bloods are being done now with the chronic disease hubs – to the point that labs can’t function anymore. Nobody seemed to think
“Well, the labs might need more capacity if you’re going to create all this extra work”

(GP, Ireland)





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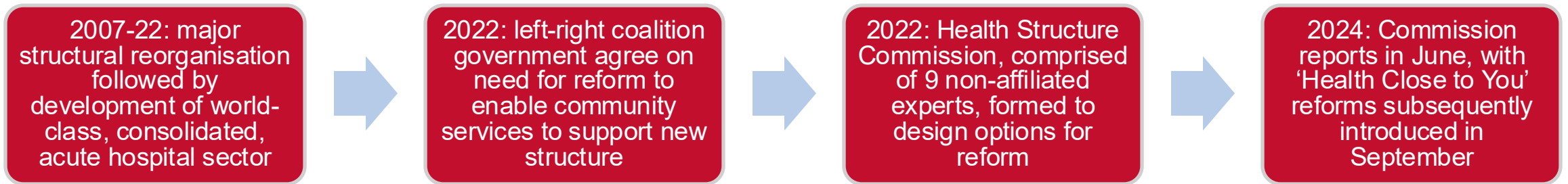
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Relative system advantages and disadvantages for reform in England, Denmark and Ireland

System feature	England	Denmark	Ireland
Ageing population with increasing chronic illness	Ageing population with rising complexity	Ageing population with rising complexity	Relatively younger population, but an ageing population with a growing prevalence of chronic disease
System size and complexity	Larger, centralised	Smaller, decentralised	Smaller, more centralised
Health care access	Universal coverage	Universal coverage	No universal coverage – entitlements to health care are based on income, age and health status
Health spending	Lower relative health spending per person	Higher relative health spending per person	Health spending per person is closely aligned with the UK in some years but is typically higher
Data and digital infrastructure	More highly developed, but community data are still limited	More highly developed, but community data are still limited	Improving, but more limited
Health care staffing	Fewer nurses per person Low numbers of GPs per person, with shortages in some areas	More nurses per person than the UK, but shortages are still a problem Low numbers of GPs per person, with shortages in some areas	More nurses per person than the UK, but shortages are still a problem Low numbers of GPs per capita with shortages in some areas
Acute pressures	Long waits for hospital treatment	Waiting times managed relative to the UK and Ireland	Long waits for public hospital treatment

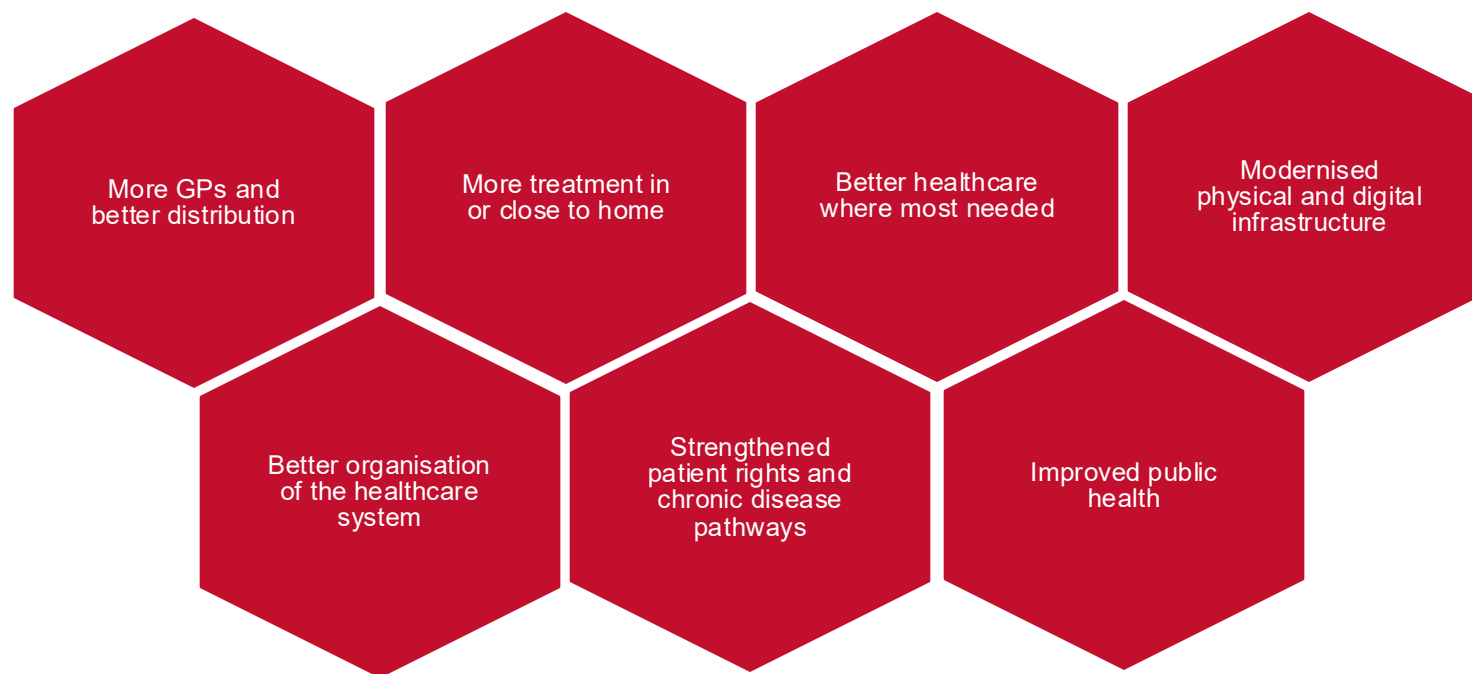
Denmark – timeline so far

- Sundhed tæt på dig (Health Close to You)



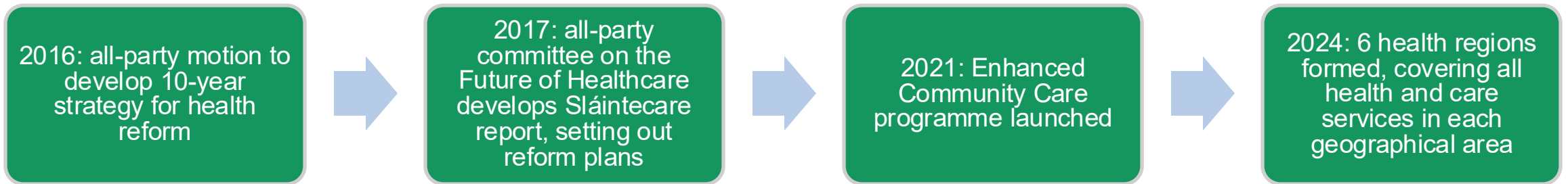
Denmark's reforms

- (Health Close to You)

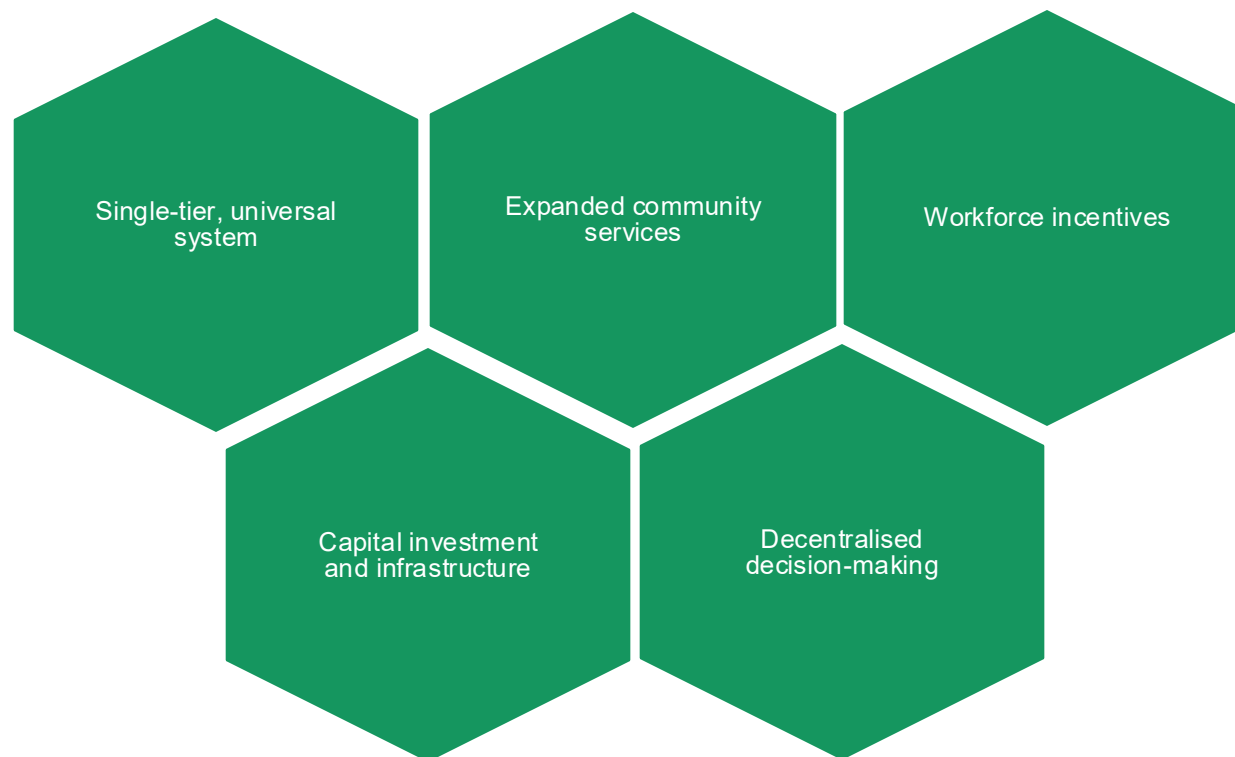


Ireland's reforms

- Sláintecare



Ireland's reforms





Integrating Care for People and Communities: Panel Discussion

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Lorna Kerin, Regional Patient Service User Lead

Mary McGrath, HSCP Regional Integration Development Lead

Eileen Whelan, Regional Director of Nursing and Midwifery

Dr Siobhán Ní Bhriain, Regional Lead for Medicine, HSE Dublin and Midlands

Sarah Reed, Senior Fellow, Nuffield Trust



Integrating Care for People and Communities: Reflections and Final Comments

Anne Lawlor, Co-Chair of the HSE Patient Forum

Tony Canavan, REO HSE West and Northwest

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