May 2025

RESHAPING HEALTHCARE

Healthcare Restructuring in Ireland:
An Update and Analysis

Mental Health Reform

COALITION CONVERSATIONS
Connecting Experiences

About Coalition Conversations

Coalition Conversations is Mental Health Reform's regular webinar series designed exclusively for our member organisations. This is more than a webinar. It's a space to connect, collaborate and help shape mental health policy and services. This briefing paper is linked to the MHR's webinar held on the 24th April 2025 which is available as a podcast on the MHR website. This update follows on from a previous MHR update in December 2024. Because of the pace of change and complexity of restructuring our health services, MHR feels that it is important that our members are kept updated. This update is not just a description but seeks to provide an analysis of these developments in a forward and constructive way.
We would urge all mental health VCS organisations to further learn and engage further within their Health Region Areas and at an IHA (Integrated Healthcare Area) level.

Who We Are

Mental Health Reform (MHR) is Ireland's leading national coalition on mental health. Our vision is of an Ireland with more accessible, effective and inclusive mental health services and supports. We seek to help shape progressive reform of mental health services and supports, through coordination and policy development, research and innovation, accountability and collective advocacy and partnership. Together with our 83 member organisations and thousands of individual supporters, MHR seeks to provide a unified voice to the Government, its agencies, the Oireachtas and the general public on mental health issues. MHR would like to thank our members for their continued insight, input and work. Further information on our members can be found on the MHR website.

Abbreviations/Acronyms

CHO	Community Healthcare Organisations
CMHT	Community Mental Health Team
EMT	Executive Management Team
GAA	Grant Aid Agreements
HIG	(Sharing the Vision) HSE Implementation Group
HSE	Health Service Executive
IHA	Integrated Health Area
MHR	Mental Health Reform
NoC	Networks of Care
PBRA	Population-Based Resource Allocations
REO	Regional Executive Officer
SA	Service Agreements
SAGAA	Service Agreement and Grant Aid Agreements
StV	Sharing the Vision, A Mental Health Policy for Everyone
VCS	Voluntary and Community Sector

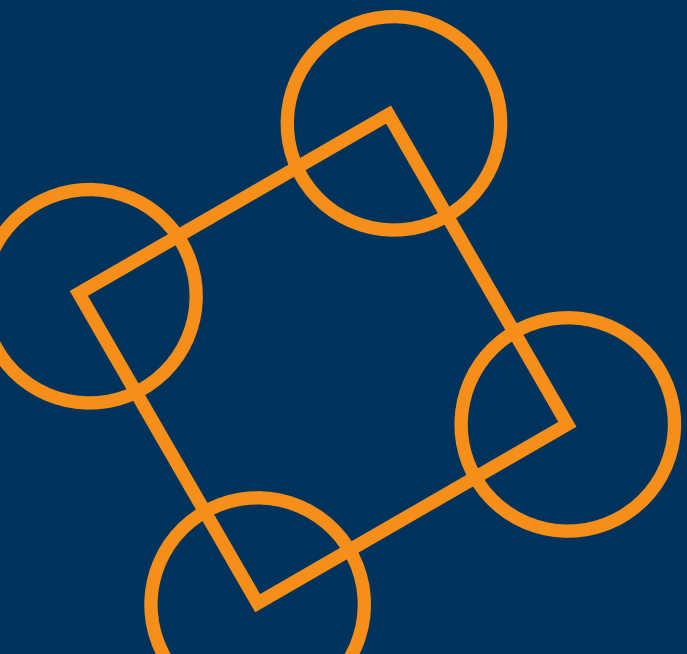
How this update and analysis is structured

Section 1 of this update provides an introduction and overview of this update. It emphasises there are 3 key dimensions to restructuring which are:

1. Regional reorganisation (the health regions)

2. Devolution of decision-making (from the HSE centre to the regions)

3. The integration of health services (including mental health services).



Section 1 urges VCS organisations to fully engage in healthcare restructuring but contends it is not a panacea for solving all issues related to mental health services which also depends on other factors that are outlined in section 2. Section 1 further summarises the challenges for the Voluntary and Community Sector arising from restructuring, including recent and forthcoming developments.

Section 2 seeks to place the healthcare restructuring process in context with other major policy developments in mental health including, overall resourcing and gaps in services and the important role of the VCS.

Section 3 seeks to briefly examine the debate between centralised control of healthcare and a more balanced, devolved approach, with reference to the Health Boards (1970-2004); the first iteration of the HSE (2005-2013); the CHO's and Hospital Groups (2013-2024).

Section 4 provides a brief overview of the restructuring process itself, including some recent progress/developments.

Acknowledgements

MHR wishes to acknowledge the work and expertise of MHR staff in contributing to this update and the related podcast. With many thanks to MHR staff: Stephen Shiel; Louise Rooney and Stephen Donnelly. We further thank Suzanne Connolly CEO of Barnardos and Elaine Teague from the Disability Federation of Ireland for their participation in the linked webinar. We also thank the Chairperson and Board of MHR for their support.

Every effort has been made to check accuracy at time of writing. Mental Health Reform (MHR) would welcome any observations or suggestions for the next update. MHR also encourages readers to check for updates on relevant HSE website pages as the pace of change remains significant and with still much to be done. Any errors or omissions are the responsibility of the author. The author is Philip Watt, Interim CEO Mental Health Reform.

Contents

1 Introduction and overview

The ongoing restructuring of health services in Ireland, including the emergence of the 6 new Health Regions is the most fundamental reform undertaken in the history of our health services since the establishment of the HSE in 2005. The origin of this present restructuring is in the Sláintecare reform process that commenced in 2017.

This update seeks to provide an overview and update on the restructuring process to Voluntary and Community Sector (VCS) organisations working in mental health. While much attention has understandably focussed on the emergence of 6 Health Regions, the present restructuring of our healthcare services in Ireland is a much more complex process that also involves devolvement of decision making within the HSE including a new role for the HSE centre and the better integration/improvement of services, including mental health services at regional and local levels.

In short, healthcare restructuring in Ireland should be primarily understood as the following 3 processes:

Regional reorganisation (health regions)

Devolution of decision-making (from the HSE centre to the regions)

The integration of health services (including mental health services)

The holistic dimension to restructuring has been consistently emphasised including by the former Minister for Health, Stephen Donnelly, TD who stated:
"While the transition to Health Regions represents a considerable change to organisational structures, it is important to note that structural change is not the primary objective of this reform. These new arrangements aim to improve the health service's ability to deliver timely, integrated care to patients and service users, planned and funded in line with their needs".
(DOH Press Release, 3 August 2023)

Bernard Gloster, CEO of the HSE, defined integrated care as follows:
"These changes aim to ensure that when we give health services to our citizens that we do it in a joined-up way via GPs, community services, nursing support, social care services and acute hospitals as needed. The idea behind reorganising our structures is to ensure that people experience just one health service, providing whatever care they need at the right time and in the right place. When we talk about 'integrated care', this is what we mean".

The present restructuring process has also sought to reset the relationship between the HSE and the Voluntary and Community Sector (VCS) arising from the principles agreed by the Dialogue Forum with Voluntary Organisations and some updates are included in this paper.

This paper also includes a summary of previous episodes of regional restructuring that have taken place since 1970, as they provide an important way of understanding the present reforms.

The challenges and opportunities for VCS mental health organisations

There are a number of key challenges and opportunities for VCS organisations, including those focussed on mental health. These can be summarised as follows:

1. Understanding all 3 key elements of the restructuring of our health services including in particular:

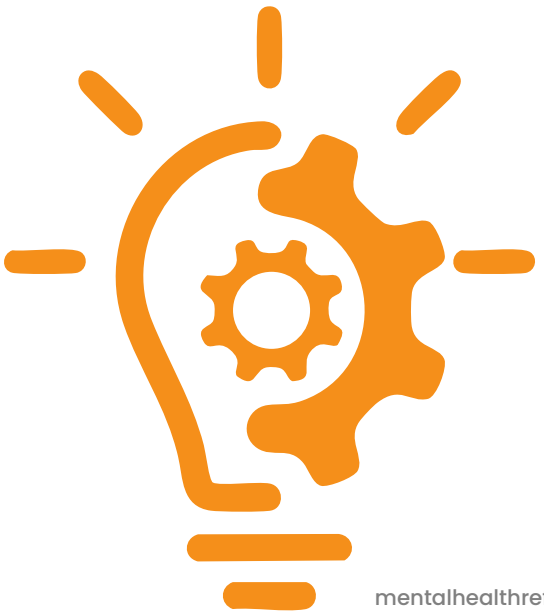
- Regional reorganisation (setting up of the Health Regions)
- Devolution of decision-making (from the HSE centre to the regions)
- The integration of health services (including mental health services)

2. At present, it is important to note we remain in a transition phase: The former 9 CHO's and 7 hospital Groups are being dissolved and the 6 new Health Regions are now established in their place and powers are being transferred, but we remain in a transition phase with some aspects of the restructuring not fully implemented.

3. Powers are being devolved to the 6 Regional Executive Officers and their teams: Under the previous CHO healthcare system in Ireland, decision making remained very centralised and top down with the HSE Directorate making all the key decisions. It is anticipated that the HSE Centre will now focus on Planning, Enablement, Performance and Assurance (PEPA).

4. Health Regions are now in charge of implementing policy: The HSE Health Regions and Integrated Healthcare Areas will be accountable for implementation of the policy and their establishment presents an opportunity to further integrate services at the point of delivery including mental health services.

5. HSE's main focus on Integrated Service Delivery (ISD): The main focus of the HSE at present is on the Integrated Health Areas and the new role of the HSE Centre. Integrated Service Delivery is a major priority. Some former members of the HSE Directorate are now being redeployed into other roles.

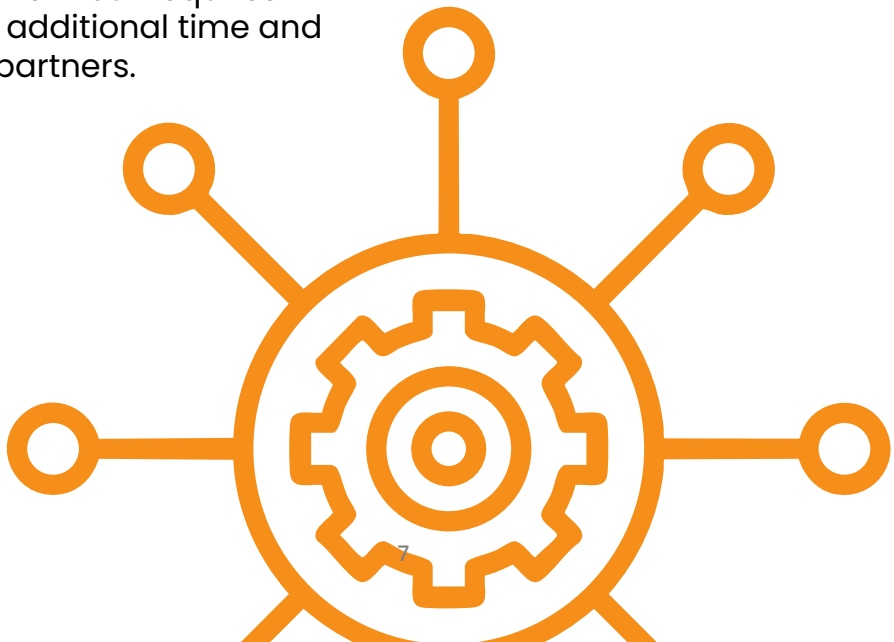


6. New structures will be put in place for VCS organisations to input into the work of Health Regions: 6 Regional Voluntary Forums, 1 for each Health Region will be established in coming months. These will be comprised of around 17-19 people. Guidelines will be drawn up on appointment and role of these Forums. An annual VCS conference will also be organised in each region. A separate Patient Council will also be established and will seek to draw on lived experience. A forum for GP's and a forum for Councillors will also be established in the next few months.

7. Commitment to better relationships between the DOH/HSE and the VCS: There has been a noticeably stronger emphasis on partnership between the DOH/HSE and the VCS as healthcare restructuring continues. Under previous HSE structures and decision making the experience of participation of the VCS in decision making on health was very mixed and occasion it was conflictual. As an outcome of the Voluntary Agencies Dialogue Forum, principles for dialogue have been established and have informed emerging structures related to the restructuring of health services in Ireland This is a very welcome development but requires on-going support, additional time and nurturing from all partners.

8. Finance from the centre to the regions will also be devolved: There will be a new method of deciding how funding will be allocated to each Health Region: Over the next few months a Population Based Resource Allocation (PBRA) will increasingly inform budget allocation. The principles and exact pathway of how PBRA will operate are still under discussion. Questions include: How PRBA will work in practice; will funding be adequate; how will HR's respond to major changes in their area if funding remains static.

9. The Minister for Mental Health and her Department are engaged in the regionalisation process: For example at a recent meeting with MHR, the Minister for Mental Health, Ms Mary Butler TD informed us she is meeting the REO's in all 6 Health Regions to ensure that mental health services remain a priority and are fully integrated into their regional strategies. This is very welcome from a VCS perspective though much work remains. Sharing the Vision's second implementation strategy published in April 2025 also seeks to continue to take into account the challenges and opportunities arising from healthcare restructuring in Ireland (see Section 2).



HSE national functions will focus on planning, enablement, performance and assurance (PEPA)

Mental Health and the Health Regions

The importance of the emergence of health regions for mental health is recognised in the second implementation strategy of 'Sharing the Vision', which states:

"As part of the implementation of Sláintecare, the HSE has been reorganised into six operational Health Regions which have responsibility for the planning and delivery of health and social care services within their geographical areas. Each HSE Health Region is divided into a number of Integrated Healthcare Areas.

Meanwhile, HSE national functions will focus on planning, enablement, performance and assurance (PEPA). The HSE Health Regions and Integrated Healthcare Areas will be accountable for implementation of the policy and their establishment presents an opportunity to further integrate services at the point of delivery. It will be important to ensure continued leadership and adequate change management resources within HSE Health Regions and Integrated Healthcare Areas to drive delivery of Sharing the Vision. This will also require a focus on how the revised national centre can best support regional implementation".
(Sharing the Vision, Second Implementation Strategy, April 2025.)

There are important commitments in Sharing the Vision that are relevant to regional restructuring and mental health. These are outlined in the MHR December update available here.

2 The policy context and HSE regional restructuring

The policy and resourcing context of mental health services is key to understanding the challenges in our mental health services that will not be redressed by regional restructuring alone. Regional restructuring also offers an opportunity to address some of these issues. These wider contexts are usefully presented in Sharing the Vision's Second Implementation Plan (2025). These are summarised below with comment from MHR as indicated:

Physical infrastructure:
'To enable a person-centred, trauma-informed and recovery-focused mental health service, there is a continuing need to ensure all premises offer appropriate therapeutic environments in line with best practice. As well as placing evidence-informed therapeutic design principles at the centre of planning work, there will be a need to ensure alignment with current models of care and regulatory requirements. The development and resourcing of a longer-term capital programme for mental health will be critical to achieving this alignment. A HSE Mental Health Capital Planning Group is now in place to progress this work'. (StV, 2025)

Our Comment

"This is an important observation. The physical infrastructure of mental health services, including some of those provided through CAMHS, requires further consideration by government as some are barely fit for purpose. This is a very welcome commitment but one that requires greater urgency."

Information and communication technology infrastructure:
'Continuity of care is particularly important in mental health, especially for people who are experiencing enduring mental health difficulties. Access to a fit for purpose digital infrastructure is fundamental to ensuring an integrated service user journey, governance and the most efficient use of resources. The adoption of electronic health records is a core element of such an infrastructure. A number of policy recommendations also require access to appropriate data systems and staff expertise to track delivery of particular programmes and guide service planning. At present, capacity to measure mental health outcomes systematically is limited.' (StV, 2025)

Our Comment

"The urgent adoption of electronic health records (EHRs) has been flagged by the VCS and clinicians and their teams for almost 2 decades. Clinicians working in Ireland from other jurisdictions are often incredulous we still do not have EHR's and continue to rely mostly on paper patient records instead. The renewed commitment on this systemic gap is very welcome. The HSE remains somewhat ambiguous on their support for Patient Registries, including those related to mental health. This needs to change. The impact of patient registries in addressing particularly challenging disease areas has been well documented."

Voluntary and community sector
'Sharing the Vision recognises the core role played by the voluntary and community sector in the provision of supports for people with mental health difficulties within an overall system-wide mental health framework. The HSE funds a range of partner organisations, which deliver critical services across all four policy domains, ranging from information and awareness raising, through to training, advocacy, counselling and other targeted therapeutic interventions. It is important that these organisations are further integrated in the mental health system to provide effective and seamless clinical pathways resulting in better service user experience and outcomes.' (StV, 2025)

Our Comment

"More sustainable and multi annual funding for VCS organisations remains a major issue of concern for all in the sector, including those in mental health and still needs to be fully addressed."

Social determinants
'Sharing the Vision is a population-based policy, and the social determinants of mental health remain important for its implementation, i.e. that the environment where we live, work, and age plays an important role in our mental health and wellbeing. While many of these factors require a broader policy response, there is a continuing need to focus on attitudes to mental health, build mental health literacy, promote positive mental health and ensure equal access to services for those who need them. This requires leadership and collaboration across the health service, the broader public sector and civil society'. (StV, 2025)

Our Comment

"The ambition for alignment of StV with the UN Convention on the Rights of People with Disabilities is to be warmly commended and is ahead of some other countries, as is the inclusion of the VCS/civil society in implementation strategies. However much remains to be done to integrate social determinants into mental health policy and services. There are particular challenges for those most marginalised including those in poverty; minority ethnic groups including Travellers, the homeless, the elderly and those with poor literacy, as outlined in StV."

Service demand
'Population growth and reduced stigma surrounding mental health have contributed to an increased demand for services. This presents a challenge for policy implementation overall, as there is a continuing need to ensure core services are appropriately resourced, in parallel with delivering service improvements. Services are also experiencing an increased diversity in people seeking supports, in part arising from the increase in international protection applicants and Ukrainians now living in Ireland. Mental health supports at primary care level remain underdeveloped within the overall provision of supports and services in Ireland. This is despite the fact that most mental health difficulties initially present at primary care level, usually through general practitioners. A transformation of how services are delivered is required so that people who experience mental health difficulties have timely access to integrated and person-centred supports at the most appropriate level of care'. (StV, 2025)

Our Comment

"There remain many gaps in MH services and the approach to providing MH services tends to be reactive rather than pro-active. MHR has recently published a major independent report by the London School of Economics (LSE) that makes the rationale for early and sustained investment in mental health services provided by the VCS for children and young people. The report makes the economic and moral case that VCS are optimally placed to provide early intervention services for those with mild to moderate mental health conditions. It is to be warmly welcomed that the StV envisages greater partnership with the VCS in the second implementation phase."

Resourcing and staffing constraints
'Many policy recommendations are resource and staffing dependent and will need a permanent uplift in funding to implement. As Sharing the Vision is a whole- of-system, population based mental health policy, its successful delivery will require investment across community and voluntary sector supports, primary care, acute services, as well as in specialist mental health services. In the latter phase of the 2022 – 2024 Implementation Plan, the pace of delivery was negatively impacted by the HSE's temporary pause on recruitment, decommissioning of posts and the requirement to work within the overall approved staffing levels for the HSE. While mental health services have been effective in filling new development posts, the recruitment and resourcing landscape of the broader health service remains challenging. The HSE Recruitment, Reform and Resourcing (RRR) Programme was established in June 2022 to grow the workforce and support services to meet projected workforce demand, while ensuring staff are enabled to work at the top of their license'. (StV, 2025)

Our Comment

"MHR and VCS partners/member organisations need to continue to make the public case for additional resources for mental health services in Ireland, not least because clinical teams are often very constrained as to what they can say in public. Ireland spends about 6% of its budget on mental health when according to Sláintecare, this should be increased to at least 10%. The long waiting lists to access mental health services is a particular challenge in the restructuring process."

Our Comment

The Mental Health Bill, 2024 will shortly progress to committee stage. The Bill seeks to align Ireland's mental health legislation with international standards. It will be important that VCS organisations in each of the 6 regions continue to help ensure that this alignment is fully implemented at a regional and local level. The extension of the remit of the Mental Health Commission to cover community mental health services will also help in this respect.

Our Comment

"The Mental Health Research Strategy; the Connecting for Life Suicide Prevention Strategy and the National Office Plan on Children and Youth mental health servcies will also be further shaped by the HSE restructuring process and vice versa."

Conclusion

All these context issues need to be taken into account in the regionalisation process. Regionalisation/restructuring is not a panacea for mental health but is a vital component. For example failure to provide adequate resources where there are regional gaps in mental health services may mean that the integration of mental health services will have a more limited impact on actual patient experience

Further, gaps and weaknesses in one part of the system tends to aggravate others. For example clinicians and their teams working in poor buildings are less likely to remain in a particular facility and may seek other employment opportunities as a result of a poorer working environment.

3 Lessons from past healthcare restructuring 1970-2019

The 4 periods of restructuring, are summarised in the following table:

EPISODE 1

1970-2004

Regional Health boards

The first major restructuring of Ireland's health services occurred in 1970/71 as a result of the Health Act (1970).

Reform included Establishment of 7 and ultimately 11 health boards, These were separate legal entities with their own boards of management compromised of a mixture of local politicians; medical practitioners and ministerial appointment.

EPISODE 2

2005-2013

Health Service Executive 4 Regions

HSE established by the Health Act (2004) commencing 1 January 2005 following a series of commissioned reports

The 11 former Regional Health Boards were dissolved.

The HSE was a very centralised model of healthcare and adopted a structure of 4 regions (HSE Dublin Mid-Leinster, HSE Dublin North East, HSE South and HSE West)

EPISODE 3

2013-2024

CHO's and Hospital Groups

The HSE Report 'Community Healthcare Organisations' recommended the establishment of 9 CHO's whose primary focus to be on service delivery

9 CHO's established

And in a separate exercise Based on a number of reports Minister for Health announces the establishment of 7 hospital Group

7 hospital Groups established

EPISODE 4

2024+

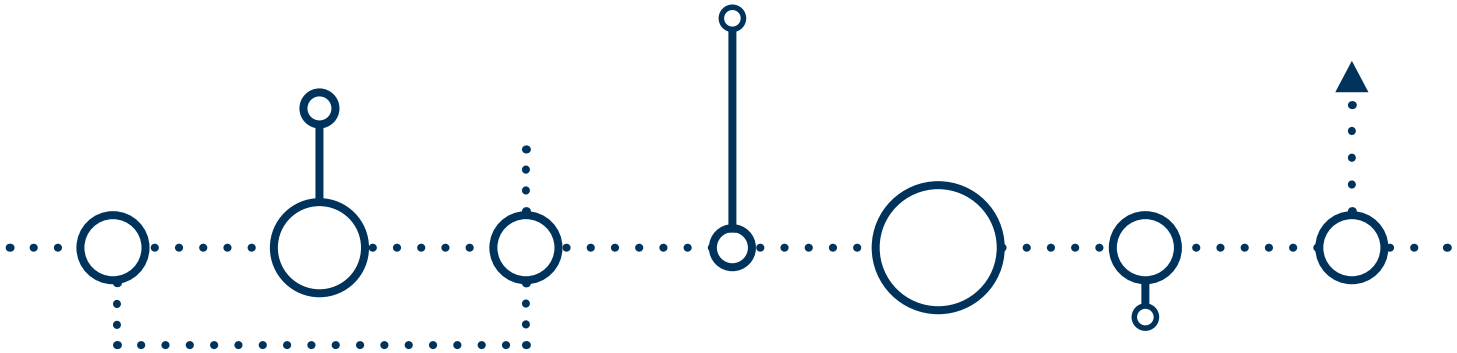
Health Regions

Present restructuring of healthcare in Ireland combining 9 CHO's and 7 Hospital Groups into 6 Health Regions

Devolvement of decision making

Integration of health services

6 Health Regions were established March 2024 with second stage end of September 2024 and final stage by the end of December 2024. CHO's and Hospital Groups to be dissolved end of September 2024



This section seeks to show how successive Irish governments have struggled with finding the right balance between centralised decision versus devolved decision making in our health services and the consequences for patient care when the balance is wrong. This centralisation/devolution debate has been around long before the Sláintecare process commenced in 2017.

Dr Sean Lucey from UCC summed up the tension between central and regional control of health services as follows:

'Striking a balance between centralised control and capacity to respond to local needs has long been central to debates about the health system. More regional and devolved health powers are seen to allow for greater integration of health services and enhanced democratic and community participation in policy. However, critics argue that increased localism lessens central government's responsibility and perpetuates inequity in funding, services and population health'. Dr Sean Lucey, UCC (2021)

In short there are valid arguments that can be put forward for both centralised and devolved healthcare systems. Most academics accept the need for a balance between both approaches. Some former Politicians and Civil Servants on the other hand may be more comfortable with a top down and highly centralised approach to health care in Ireland.

Healthcare restructuring in Ireland has veered considerably from the very decentralised/autonomous Health Board system established in 1970 to the very centralised and top down original iteration of the HSE established in 2005 with 4 fairly nominal health regions. The plethora of small hospitals with acute services that plagued the hospital system in Ireland until recent times and is one example of how decentralisation/greater regional autonomy can be the expense of good national healthcare planning and services.

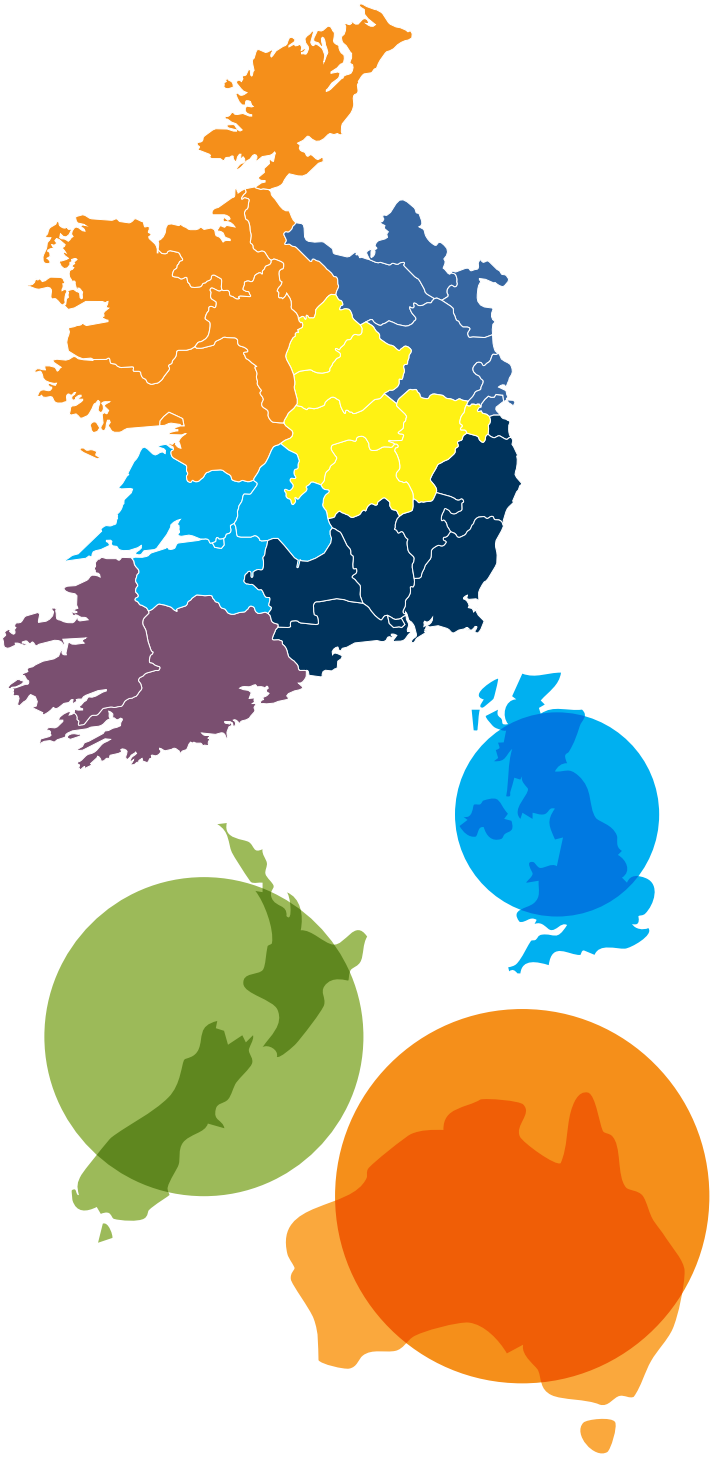
Despite the CHO/Hospital group system that was established in 2013, there remained poor integration of services, including between acute hospitals and community health services, and power remained very centralised in the HSE centre. This lack of integration was unsurprising given that 2 separate government reports established the CHO's and the Hospital Groups.

Conclusion

The debate between a highly centralised decision making processes and a highly devolved system has dogged many other countries health care systems. These include the UK, New Zealand Australia and Canada. In a report published by the Health Research Board in 2019 on this issue the author concluded:
'Regionalisation is a complex process, for which outcomes are neither straightforward nor predictable, but dependent on a country's socioeconomic, institutional, and cultural context'.....'The impact of regionalisation will not be fully estimable for many years post-reform; however, a monitoring and evaluation process will be required at the start of regionalisation to ensure that the short-term and intermediate goals are being met, in order to achieve the ultimate long-term goals of regionalisation. (Quigley et al HRB, 2019. Regional Health Organisations, An evidence Review).

This conclusion also reinforces the need to improve the wider policy context to optimise regionalisation and linked processes.

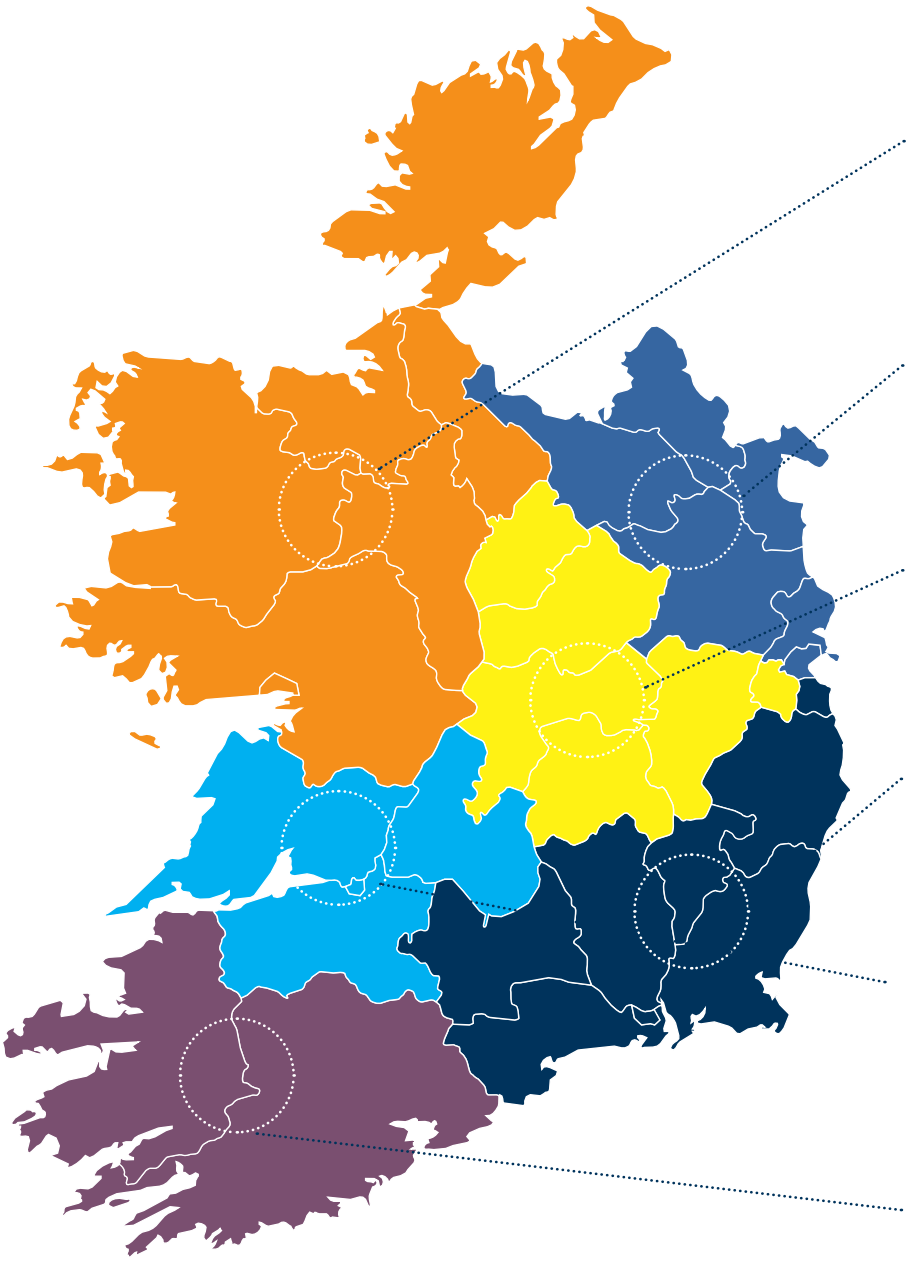
We will need to continue to learn from other countries in their similar striving to find the right balance of control between the centre and the region. This should be an important consideration of the new Mental Health Research Strategy.



4 An Easy-guide healthcare restructuring in Ireland

This section provides seeks to provide a short easy guide to healthcare restructuring in Ireland.

There are now 6 Health Regions as set out below.



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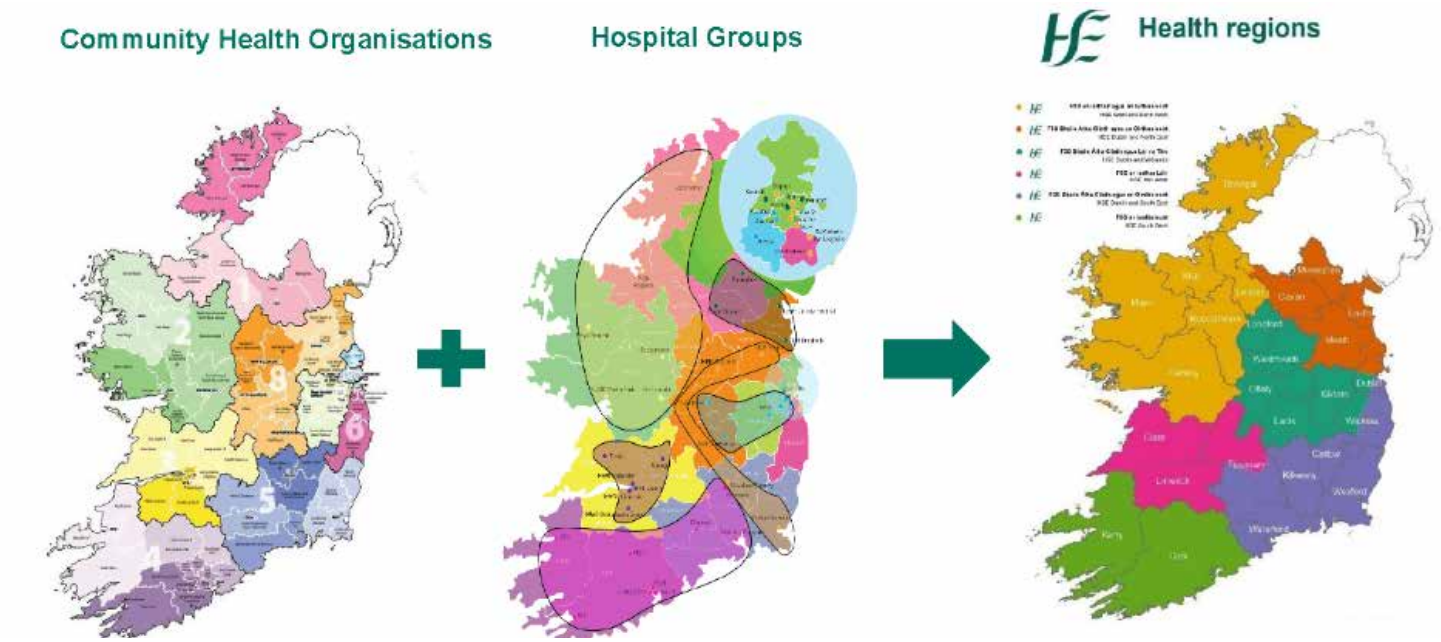
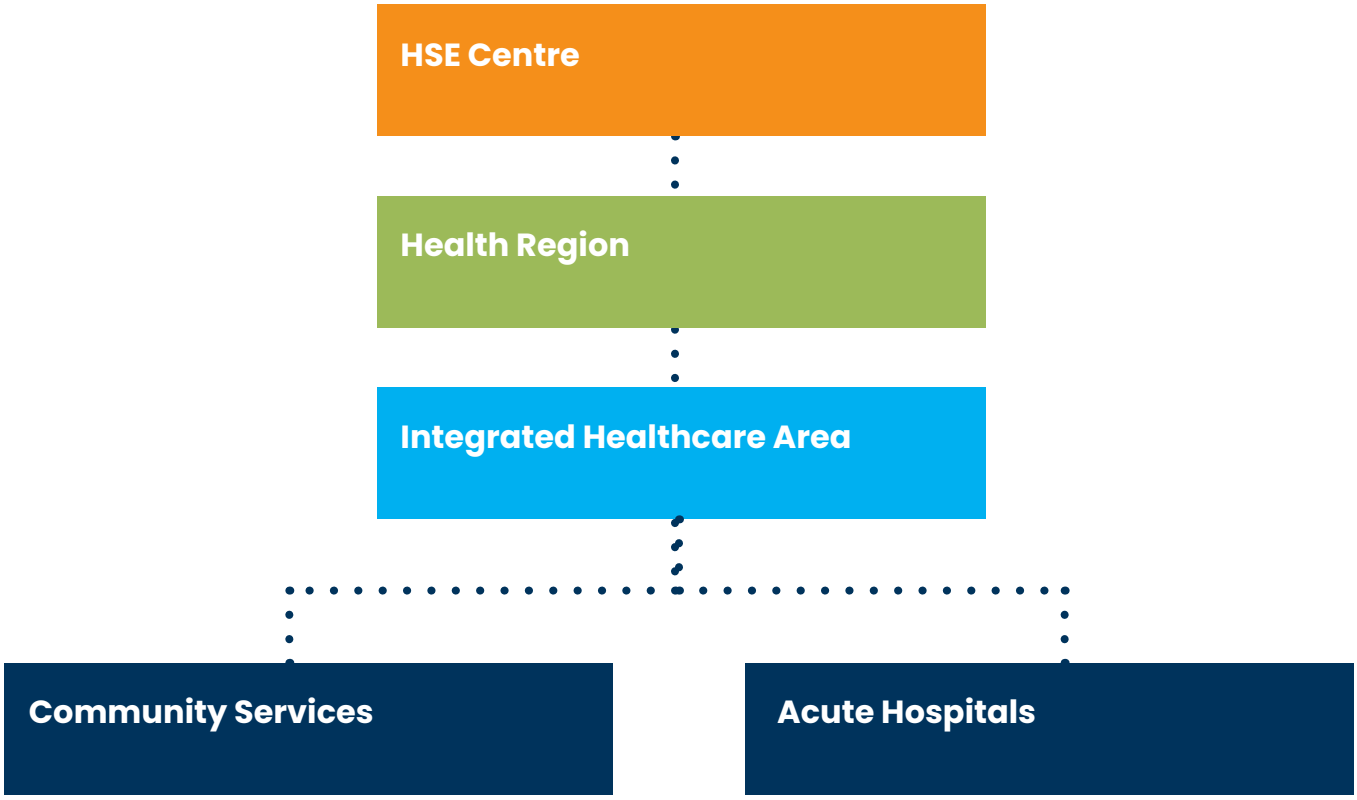
The transformation of the CHO's and HG's into Health Regions

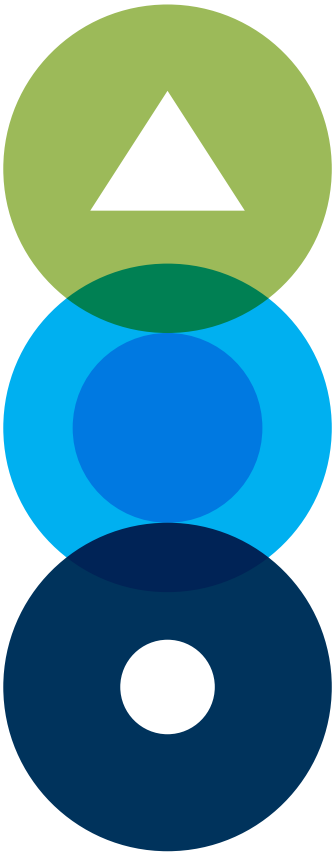


How health services will be organised



One of the most important changes to the HSE is how we will bring services and decision-making closer to the patient and closer to the community as:

- **Health Regions** will plan and deliver health services, with support from the HSE Centre. Each Health Region will have between 2 and 4 Integrated Healthcare Areas
- **Integrated Healthcare Areas** will will bring together both acute and community services under one geographically-based structure for their populations of between 150,000 and 450,000
- **Community Healthcare Networks** will be the building blocks for organising services within each IHA, and there will be approx. 2-8 CHNs and 1-3 Hospitals in each IHA. More information on CHNs available here



Financial Planning

- Funding provided to each Region via annual Estimates will be increasingly informed by a population-based resourcing approach (PBRA) (excluding national specialist services).
- Regions have appropriate autonomy in deciding how that budget will be spent in line with the services that they are planning for their defined population. This planning will be informed by a Health Needs Assessment (HNA).
- Goal is to improve equitable regional investment and balance national consistency with appropriate local autonomy to maintain consistent quality of care across all Regions.

The HSE Centre

The HSE Centre will have a key role in providing national oversight of the regions and health and social care system as a whole, with a primary focus on Planning, Enabling, Performance and Assurance. In addition, the HSE Centre will continue to provide operational delivery of identified specialised services nationally.

The Service Arrangement and Grant Aid Agreement (SAGAA) Review

The Service Arrangement and Grant Aid Agreement (SAGAA) Review is almost completed. The review was conducted in the context of the following important developments:

- The work of the Voluntary Agencies Dialogue Forum
- The publication of the Partnership Principles
- The work of the Case Study Programme (ongoing)

Up to date and comprehensive information on the Service Arrangement and Grant Aid Agreement (SAGAA) Review is available at here.

Integrated Care and integrated Service Delivery

Integrated care

The new health region structures will support and strengthen integrated care. This includes integration between:

- primary care and community services, including GPs, pharmacies and voluntary organisations
- acute hospitals and community services
- the HSE and wider public service organisations, such as local authorities

While structural change alone will not deliver integrated care, it will clarify roles and responsibilities at all levels of the organisation. It will create the conditions for more integrated working.
Learn more about why we're integrating health and social care services

Integrated Service Delivery (ISD) model

The ISD model sets out how health regions and the Integrated Healthcare Areas operate. It includes the structures, ways of working and processes designed to make our services easier for people to navigate. It is also designed to support:

- more integration
- stronger accountability
- greater transparency

REOs and their teams have worked with staff and stakeholders on how best to apply the ISD model in each Integrated Healthcare Area. The structure of the management team in a standard Integrated Healthcare Area has been agreed and will be applied consistently in each IHA.

View the ISD model

View the IHA structure

RESHAPING HEALTHCARE

Healthcare Restructuring in Ireland:
An Update and Analysis

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