Commission on Financial Management and Control Systems in the Health Service

31 January 2003

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EXECUTIVE SUMMARY

The Commission carried out a detailed examination and review of the financial management and control systems in the Irish health service.

The Commission found problems in the existing systems, including:

- The absence of any organisation responsible for managing the health service as a unified national system.
- Systems are not designed to develop cost consciousness among those who make decisions to commit resources and provide no incentives to manage costs effectively.
- Insufficient evaluation and analysis of existing programmes and related expenditure.
- Inadequate investment in information systems and management development.

The Commission adopted four core principles in addressing the problems:

- The health service should be managed as a national system.
- Accountability should rest with those who have the authority to commit the expenditure.
- All costs incurred should be capable of being allocated to individual patients.
- Good financial management and control should not be seen solely as a finance function.

The Commission made 136 recommendations including:

- The establishment of an Executive to manage the Irish health service as a unitary national service.

- A range of reforms to governance and financial management, control and reporting systems to support the Executive in the management of the system.

- The designation of clinical Consultants and General Practitioners as the main units of financial accountability in the system.

- Substantial rationalisation of existing health agencies.

- All future Consultant appointments to be on the basis of contracting the Consultants to work exclusively in the public sector; more transparent arrangements for existing Consultants.

- Reform of the medical card scheme to include a Practice Budget for each GP, monitoring of activity and referral patterns etc.

- Strengthening the process of evaluation of clinical and cost effectiveness for publicly funded drug schemes.

- Pending the establishment of the Executive, the creation of a high level and well resourced Implementation Committee.

1. Introduction

In a modern, democratic society every citizen should have access to a quality public health system. The people who work at all levels of our health service are entitled to expect the system to be organised in a way which best allows them to use their skills and energy to provide quality care within the resources available.

We approached our task with the belief that the primary responsibility of the health system must be to meet the needs of the patient or other person using the service. All the analysis and recommendations that follow are made with the objective of providing a better, more cost-effective, more accountable system where the patient/service user is the number one priority.

2. Health Service Spending

The Irish health service employs almost 100,000 people and spends almost ¤9 billion annually. It has grown substantially in the last five years. Between 1997 and 2002 spending has gone up by 125% and employment has risen by over 25,000.

Demographic changes will increase the demands on the health system. To continue to increase the resources at the rates achieved in recent years is unsustainable; hence much greater effectiveness and efficiency will be required.

3. Evidence on Adequacy of Resources

Despite the substantial increase in health spending, we heard evidence that:

- 3,000 additional acute hospital beds and 1,000 additional medical Consultants are needed to satisfy current demand.
- Some of the most expensive acute hospital beds in the health service are used inappropriately.
- Some of the time of Consultants is wasted because they have to cancel admissions, surgery or treatments when their beds are reassigned to patients admitted through Accident and Emergency departments.
- The underutilisation or underprovision of walk-in (ambulatory) day surgery was seriously compromising the throughput of patients and productivity.

These conflicting perspectives between the need for more money on the one hand and the opportunities for eliminating waste and increasing productivity in the use of existing resources on the other, highlight the complexity of the management challenge in running the Irish health service and the need to evaluate whether existing resources could satisfy demand by radically restructuring how those resources are organised and managed.

4. Our View

In our view many of the problems are fundamentally structural. They relate to how the system is organised and managed. We believe that just improving the systems of financial management and control will do little to improve the efficiency and effectiveness of health expenditure unless there is fundamental reform in how the system is organised and managed. For this reason we have recommended very substantial changes to the way the system is structured and managed.

We do not underestimate the challenges involved in introducing change on the scale we recommend. However, those who work in the health service and whose commitment we acknowledge deserve no less than the opportunity to work in a system which is much better managed and controlled and so will support them in doing what they wish to do; offer the highest quality service to the public.

5. The Issues

The main problems we have identified in the areas of financial management and control are:

- Management and control of services and resources is too fragmented; there is no one person or agency with managerial accountability for how the overall system performs on a day-to-day basis.
- Those who make decisions (mainly Consultants and other medical practitioners) which commit resources are not accountable for that expenditure and the outputs to be delivered.
- Systems of governance, financial control, risk management and performance management need to be developed further.
- The capacity of existing systems to provide relevant, timely and reliable information for linking resources to outputs/outcomes is severely limited.
- There is insufficient evaluation of existing expenditure and too much focus on obtaining funding for new developments.
- The capacity of existing systems to develop cost consciousness and provide incentives to manage costs is severely constrained by the under-development of systems such as activity based costing.
- The usefulness of data for resource management and for strategic planning purposes is limited because the data is not being interpreted by the clinicians treating the patients (Consultants and GPs).
- Patient cost information is not available. Such data is essential to any review of the system of allocating funds or in deciding where the most cost effective treatment can be obtained for various conditions.

6. Proposals For Change

We recommend that:

The Executive
A new Executive should be established outside the Department of Health and Children to assume management responsibility for the delivery of health care in Ireland and for planning and managing the application of the resources used by the health service in a comprehensive integrated way.

- The new Executive should operate under a board, whose Chairman should report to the Minister for Health and Children.
- A substantial number of existing executive agencies should be subsumed by the new Executive.
- Staff recruitment should be by open competition.
- The Chief Executive Officer (CEO) of the Executive should be accountable to the board of the Executive.
- The CEO of the Executive should be accountable for the performance of the CEOs of the regional health boards.
- The CEOs of regional health boards should retain their role as accounting officers.

Executive Functions

The new Executive should subsume the statutory functions of many existing executive agencies and be given any additional powers needed to manage the health service as a unified entity. These functions should include:

- Planning and managing the organisation of specialist services/hospitals.
- Deciding on the number and type of Consultant posts in each specialist service/hospital.
- Planning and organising the provision of primary medical services.
- Coordinating the management of the various interdependent functions necessary to run the health service as a unified service e.g. manpower planning and recruitment, procurement, systems of funding and resource allocation.
- Ensuring that corporate governance meets the principles of best practice.

Executive Tasks

The following priority resource management issues should be addressed by the new Executive:

- Putting in place the new budgetary and accountability systems.
- Managing the investment in information systems which is necessary.
- Negotiating the changes necessary for the effective management of the health service with key stakeholders.
- Putting in place performance management and management development programmes.
- Eliminating the inappropriate use of expensive acute hospital beds by providing alternatives for the long stay patients who occupy them.
- Reorganising the Accident and Emergency services so as to keep more beds available for elective cases.
- Introducing more ambulatory day surgery to reduce waiting lists and increase throughput of patients.

Department of Health and Children

The creation and maintenance of the national policy framework within which the new Executive performs will place heavy demands on the Department of Health and Children. The work of the Department will require close interaction with the new Executive to ensure that the political and the executive systems for delivering the health service are kept closely aligned.

Regional Health Boards

The health board structure should be retained (although their number and functional areas should be reviewed) to safeguard the need for local democratic representation. The CEO of the Executive should be accountable for the performance of health board CEOs. The executive functions of health board CEOs should be expanded to include that of agreeing with the new Executive the Service Plan for the region, the implementation of national Service Plans/strategies within the region and the development of uniform financial planning, management and control systems for the health service.

Service Planning, Budgeting and Supplementary Estimates

A single comprehensive and standardised template for Service Plans should be adopted. Plans and budgets should derive from the individual plans of clinical Consultants and General Practitioners and from individual managers responsible for services not provided by clinically independent doctors. A three-year rolling indicative financial and service planning system should be introduced. Changes should be made in current arrangements for budgeting and for controlling expenditure on

"demand-led" schemes.

Accountability for Financial Management and Control in General Hospitals
The accountability for managing resources and for financial control should be devolved to those persons with the authority to commit or expend resources. Such persons should be accountable for how those resources are used. Systems of clinical budgeting at the level of individual clinical practices should be developed. Budgets should focus on producing targeted outputs for patients in the most cost effective way. These systems should identify the true economic cost of treating private patients.

Existing arrangements, which enable medical Consultants to combine their public hospital commitment with private practice, are inherently unsatisfactory from a management and control perspective. To address this, we recommend that all new public consultant appointments be on the basis of a commitment to work exclusively in the public sector.

Accountability for Resource Management in the GMS and Drug Refund Schemes
There should be a fundamental review of the General Medical Service with a view to agreeing with General Practitioners how budgets can be established to deliver agreed levels of service and treatment to patients which is in the interests of patients and of reducing unnecessary demands on expensive hospital services. Arrangements under the Drug Payment Scheme should also be reviewed.

Accountability for Controlling Pay Costs
There should be a detailed review of the drivers of pay costs including systems for control of numbers, for manpower planning and for work planning and scheduling which can control or reduce premium payments for non-emergency work outside core working hours.

Financial Information Systems
There needs to be an accelerated programme of investment in information systems to extend SAP and PPARS to all major spending agencies. This recommendation is contingent on the evidence of a detailed business case, parallel implementation of the organisational changes we recommend and the recruitment of certain key financial, human resource management and information technology personnel. Investment without the necessary other changes could be a waste of money.

Other Systems
We have also made recommendations on the development of governance structures such as internal and external audit, financial control, risk management and performance management.

Implementation
We do not underestimate the challenges that our recommendations pose. The scale of the changes we envisage illustrates the size of the task. These include:

- The creation, re-organisation and consolidation of agencies;
- Changing staff conditions;
- Engaging clinicians in resource management in a meaningful way;
- Addressing the issues in their contracts to enable this happen; and
- The legislative programme.

To ensure that the major changes we have recommended are implemented pending the establishment of the new Executive, we recommend that a National Implementation Committee under an

independent Chairman be set up to drive the implementation process. Resources and skills in change management will be needed.

7. Conclusion

We believe that there is scope to significantly increase the efficiency and productivity of the health system in Ireland – in effect to provide better service to those who require healthcare and to provide better value to the taxpayer for the substantial investment in health services.

TERMS OF REFERENCE

"The Value for Money Audit of the Health Services identified the need to enhance the capability of the health services in regard to:

- Performance measurement and evaluation
- Management accounting
- Costing
- Associated information systems

Taking account of these findings and the proposals for developing a civil service wide Management Information Framework the Commission will:

Examine the various financial management systems and control procedures currently operated in the Department of Health and Children, and by the key budget holders in the health boards and in the main spending and service areas of the health sector.

Assess the various reporting procedures in these services.

Assess the capacity of the systems and procedures to provide relevant, timely and reliable information, in relation to;

- current expenditure
- capital expenditure

with particular reference to

- the measurement of resource use against outcomes and
- management of resources within budgets.

Evaluate the capacity of these systems to develop cost consciousness among resource managers and to provide incentives to manage cost effectively.

Examine international best practice in regard to health service financial management systems, cost control and reporting arrangements.

Examine how the estimates in the health area are compiled and allocations finalised and monitored.

Consider how the presentation of financial data can be enhanced so as to provide better information on how service delivery is proceeding.

Make recommendations in accordance with its findings, with a view to enhancing the timeliness and quality of financial management information throughout the health services and provided to Departments.

The Commission will report to the Minister for Finance by end 2002, with appropriate interim reports on any aspects of particular concern. "

GLOSSARY

TERM	DEFINITION
Accounting Officer	An Accounting Officer has responsibility for the propriety aspects of the accounts, for economy and efficiency in the use of resources and for the management system used to evaluate effectiveness. When required to do so, the Accounting Officer is required to give evidence on these issues before the Public Accounts Committee.
Annual Financial Statement	Statutory accounts of health boards.
Annual Report	Report/statement on the services provided by a health board in the preceding year and any other particulars (including financial statements) that the board considers appropriate.
Appropriations-in-Aid	Income and Receipts on the Health Vote.
Capitation Fee	A flat rate payment to GPs for each medical card holder registered to his/her practice.
Casemix	The comparison of activity and costs between hospitals by measuring hospital output. The rationale for Casemix is to base funding on measured costs and activity, rather than on less objective systems of resource allocation.
Census of Health Service Employees	The Census is a snapshot of total employment levels in the health service conducted annually by all health boards, on the instruction of the Department of Health and Children, over the last two weeks in each calendar year. See also "Whole-time Equivalent".
Corporate Governance	The way in which an organisation is directed and controlled so as to achieve its organisational goals and to deliver accountability, transparency and probity.
Determination	The annual allocation of funds from the Department of Health and Children to each health board.
Development Funding	Funding provided specifically for the development of new services.
Diagnosis Related Group	Diagnosis Related Groups are groups of cases with similar clinical attributes and resource requirements – e.g. a simple appendicitis versus one where the appendix had burst. See also Casemix.
Dispensing Fee	Fee paid to pharmacists in respect of each prescription filled under community drugs schemes.

Estimates for Public Services	The breakdown by Department of planned Government expenditure for the year. An "abridged" version is published annually prior to the Budget. A "revised" version is published annually post-Budget.
Existing Level of Service	An assessment of the costs of maintaining all public services, including health services, at their existing level.
Group 1 Hospitals	The major academic training hospitals (i.e. Beaumont Hospital, Cork University Hospital, James Connolly Memorial Hospital, Mater Hospital, St. James' Hospital, St. Vincents' Hospital and University College Hospital Galway).
Group 2 Hospitals	Non-teaching hospitals (i.e. all hospitals other than those categorised as Group 1).
Health Board Hospital	A hospital fully owned and managed by a health board.
Integrated Management Report	This is the main means by which health boards report on their financial performance to the Department of Health and Children.
Internal Audit	An independent, objective assurance activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.
Net Expenditure	Total expenditure less appropriations-in-aid.
Operational Plans	Within each health board, in addition to the formal health board-wide Service Plan, each care group (e.g. community care, mental health etc.), prepares its own Operational Plan. This underpins the Service Plan, but at a greater level of detail.
Performance Indicator	The health board Service Plans include key performance indicators across a number of headings as well as targets for delivery of service developments. They are output-based indicators.
PPARS	Personnel, Pay, Attendance and Recruitment System - the human resource module of SAP.
Public/Private Mix	This is the mix of activity in respect of public and private patients within a public hospital setting.
Reserved Functions	Functions "reserved" under statute to the members of the health board.
SAP	A fully integrated software package with available modules including financials, materials management, human resources, payroll, asset management and asset maintenance.

Service Plan	Under the Health (Amendment) (No.3) Act 1996, health boards are required, within 42 days of receipt of their Letter of Determination, to adopt and submit to the Minister for Health and Children an annual Service Plan, outlining the planned activity which they will deliver for the funding they have received.
Voluntary Hospital	A publicly funded but privately owned hospital – typically these would have been owned and run by religious orders in the past.
Whole-time Equivalent	Within the annual "Census", employee numbers are reported by the absolute number employed and are also expressed as "whole-time equivalents" (i.e. converting the number of part time workers into an equivalent number of full time employees, by reference to the average length of the working week).

CHAPTER 1
INTRODUCTION AND BACKGROUND

This Chapter explains how and why the Commission was set up, its membership, terms of reference and working methods.

1.1 BACKGROUND

The Minister for Finance in his Budget Statement of December 5, 2001 announced the establishment of the Commission on Financial Management and Control Systems in the Health Services (the Commission). In that Budget Statement the Minister indicated that an independent Commission would examine, evaluate and make recommendations on relevant financial systems, practices and procedures throughout the health services. He placed particular emphasis on the need to improve the management of public expenditure. The Minister stated, "*We must focus on what we are achieving in terms of real outputs and outcomes. Such an approach will help deliver better public services. Increased expenditure is not always enough on its own*". In the context of a 125% increase in gross health spending between 1997 and 2002 (from ¤3.6 billion to over ¤8 billion), the Minister went on to point out the challenge of ensuring that "*the quality and quantity of services that people receive match this investment*".

On April 25, 2002, in consultation with the Minister for Health and Children, the Minister for Finance formally established the Commission. The Commission was given a mandate to report by the end of 2002.

1.2 MEMBERSHIP

The members of the Commission appointed by the Minister for Finance are:
Professor Niamh Brennan (Chairman)
Dr. Sean Barrett
Dr. Donal de Buitléir
Mr. Diarmuid Collins
Mr. Pat Farrell
Mr. Tommie Gorman
Mr. John P Greely
Mr. George Mansfield
Mr. Jim McCaffrey
Mr. Michael McLoone
Mr. Dermot Smyth
Mr. Maurice Tempany

Biographical details of Commission members are attached in *Appendix 1*.

The Department of Health and Children and the Department of Finance provided the Secretariat. The members of the Secretariat were: Derek Moran (Secretary), Tom Murphy, Fiona Prendergast, Deirdre Galvin and Pat Creedon.

1.3 PROCEDURES

We held our first meeting on 7 June 2002 and met on 17 further occasions until our final meeting on 31 January 2003. At each meeting, we considered various papers that were provided to us by:

- The Secretariat,
- Staff at the Department of Finance,
- Staff at the Department of Health and Children,
- Staff at health boards, and
- Individual members.

In addition, we commissioned an analysis of international best practice from Dr. Gerardine Doyle (see *Appendix 1* for further information about Dr. Doyle).

Our conclusions and recommendations were reached during an intensive eight-month period of examination and consideration of:

- The information provided in respect of the existing systems,
- Research into international practice,
- Submissions and oral contributions, and
- Other material arising from the procedures adopted.

Given our original reporting deadline of end-2002 and the focused nature of our terms of reference, we decided that it would be inappropriate (within the time limit) to seek submissions through public advertisement. Instead we invited submissions from a range of interested parties that might reasonably be expected to have a substantive contribution to make to our deliberations. Invitations were issued to a total of 46 groups and individuals. They were asked to provide written submissions consistent with the terms of reference by the end of July 2002. In all, written submissions were received on behalf of 20 groups. *Appendix 2* lists the persons and organisations that were invited to make submissions, indicating those from whom submissions were received.

In addition, we met with representatives of the chief executive officers of the health boards, a delegation from the Irish Hospital Consultants Association and the Comptroller and Auditor General.

1.4 TERMS OF REFERENCE

In line with our terms of reference (reproduced at the start of the report) we limited ourselves to consideration of systems of financial management and control together with recommendations for improving their effectiveness. We addressed only those structural and organisational issues that we felt to be essential to the improvement in the management of public expenditure referred to in the December 2001 Budget speech by the Minister for Finance when he stated "*we must focus on what we are achieving in terms of real outputs … increased expenditure is not always enough on its own*".

1.5 IMPLEMENTATION

We have no role in relation to the implementation of our recommendations, nor in relation to

how they might be funded. These are matters for Government. However, we consider the implementation of our 136 recommendations vital to facilitate the necessary overhaul of the current system. For this reason, we have included a separate chapter on implementation (Chapter 11).

1.6 ACKNOWLEDGMENTS

Our report on such a large, complex and controversial area as the health services was produced in a period of eight months. This could not have been done without the support of our Secretariat, Derek Moran (Secretary), Tom Murphy, Fiona Prendergast, Deirdre Galvin and Pat Creedon. Initially, they provided us with many briefing papers, often liaising with third parties in obtaining information in response to our many requests. Their inputs as authors of a large number of high quality papers and draft chapters were the catalysts to the progress we were able to make in such a short timeframe. Their knowledge of the health services, combined with their ability to bring together in a coherent way the output of our many vigorous debates, is testament to their skilled professionalism.

We also thank all the individuals, groups and organisations that made submissions and provided us with information. These were informative and of considerable assistance in progressing our discussions and deliberations. Also of great assistance were our meetings with representatives of chief executive officers of the health boards, with a delegation from the Irish Hospital Consultants Association and with the Comptroller and Auditor General.

As has already been mentioned, Dr. Gerardine Doyle, who has a particular knowledge of control systems in the health services, provided us with information on best practice internationally. Ceara Roche volunteered her considerable expertise in assisting with the final production of this report.

CHAPTER 2
OVERVIEW AND ISSUES

In this Chapter, we look at the structures, strengths and weaknesses of the health service and recommend a number of core principles to be followed in dealing with the problems we have identified.

2.1 SUMMARY

The health service is the largest single employer in the State. Compared with other public or private enterprises, it presents a unique management challenge because of:

- The range of services involved;
- The number and diversity of professional, technical and general staff employed;
- The implications of clinical autonomy in the relationship between doctors and patients for how accountability for outputs and budgetary control is structured;
- The ever increasing opportunities offered by new medical technologies and drugs for more expensive treatments; and
- The expectations of service users, including patients.

We recognise:

- The dedicated and committed staff with a strong public service ethos throughout the sector, many of whom are working in difficult situations;
- The improvements to budget controls since 1996;
- That the health sector leads the public sector in service planning; and
- The value of legislative accountability arrangements.

However, we have identified two major structural weaknesses in the health service. These are:

- No single institution or person is responsible for the day-to-day management of the service as an integrated national entity; management and control is too fragmented.
- The absence of clear accountability for relating clinical and other budgets to outputs.

The following deficiencies are symptoms of these structural weaknesses:

- Inadequate planning/costing;
- Unapproved capital expenditure;
- Unauthorised staff numbers;
- Non-imposition of charges;
- Accounting deficiencies; and
- Inadequate records/vouching.

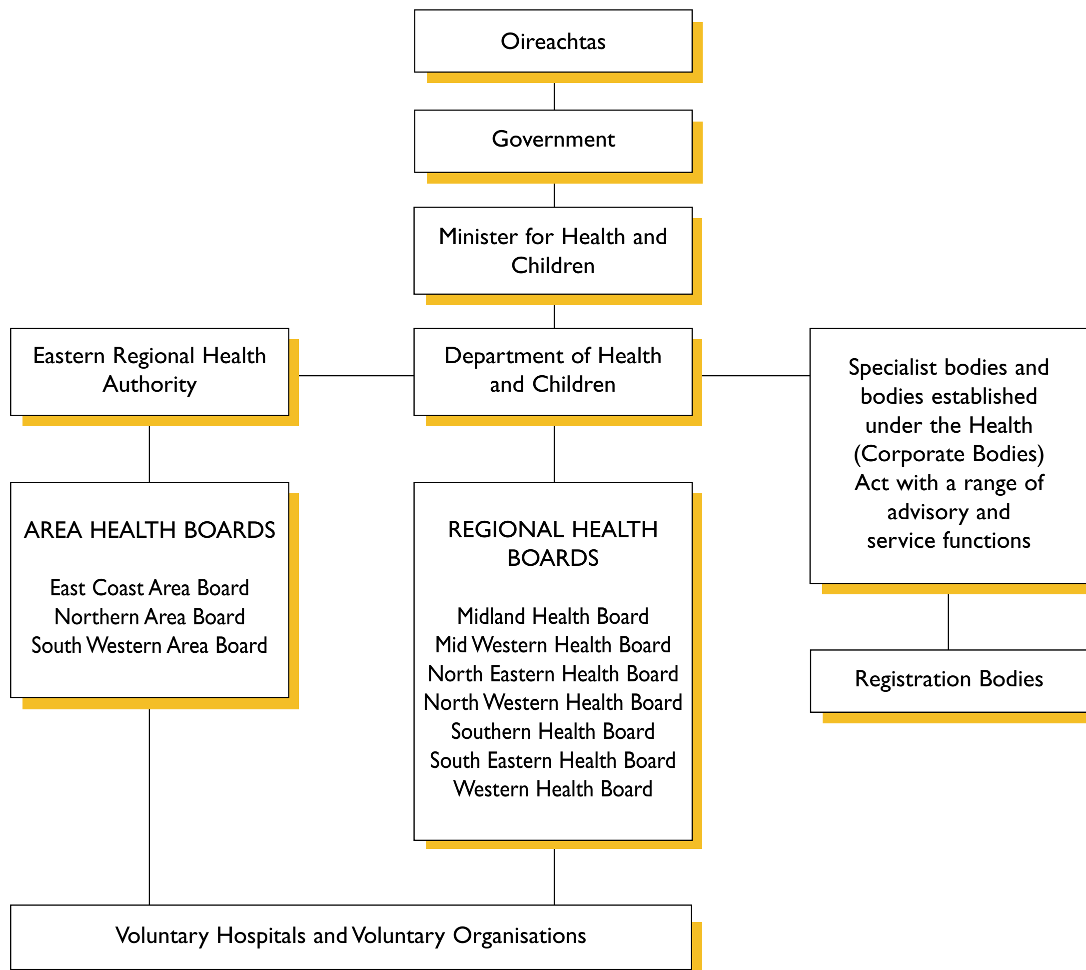
We have identified four core principles on which the recommendations of this report are based:

- The health service should be managed as a single national system.
- Accountability should rest with those who have the authority to commit the expenditure.
- All costs incurred should be capable of being allocated to individual patients.
- Good financial management and control should not be seen solely as a finance function.

2.2 ORGANISATION OF THE HEALTH SERVICE

The health service is not a unitary service but a complex collection of services provided by a variety of authorities (*see Appendix 3*), agencies and service providers (see Figure 2.1).

Figure 2.1: Organisation of the Health Service

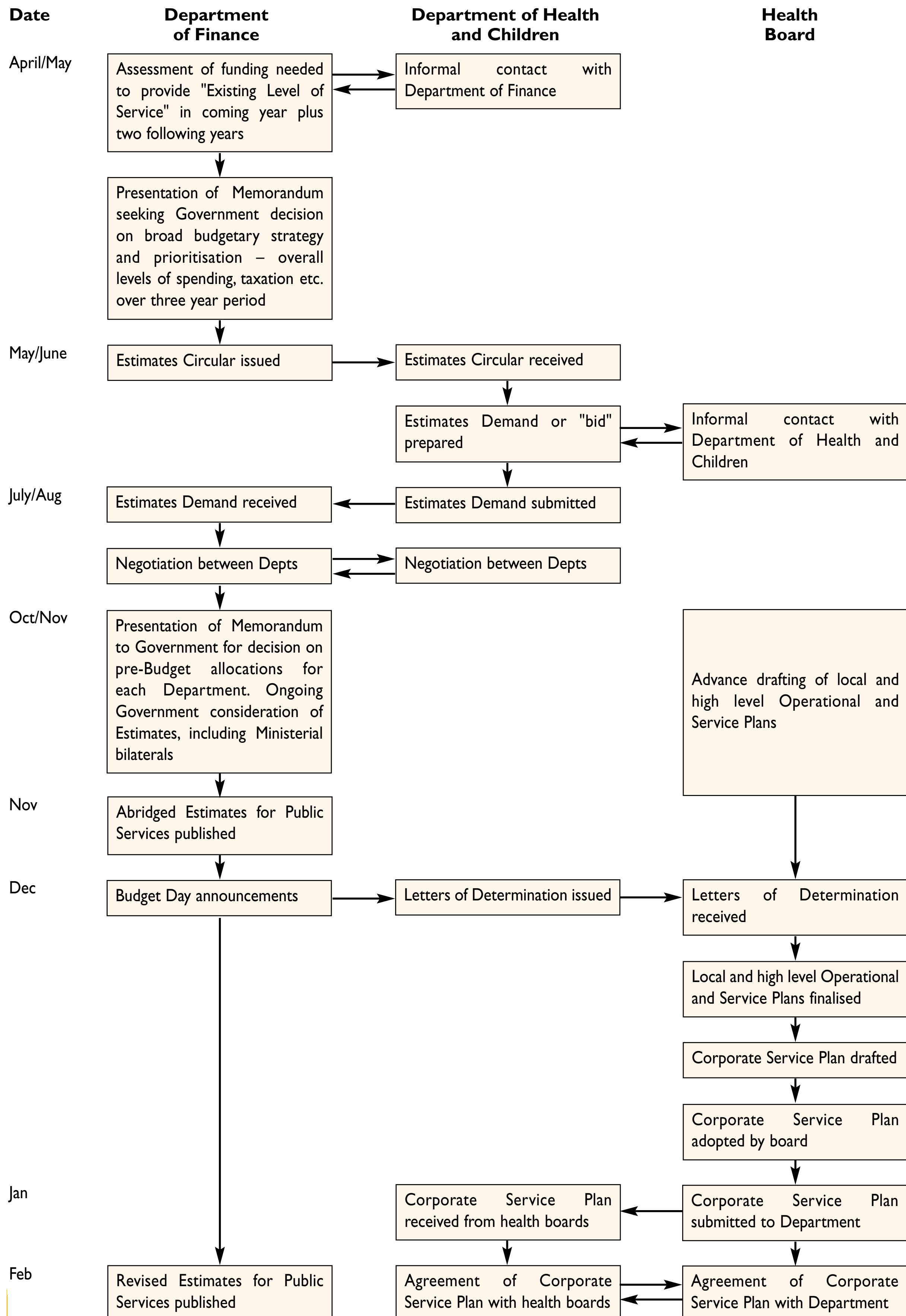


The responsibilities and functions of the various stakeholders (health boards, Department of Health and Children, Department of Finance etc.) are significantly different. However, they all require information, on a timely basis, of a type and quality that allows, on the one hand, the professional management of the day-to-day activities of the service, and, on the other, the facilitation of better evidence-based planning and coordination and improved support for policy making at Government level.

2.3 ESTIMATES, ALLOCATIONS AND CONTROL OF THE SERVICE

The provision of money to provide public health services is made through the annual estimates and allocations process. This involves a complex set of interactions between the service providers (e.g. health boards), the Department of Health and Children and the Department of Finance. This process is summarised in Figure 2.2 below.

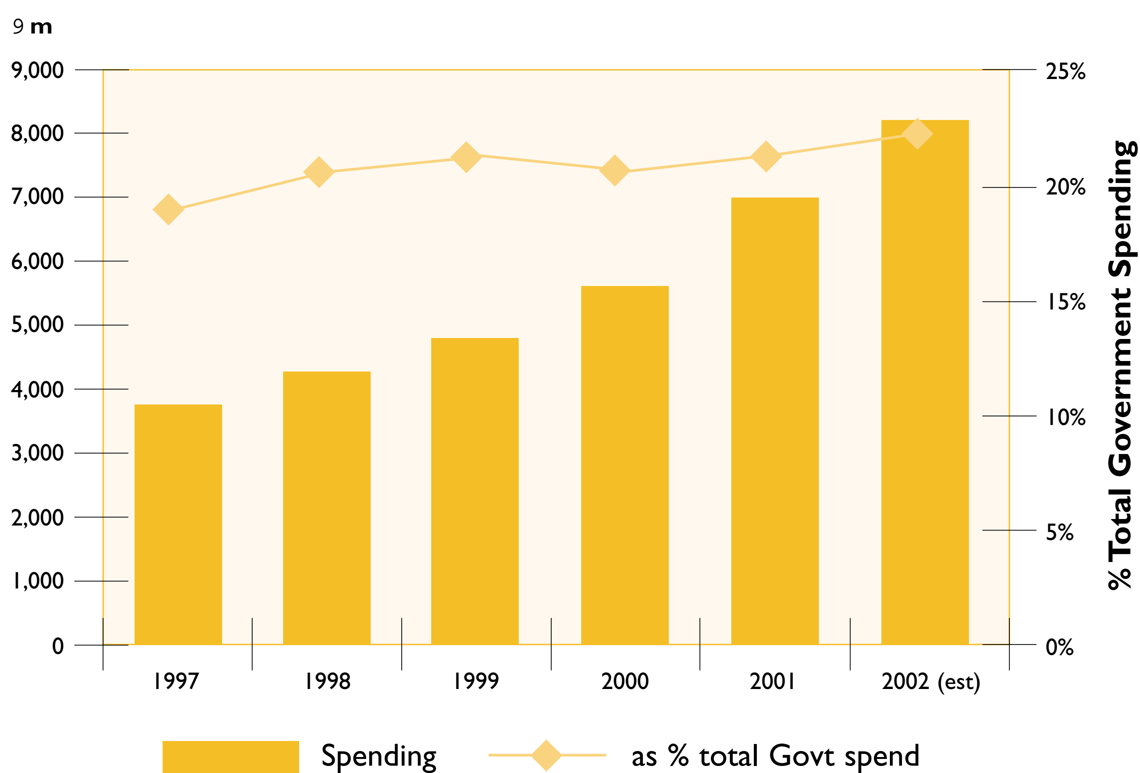
Figure 2.2: Summary of the Estimates and Allocations Process



Appendix 4 describes the process in greater detail and, as far as possible, the various stages are described chronologically in order to convey the step-by-step process involved. *Appendix 4* simply describes the system. It provides neither a critique of the systems as described nor an assessment of the extent to which these arrangements are actually followed in practice. A full critique and recommendations for change are set out in the body of this report.

The health service is an important issue for every citizen, both in terms of the quantity and quality of the service being provided, and the cost of that service to each of us. The share of total national public expenditure spent on health has increased from 19.2% in 1997 to 22.8% in 2002 while gross expenditure (i.e. before taking account of any receipts, for example from the health levy) on Ireland's public health system more than doubled (increase of 125%) between 1997 and 2002, from ¤3.6 billion to ¤8.2[1] billion (see Figure 2.3). For the year 2002, this amounted to over ¤2,000[2] for every person in the country or a charge of over ¤6,800[3] to each income tax payer.

Figure 2.3: Evolution of Exchequer Allocations to Health 1997 - 2002



Source: Revised Estimates for Public Services 1998 to 2002; Department of Finance

[1]Source: Revised Estimates for Public Services 1998 and 2002. These figures are gross and include capital spending.
[2]Source: Revised Estimates for Public Services 2002; Central Statistics Office.
[3]Source: Revised Estimates for Public Services 2002; Department of Finance.

Table 2.1: Evolution of Exchequer Allocation to Health 1997 – 2002

Year	Gross Vote ¤ Million	Increase ¤ Million	% Change	Cumulative % Change
1997	3,637			
1998	4,125	488	13%	13%
1999	4,831	706	17%	33%
2000	5,656	825	17%	56%
2001	7,077	1,421	25%	95%
2002 (est)	8,189	1,112	16%	125%

Source: Revised Estimates for Public Services 1998 to 2002

Table 2.2 and Figure 2.4 below, illustrate the scale of increase in funding in a range of areas of the health service for the period 1997 to 2002. This shows that in areas such as hospitals and GP Services, funding has more than doubled, with other areas recording even larger increases.

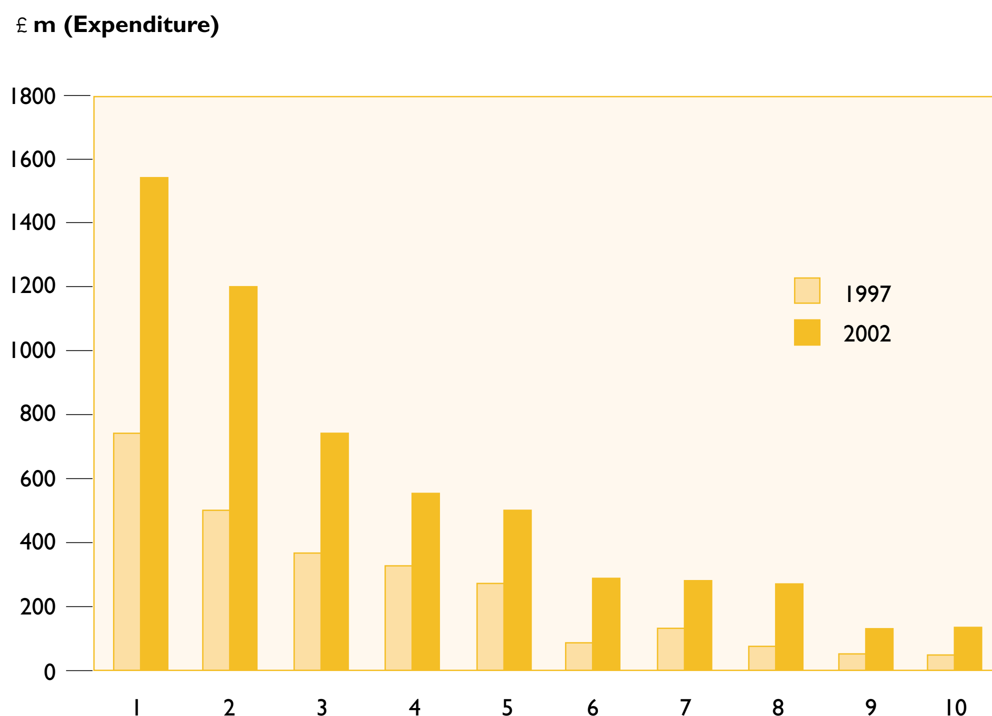
Table 2.2 : Growth of Non-Capital Expenditure in Selected Areas 1997 - 2002

		1997 (¤ million)	2002 (est) (¤ million)	% Increase
1	Services in Public Voluntary Hospitals	744	1,558	109
2	Services in Regional Hospitals	502	1,191	137
3	GP Services (including prescribed drugs)	366	738	102
4	Psychiatric Programme	327	570	74
5	Mentally Disabled Special Home Care	246	522	112
6	DPS: Subsidy for drugs not covered by GMS	93	295	217
7	Services in Long-stay Hospitals	131	255	95
8	Child Care Services, including residential care	84	245	192
9	Superannuation	48	129	169
10	Dental Services	48	123	156

(See also Figure 2.4 below)

Source: Department of Health and Children

Figure 2.4: Growth of Non-Capital Expenditure in Selected Areas 1997 - 2002



Source: Department of Health and Children

This increased expenditure has been accompanied by an increase in output. For example,

- In-patient discharges have increased by 4% from 536,236 in 1997 to a projected 557,130 in 2002 (for the same period, in-patient beds available to the system increased by 3% from 11,861 to 12,200).
- Day patient activity increased by 65% from 249,472 in 1997 to a projected 410,481 in 2002.
- Development of GP out of hours co-operatives in each health board area (12 nationally).
- Further enhancement of home based and outreach mental health services – three new mental health units have opened at Dublin, Cork and Clare.
- Health Promotion initiatives on immunisation - an overall 75% reduction in the number of Group C meningitis cases.
- Development of regional cancer and cardiac services - 76 additional Consultant cancer specialists have been appointed since 1997.
- Development of Community Rehabilitation Units for elderly - 1,300 staff recruited for these services, over 550 additional beds in new community nursing units and over 1,250 day places per week have been provided in new day care centres.
- Additional respite, day and long stay places for physically and intellectually disabled - 465 dedicated respite places and around 1,300 additional residential places have been provided.

Source: Department of Health and Children

Given the importance of the health service in the life of the country and the sums of public money involved, it is imperative that health service organisations and agencies have financial processes that are efficient, modern, transparent, geared towards service provision and based on value for money principles.

2.4 POSITIVE ASPECTS OF THE SYSTEM

Foremost among the strengths of the health service are the very many dedicated and committed people working in all areas of the sector. This commitment has ensured that high standards of care are provided to those in need, despite the difficult circumstances in which staff frequently operate. The people who work at all levels of our health service are entitled to expect the system to be organised in a way which best allows them to use their skills and energy to provide quality care within the resources available. They deserve no less than the opportunity to work in a system which will support them in doing what they wish to do: offer the highest quality service to the public. This ideal has informed our deliberations throughout.

In terms of systems, since the passing of the accountability legislation in 1996, the Department of Health and Children has been putting in place a framework of control in the finance and service planning areas particularly.

The key elements of this control framework are:

- Annual Service Plans linked to approved budgets;
- First charge on the following year's budget of any excess above the current year's budget determination;
- Accrual based income and expenditure accounting;
- Accounting standards;
- Monthly management reports and formal quarterly meetings between Department officials and health board executives; and
- Weekly monitoring and control of cash disbursement.

These controls, some of which do not feature in the public service generally, are largely underpinned by legislation.

However, we recognise that planning, management and financial accounting within the highly complex health service requires to be improved further.

2.5 PROBLEMS WITH THE EXISTING STRUCTURES

The two central weaknesses in the system that continually stand out in the work carried out by us and in the various submissions and contributions that we have received are:

- No single institution or person is responsible for the day-to-day management of the service as an integrated national entity; management and control is too fragmented.
- The absence of clear accountability for relating clinical and other budgets to outputs.

Management of the Service

The present structure has 10 health boards (plus the Eastern Regional Health Authority) responsible for the management and delivery of health services in their areas and as many as 53

other agencies (including six statute-based hospitals) at national level with various administrative, service delivery and other regulatory functions (*see Appendix 3*). No one organisation has overall responsibility for day-to-day co-ordination and management of the service nationally i.e. there is a managerial vacuum at the centre. Under the 1970 Health Act, health boards were given, by the Government, the function of managing the vast bulk of health services. The Department of Health and Children holds the health boards and their CEOs accountable for the delivery of those services. In recent years, other executive agencies have been established with the agreement of Government to provide specific services which were considered more appropriate to be placed outside the Department so it could better concentrate on its key roles of advising the Minister and Government, policy making, drafting legislation, international responsibilities etc. In this current configuration, the roles played by the Department of Health and Children are not sufficiently defined to address the managerial vacuum at the centre of the health service. Any meaningful reorganisation of the country's health system will have to deal with this basic structural and operational weakness.

Accountability in the System

With an absence of full accountability throughout the system, there is no built-in mechanism that links clinical decision-making and its financial consequences to those who actually make the clinical decisions. As a result, the service is not providing, as a matter of routine, high-quality information on factors impacting on efficiency and effectiveness including clinical outputs and the costs involved. Clinicians, service users and those charged with overseeing the service do not currently have sufficient quality information to assess the value obtained from expenditure. At present, those with authority to commit resources and incur expenditure - including clinical Consultants and General Practitioners - are not designated as budget holders or expenditure controllers. This absence of a system of structured accountability has far reaching consequences for the way the entire health care system is organised, financed, managed and controlled.

2.6 CONSEQUENCES OF THE STRUCTURAL WEAKNESSES

The consequences of the structural weaknesses in the present health system are:

- Patient costing is not at the centre of the system of financial management and control.
- The individual medical or clinical practice is not the fundamental unit of accountability in the system.
- The collection and interpretation of primary source data about patients is not done by the professionals who prescribe the services or drugs.

Consequence 1: Patient Costing is not at the centre of the system

Information is not available at the level of the patient on the comparative cost of treating a particular condition. The absence of data such as, for example, the marginal cost of treating a particular condition in different types of care settings (e.g. at home, in a day-care unit, in a 5-day facility or in the acute bed of a teaching hospital) or in different areas of the country, makes it difficult to compare costs and value for money between different institutions providing the same service. This lack of information also inhibits the capacity to plan for services, based on fair comparisons of costs between different public hospitals or between private and public hospitals either at home or abroad. A costing system is also needed to accurately determine the full cost of treating private patients in public hospitals. From the perspective of service provider and service user, this costing information gap is an issue.

Consequence 2: Clinicians are not the fundamental unit of accountability in the service

The individual medical or clinical practice is not the fundamental unit of accountability in the Irish health care system. As a consequence, the 600 (circa) admitting clinical Consultants who treat all the public and some private patients in the general public hospitals in Ireland do not have budgets negotiated with them within which to manage their clinical activity. The absence of this structure creates an anomaly in the operation of financial management and control systems in the general hospital sector which alone accounts for almost 50% of the total health budget (see Figure 2.5 and Table 2.3). The anomaly is that the chief executive officer of the health board, who is legally accountable for dealing with overruns on budget and for modifying Service Plans accordingly, has only limited, crude powers for agreeing these budgetary adjustments with the clinicians that have the authority to commit resources. In the absence of agreed mechanisms between clinicians and management, any attempts to curtail clinical activity is likely to be met with an outcry that patients will suffer or die. There is currently no incentive built into the system for clinical Consultants to budget for their practices, to manage expenditure to produce an agreed output, or to suggest ways of running their units or hospitals more cost effectively.

The same weakness exists in relation to contracts for services with General Practitioners – i.e. there is no mechanism for negotiating with over 1,800 General Practitioners an annual budget to provide an agreed level of service to their patients. At present, the focus of the medical card scheme is to pay doctors by reference to the number of patients on their panel rather than through a system designed to get the desired clinical output in the most cost effective way. In total, the community health services, including the medical card and drugs refund schemes, account for 17% of total health spending (see Figure 2.5 and Table 2.3).

Figure 2.5: Health Expenditure 2002 by Programme

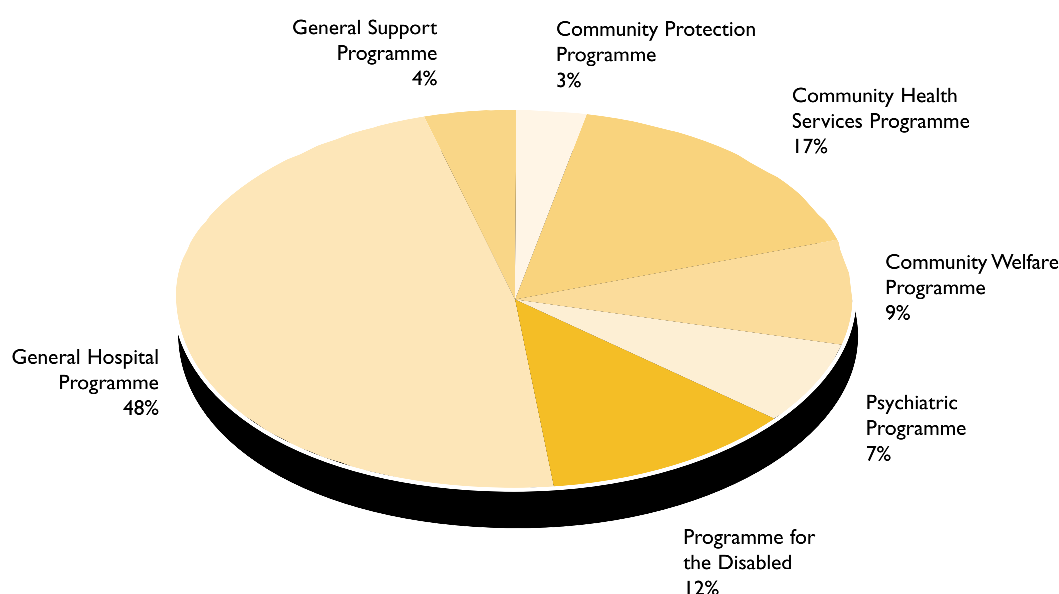


Table 2.3: Health Expenditure by Programme 2002[4]

Programme		Expenditure ¤ Million	% of Total Non-Capital Programme ¤ Million
1.	General Hospital	3,832	48%
2.	Community Health Services	1,332	17%
	Including: GMS GP Service (¤ 738m)		
	Drug Refund Schemes (¤ 344m)		
3.	Community Protection/Welfare	985	12%
4.	Programme for the Disabled	969	12%
5.	Psychiatric	570	7%
6.	General Support	339	4%
Total		**8,028[5]**	**100%**

Source: Revised Estimates for Public Services 2002.

Consequence 3: Primary source data on patients
Primary source data about patients, their needs and the comparative costs and effectiveness of different treatment options are not collected and so are not available to the professionals who prescribe these treatments. For example, data collected from records on "Diagnosis Related Groups" and "Casemix" (*see Appendix 5*) are not systematically reviewed and interpreted by the clinicians from whose practices it is collected.[6] The result is that quality information on clinical work, clinical outputs and their comparative cost, agreed by clinicians, is not available to clinicians and management to evaluate the cost effectiveness of services provided. This is a fundamental weakness when trying to determine the real costs of providing services and conducting teaching and research. Such information is basic in the evaluation of performance and in planning changes in the configuration of primary, secondary or tertiary medical services in order to improve services to patients or to control costs. Examples of the problems created by the absence of systematic evaluation of resource use were presented to us by the Irish Hospital Consultants Association. They highlighted the bed blockage problem existing in Dublin hospitals because patients that are medically fit to be discharged have nowhere to go.

They also highlighted the waste of Consultants' time arising from the cancellation of elective admissions to make beds available for Accident and Emergency admissions. Until the underlying causes of the waste of such expensive resources are tackled, it is not possible to decide whether an extra 3,000 acute hospital beds and 1,000 extra Consultants, as

[4]Because of an accruals adjustment, the totals in this table do not directly accord with the cash allocation from the Exchequer as shown in Table 2.1.
[5]Rounding affects the total.
[6]We understand that the entire national Casemix dataset (both activity and costs), is shared with all hospitals, and their staff (both clinical and management) who participate in the system. Data for both the hospital itself, and all other hospitals in the programme, can be accessed and viewed locally.

recommended by the Irish Hospital Consultants Association, are needed to satisfy current demand.

The absence of this basic information on a systematic basis leads us to conclude that the health service is under-managed despite the popular perception that it is over organised, over administered and bureaucratic.

2.7 SPECIFIC PROBLEMS DERIVING FROM THE STRUCTURAL WEAKNESSES

The combination of these structural weaknesses has led to specific and ongoing problems over the years that are symptomatic of the underlying organisational fragmentation of the system. These specific problems relate to failures in respect of planning, control and financial accounting, delays in producing statutory accounts and reports for the Department of Health and Children and unauthorised recruitment of staff. We recognise that the low levels of investment in national modern enterprise-wide information systems and commensurate investment in financial expertise has been a factor in inhibiting best practice in financial management. Some examples of these problems may be instructive.

Problem 1: Inadequate Planning and Costing

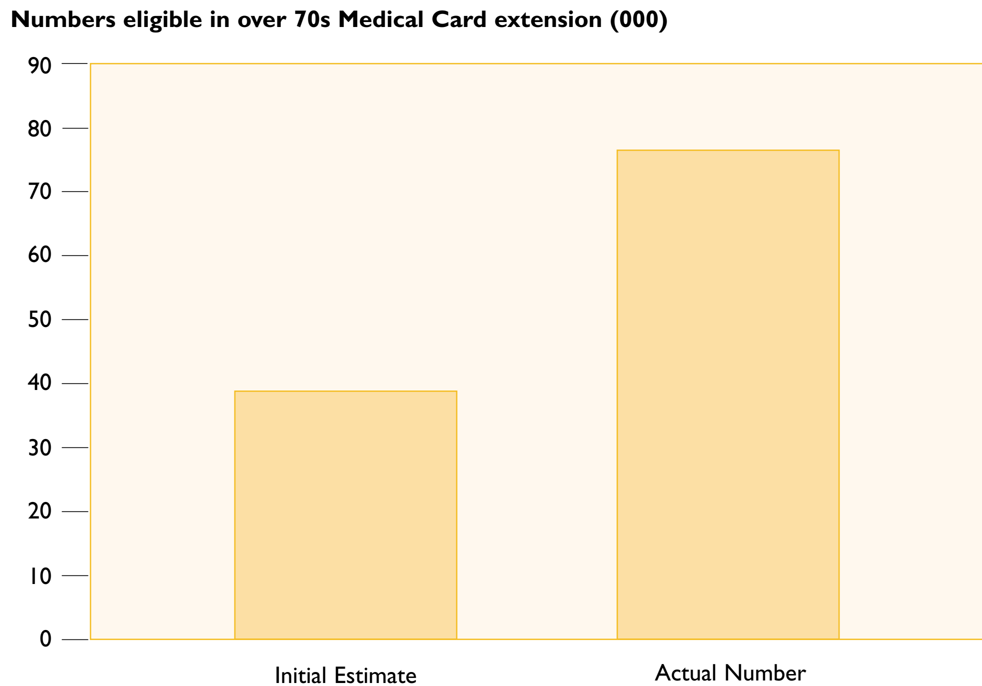
Three costly examples follow – the over-70s medical card extension, the 2001 childcare workers pay agreement and the problems of over-runs in the General Medical Services (GMS).

The over-70s medical card extension

The extension of medical cards to all people over 70 years of age is a stark example of totally inadequate planning and costing. The following sequence of events is drawn from the 2001 annual report of the Comptroller and Auditor General (C&AG).

In his 2001 Budget speech, the Minister for Finance announced the extension of the medical card scheme to cover all persons aged 70 and over, irrespective of means, to take effect from 1 July 2001. The Secretary General of the Department of Health and Children informed the C&AG that his Department was made aware of the decision "*a few days prior to Budget day.*" The Secretary General informed the C&AG that his Department provided "*such data as was readily available to it in the extremely short time involved in order to assist the Department of Finance in determining the likely cost of implementing the scheme in 2001*". The initial estimate that 39,000 people would become eligible was substantially incorrect. The Department of Health and Children have advised us that the actual number is now over 77,000. The cost of the scheme was projected to be ¤19 million and is now put at ¤55 million.

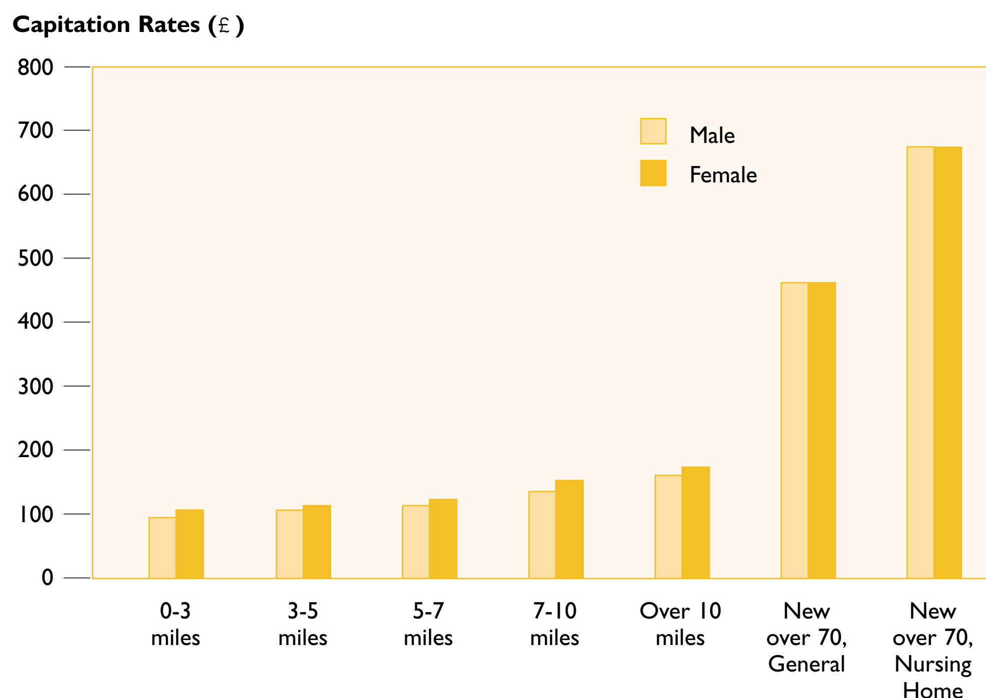
Figure 2.6: Forecasted and Actual Numbers Eligible for over-70s Medical Card Extension



The extension had exposed serious weaknesses in the areas of advance costing. Other problems soon surfaced. The Department of Health and Children informed the C&AG that, when the introduction of the new scheme was being considered, it put down "a clear marker" about the potential dangers involved in announcing an extension without the prior agreement of the Irish Medical Organisation and the Irish Pharmaceutical Union.

The warning proved prophetic: the Department of Health and Children eventually agreed a capitation rate with the Irish Medical Organisation for those covered by the new scheme. The rate for non-means tested medical card holders is a multiple of the fee paid for pre-existing means tested medical cardholders aged 70 and over. As of 31 December 2001, the annual capitation fee for medical cardholders aged 70 and over varies from ¤95.43 to ¤160.58 for males and from ¤106.11 to ¤171.33 for females, depending on the distance between the service user's home and the doctor's surgery. The capitation rate for newly eligible non-means tested service users aged 70 years and over is ¤462.16 and ¤669.79 for those in a private nursing home (Figure 2.7).

Figure 2.7: Capitation Rates for Existing and Newly Eligible Medical Card Holders over 70 Years of Age



Source: GMS (Payments) Board Annual Report 2001

The extension of the medical card scheme gave all persons aged 70 years and over entitlement to free drugs and medicines as well as free medical services. Negotiations with the Irish Pharmaceutical Union for the provision of services have not yet been concluded.

Our view is that the over-70s medical card extension is a classic example of totally inadequate planning and costing. The bill for the scheme is a multiple of the original costs envisaged and it continues to rise.

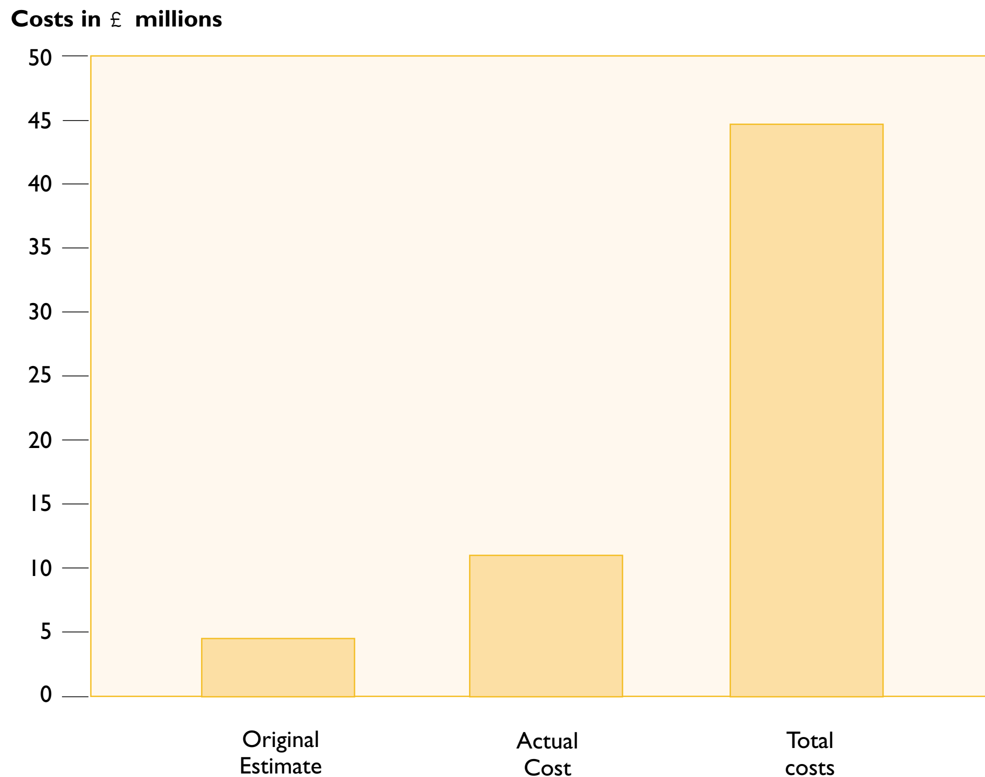
Childcare Workers 2001 Pay Deal

Many of the deficiencies found in the over-70s medical card extension also featured in a pay deal for childcare workers negotiated in 2001 (see Figure 2.8):

- The original estimated cost of this pay deal was ¤ 4.7 million per annum.
- The actual cost for childcare workers alone turned out to be ¤ 11.4 million per annum.
- The knock-on costs for linked grades are expected to come to an additional ¤ 34 million to ¤ 38 million per annum.

- The total eventual cost is therefore in the range ¤45 million to ¤50 million.
- Arrears of ¤30 million to ¤34 million are also due to be paid on this deal.

Figure 2.8: Childcare Workers Pay Deal 2001



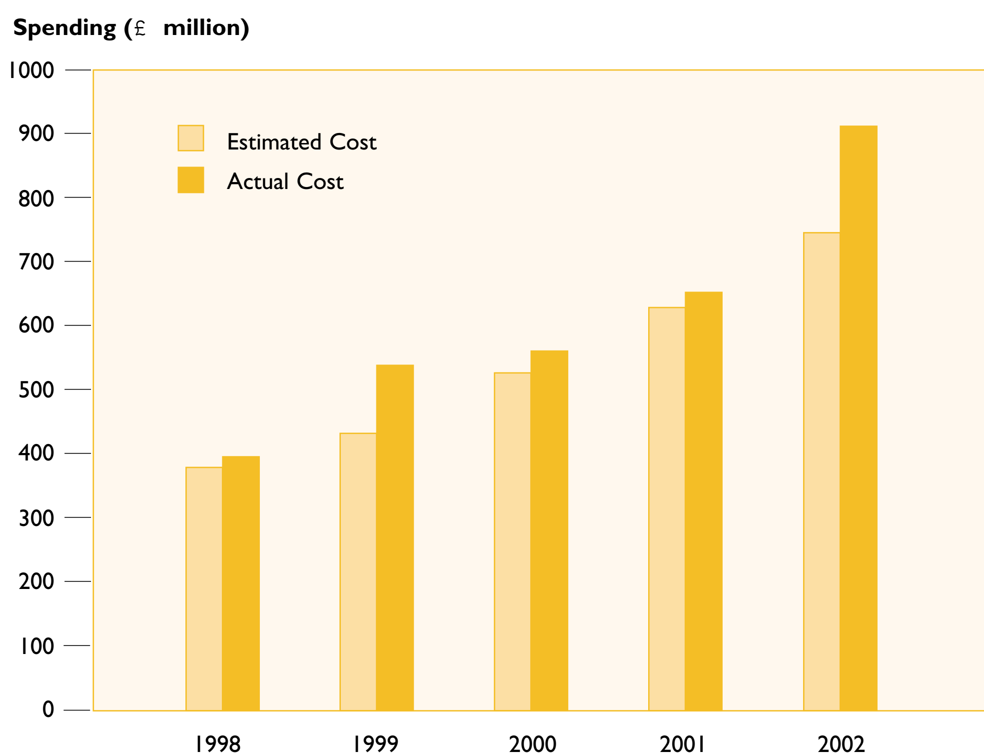
Source: Department of Health and Children

This is an example of how the absence of a comprehensive risk assessment procedure, which would examine the full effects of such a change, can have enormous consequences. We acknowledge that this problem is not unique to the health sector.

Overruns in the General Medical Services

The estimated spending overshoot in 2002 for the General Medical Services (GMS) is ¤183 million on a budget of ¤739 million – 25%. While we acknowledge that because this is a demand-led scheme it is difficult to forecast its costs, the extent and systematic nature of the underestimation of costs have surprised us. An analysis of the period 1997 to 2002 (Figure 2.9 and Table 2.4) shows an estimated annual average increase of around 6.8% in the annual Estimates. The actual annual average increases in costs were in excess of 21% for the same period. Figure 2.9 shows the problem is getting worse.

Figure 2.9: Estimated and Actual Cost of the Medical Card Scheme 1998 - 2002



Source: Revised Estimates for Public Services 1998 – 2002; Department of Health and Children

Table 2.4: Estimated and Actual in Costs of the Medical Card Scheme 1998 - 2002[8]

Year	Estimate ¤ 000	Outturn ¤ 000	Increase in Estimate over previous year's outturn	Increase in actual spend based on outturn
1997	-	361	-	-
1998	380	400	5.3%	10.9%
1999	422	543	5.4%	35.7%
2000	517	551	-4.8%	1.4%
2001	633	653	15%	18.4%
2002	739	922[7]	13.3%	41.3%
	Average		*6.8%*	*21.5%*

Source: Revised Estimates for Public Services 1998 – 2002; Department of Health and Children

[7] The "outrun" figure for 2002 is the sum of the original estimate for 2002 (£739m) and a supplementary estimate of £183m.
[8] Rounding may affect totals

In 2002, the estimated increase in expenditure on the GMS over 2001 was 13.3%. The actual increase in spend was 41.3% higher than the previous year – thus requiring a supplementary estimate of ¤ 183 million. Each year since 1998 predictions about increases in spending have failed to anticipate how much Exchequer funding will be required. In 2003, the estimated increase in costs is 5.2%. We recognise the challenge that this estimate poses for the Government in terms of its policy choices on the GMS. We deal with these challenges in more detail in Chapter 6.

Problem 2: Unapproved Capital Expenditure

Early in 2002, the Department of Health and Children became aware that the capital contractual commitments of health boards included approximately ¤ 115 million not approved by the Department of Health and Children. These related to a wide range of projects, some of which had partial or limited Department of Health and Children approval and others which had no approval from the Department. It would appear that all of these unapproved contractual commitments relate to appropriate health service projects in different care programmes. It must be emphasised that on larger construction projects where Department of Health and Children professional staff have had a direct involvement, budgetary difficulties have not arisen.

Some health boards incorrectly took the view that the indicative funding which had been notified at the commencement of the National Development Plan (NDP) for planning purposes only could be regarded as a capital allocation and engaged in expenditure on capital projects without seeking approval from the Department of Health and Children. Also, circulars issued since the commencement of the NDP instructing health boards to comply with the established and normally rigorous procedures for the approval of individual projects were in some cases not adhered to (*see Appendix 4*).

The unapproved commitments were generated in 2000/2001 at a time when health boards, supported by the Department of Health and Children, were striving to ensure the implementation of the National Development Plan and were putting in place resources to properly plan and to cost projects. Health boards were developing their NDP programmes in the context of high local expectations and significant public pressure to meet the aspirations created by the launch of the NDP and the then buoyant economic climate. This was clearly a difficult developmental stage in the transition of the capital programme to a major multi-annual investment plan. Before the NDP, the boards were relying on weak organisational structures and on older systems of planning, monitoring and control which had been in place for many years to support a relatively modest annual capital programme.

The management of the NDP programme within some boards, and the expectation associated with same, has certainly been problematic and has generated unapproved expenditure. This must be corrected and the NDP programme operated in line with requirements set down by the Department of Health and Children. We regard what occurred in relation to some health boards in respect of unauthorised expenditure as unsatisfactory, particularly in the light of the clear instructions issued by the Department of Health and Children on the process of NDP management at central and local level. We understand that the Comptroller and Auditor General is examining this issue.

The Department of Health and Children has emphasised that no additional capital funding has

been sought to address this issue and the Department does not intend to seek any additional Exchequer funding for this purpose. The Department has, however, due to the resulting cash difficulty arising from this unauthorised spending, agreed to fund about ¤77 million of the above figure.

Since February 2002, the Department of Health and Children has strengthened controls to ensure no recurrence of the matter.

Table 2.5: Example of Unauthorised Expenditure in the Health Service

Year	Agency	Problem Identified
2000/1	Health boards	Health board management spent £115 million on capital projects that had not been authorised by the Department of Health and Children. *[Dept. of Health and Children, Dept. of Finance]*

Problem 3: Unauthorised Staff Numbers

The numbers to be employed in the entire health service is determined and authorised by the Department of Finance consistent with the Government's overall employment policy. The Department of Health and Children then authorise employment limits for each of the health boards/agencies within that total. There is evidence that these ceilings on employment numbers have been breached on occasions in the past. We are also aware that for the years 2001 and 2002, the process for controlling numbers in the health boards moved to one that linked posts directly to the resources available. For both those years, boards have stayed within these available resources although the overall sanctioned employment limits were exceeded.

Table 2.6: Examples of Unauthorised Staffing in the Health Service

Year	Agency	Problem Identified
1998	Eastern Health Board	Eastern Health Board exceeded its authorised staffing levels throughout the year. *(C&AG Annual Report 1998)*
2000	All health service	The annual Census of Health Service Employees, covering the entire health service, shows an excess of 500 over the approved employment ceiling. *(Dept. of Health and Children, Dept. of Finance)*
2001	All health service	The annual Census of Health Service Employees shows an excess of 3,800 over the approved employment ceiling for the entire health service. *(Dept. of Health and Children, Dept. of Finance)*

The annual employment census for the entire health service for 2001 shows an excess of 3,800 over the approved employment ceiling while keeping within budget. However, we recognise the weakness of the census insofar as it does not take funded vacancies into account in calculating numbers.

Problem 4: Non-Imposition of Charges

The Comptroller and Auditor General has reported a number of instances where charges have not been properly imposed or collected (Table 2.7). The most significant cases relate to the failure to charge for tests relating to the private activity of Consultants in the public hospital system (i.e. the taxpayer has met the costs which should have been charged to the private practice of certain Consultants). In addition, there was a case where a failure by Consultants to provide information about their private patients to hospital management resulted in more than ¤ 1 million not being billed to private health insurers.

Table 2.7: Examples of Failure to Impose Due Charges in the Health Service

Year	Agency	Problem Identified
1998	Longford Westmeath Hospital	While the hospital improved the situation over 1997 during Hospital the first half of 1998 (collecting some ¤ 103,000 in outpatient charges), they once again ceased billing patients and no invoices were issued up to the end of the year. *(C&AG Annual Report 1998)*
1998	Waterford Regional Hospital	In excess of ¤ 1 million in private patient charges (recoverable from VHI/BUPA) could not be billed by Waterford Regional Hospital to the insurers because hospital Consultants had not supplied the necessary information in respect of their patients. The patients of three Consultants accounted for almost half of the outstanding monies. *(C&AG Annual Report 1998)*
2001	Virus Reference Laboratory	Charges for all laboratory services were levied against the public health system including those tests performed on behalf of private hospitals/clinics.

Problem 5: Accounting Deficiencies

In reviewing the Comptroller and Auditor General's reports on the audit of health boards' statutory accounts, a wide range of accounting failures feature. These include failure to:

- Observe accounting standards;
- Record fixed assets; and
- Meet statutory accounts deadlines.

It is unacceptable that the audited accounts of health boards (or any other public sector organisation) are not available within the statutory auditing deadlines.

The Minister for Health and Children laid down, effective from 1 January 1994, as amended from 1 January 1998, accounting standards to be adhered to by the health boards. These include very many prescriptive formats and directions for the recording of transactions in the books and

records of each board. They include the mandatory design of the basic annual accounts together with a very large number of ancillary financial management accounting schedules or accounts which altogether form the package of financial figures that are called the Annual Financial Statements (AFS).

The annual preparation of the entire financial package, which is required to be completed and signed off by the CEO and the Chairman/member of the health board and submitted to the Minister and the Comptroller and Auditor General not later than 1 April following the year of the accounts to 31 December previously, presents difficulties for the health boards. We have ascertained that the accounts presented for audit have at times contained accounting errors and other issues identified during the course of an audit, which subsequently become either:

(a) The subject of an unsatisfactory report (known as a Section 6(4) Report) by the Comptroller and Auditor General where these issues are considered so significant as to require such a report, or
(b) The subject of a letter issued to the CEO of the health board by the Comptroller and Auditor General after completion of the audit which is referred to as a "Management Letter".

Table 2.8 summarises the number of satisfactory and unsatisfactory section 6(4) audit reports for the three years 1998 to 2000. Of the eight health boards (then in existence), all but one received an unsatisfactory audit report at least once in the three-year period we reviewed. In the case of one of the eight health boards, its audit report was unsatisfactory in all three years examined. At the date of completing this report (January 2003) the year 2000 audit report for the Eastern Regional Health Authority is not yet to hand. By statute, the audit should have been completed by 30 September 2001. The issue of timeliness of audits is discussed in more detail in Chapter 8.

Table 2.8: Comptroller and Auditor General Audit Reports for the Health Boards

Financial year ended	**1998**	**1999**	**2000**
Satisfactory Section 6 audit report	3	4	5
Unsatisfactory Section 6 audit report	5	4	2
Audit report not yet available	-	-	1
	8	8	8

Table 2.9: Examples of Issues Highlighted by Section 6(4) Reports

Year	Agency	Problem Identified
1998	Eastern Health Board	Persistent delays in the submission of accounts by the Eastern Health Board resulted in statutory deadlines for audits not being achieved. Audit backing documentation was not available to substantiate a debtor of £356,541 and its related bad debt provision of £273,730. At 31 December 1998, cheques totalling £273,732 drawn by the board and recorded as expenditure in the board's financial statements had not been issued to payees. Errors in accounting for fixed assets and maintenance expenditure. The 1998 opening ledger balances for debtors and creditors did not agree with the 1997 audited closing balances. *(C&AG Annual Report 1998)*
1999	Western Health Board	Expenditure incurred by the Board during the year in excess of its approved allocation. *(C&AG Annual Report 1999)*
2000	Western Health Board	There were serious inaccuracies in the financial statements as presented. The identification and correction of these deficiencies meant that there was a very significant delay in completing the audit of accounts. *(C&AG Annual Report 2000)*
2001	Western Health Board	Failure to submit board certified accounts by 1 April 2002 in accordance with section 1.1.1(3) of the Health Board Accounting Standards. These accounts were submitted on 4 November 2002. *(Dept of Health and Children)*
2001	Eastern Regional Health Authority	Failure to submit board certified accounts by 1 April 2002 in accordance with section 1.1.1(3) of the Health Board Accounting Standards. These accounts were submitted on 13 December 2002. *(Dept of Health and Children)*

In a management letter, the Comptroller and Auditor General seeks explanations from the CEO or the health board's Director of Finance of certain items (e.g. the financial treatment of certain items; the deficiency of financial records; general administration issues; other less material items) which have come to the attention of the Comptroller and Auditor General's staff in the course of the audit. The letter requires a meaningful response, which will include an undertaking to ensure that such errors or deficiencies will not recur in following years. Thus, there is an expectation of financial risk control flowing from this discipline, if the parties stringently adhere to it. The facts, however, demonstrate that there is at times a lax regard for the objectives of this control mechanism.

The management letters (issued by the Comptroller and Auditor General to health boards) for the financial year ended 31 December 2001 have not been issued at the date of preparation of this report. The effectiveness of such letters when they are issued must be extremely doubtful. Table 2.10 shows selected examples of the many matters which were to be found in the management letters, issued on the dates indicated by the Comptroller and Auditor General, in regard to the 2000 accounts, to the health boards indicated.

Table 2.10: Examples of Matters Raised in Management Letters by the Comptroller and Auditor General

Year	Agency	Selected Query of the C&AG
2000	Midland Health Board	Included in debtors is a salaries and wages overpayment of £115,429. *(Letter of 20 February 2002)*
2000	Mid Western Health Board	There is no continuous stocktaking facility in use in Board's pharmacies. *(Letter of 8 November 2002)*
2000	Southern Health Board	Salary overpayment: the largest of these was an overpayment of £23,000 to an individual over a 10 month period. *(Letter of August 2002)*
2000	Eastern Regional Health Authority	Debtors: Wicklow Co. Council: outstanding at 29 February 2000 (accounts year-end) was an amount of £411,653.42. There is an amount of £383,320 which relates to pre 1997 included in the above balance. *(Letter of 19 July 2002)*
2000	North Eastern Health Board	Housing Aid for Elderly: It was noted that the balance unspent on the Housing for the Elderly Account increased to £838,277 in 2000 (£469,328 in 1999). *(Letter of July 2002)*
2000	South Eastern Health Board	The board entered into finance lease arrangements for the purchase of four haematology analysers. All managers to seek prior approval before entering into this type of arrangement. *(Letter of 25 February 2002)*
2000	North Western Health Board	Land and Buildings: purchase of site at Ballinamore for £350,000. A note from the Board's solicitors dated 23 July 2001 states that the purchase was still not complete because of problems over title. A cheque for this amount was still outstanding and had to be re-issued to the vendors in 2001. Information is sought as to the reasons why a cheque for £350,000 was issued prior to clearance of title. *(Letter of 31 January 2002)*
2000	Western Health Board	Bank Reconciliation: it transpired that the overall bank figure in the balance sheet required an adjustment of £6 million from the original draft account submitted in March 2002 and the final account. *(Letter of 6 August 2002)*

Problem 6: Inadequate Records/Vouching
The starkest example of the absence of control under this heading arises in the General Medical Service (GMS). The Comptroller and Auditor General reported significant numbers of duplicate registrations for medical cards and also significant numbers of medical card holders without a pharmacy claim for some time (suggesting that they may, for whatever reason, no longer be card holders) but for whom capitation fees continued to be paid to General Practitioners.

Table 2.11: Examples of Inadequate Records in the Health Service

Year	Agency	Problem Identified
1998	Eastern Health Board	There were deficiencies in documentation supporting certain payments made by the Eastern Health Board. These included: • Grants to Voluntary Bodies: The absence of completed application forms, evidence of grant approval, tax clearance certificates etc. • Home Help Vouching: In one location payment substantiation was not countersigned, weekly hours not totalled and there was an absence of how actual payments were calculated (spend c. ¤ 612,000 in this area). • Inter Account Transfers: No supporting explanation for transfers. • Debtor Balance Substantiation: Documentation unavailable to substantiate a debtor of c. ¤ 464,000 and its related bad debt provision of ¤ 348,000. *(C&AG Annual Report 1998)*
2001	GMS	The General Medical Service had advised that there were a potential 8,000 duplicate medical card registrations and a further 28,000 people with no

2.8 CONCLUSION

We believe that the problems cited above show an inescapable need for fundamental reform in the financial management and control systems within the health service. We are not in the business of apportioning blame for what has happened in the past but we consider it our function to make the case for change. What these examples show is that financial management must improve further to urgently address the issue of accountability within the system. It is not in the interests of anyone (service user, taxpayer, health professional, service provider or Government) to see this continue. We believe the case for reform is compelling.

To do this, we must address, as a matter of priority, the two major structural weaknesses with in the health service that give rise to these specific problems. Specifically, we have identified these as:

- No single institution or person is responsible for the day-to-day management of the service as an integrated national entity; management and control is too fragmented.
- The absence of clear accountability for relating clinical and other budgets to outputs.

If these core structural weaknesses are not adequately addressed then the prospects of successfully putting in place practical and sustainable financial management systems are substantially reduced.

2.9 CORE PRINCIPLES

We believe that there are a number of core principles that are fundamental to the design of good financial management and control. These principles form the basis for all the recommendations in this report.

Principle 1: A Unitary Health Service

The health service should be organised and managed as a unitary national service that is tightly controlled at the centre and is without the fragmentation of services and accountability that typifies the existing arrangements.

Principle 2: Personal Accountability

Accountability for resources expended should rest with those who have the authority to commit the expenditure. It follows that the structure of accountability in the Irish health service for containing expenditure within budget should be redesigned using this principle.

Principle 3: Centred on the Service User

The patient/service user should be at the centre of any system for managing and controlling the use of resources. By creating awareness of the financial implications of decisions both patients/service users and service providers will be better informed of the most cost-effective clinical pathways in pursuit of the best clinical outcome. A system of patient costing would enable better decisions to be taken on the most cost-effective ways of achieving the same clinical outcome for the patient.

Principle 4: Financial Management

Good financial management and control should not be seen solely as a finance function. All staff with authority to spend money should have appropriate training to understand the basic principles of financial management.

Observing these principles will create the opportunities for financial transparency, greater accountability, increased value for the money invested in the service and, most importantly, help identify opportunities for treating more service users within the limits of available budgets.

The implications of these principles for the organisation of the health service and for the role of clinical Consultants, General Practitioners and other professional staff with authority to commit expenditure will be examined in some detail in the following chapters.

CHAPTER 3
MANAGING THE HEALTH SERVICE

In this Chapter, we recommend the actions required to deal with a major structural weakness in the health system – the fact that no single institution or person has overall responsibility for the day-to-day management of the service as an integrated national service. We examine the corporate governance arrangements that should apply to a restructured health service.

3.1 OVERVIEW

The primary role of the Department of Health and Children is the development of policy and services. It acts as advisor to the Minister (for Health and Children) and the Government on these issues. Actual management of the service has been devolved to health boards. They, in turn, liaise with the various agencies under their remit. But, at national level, no one has explicit responsibility for the effective executive management of the system as a national service nor for ensuring the application of appropriate financial management and control systems.

The estimates process is based on historical expenditure trends and is incremental in nature, although some allowance is made for demographic changes. At national level, there is no one in the health service carrying out a systematic continuing evaluation of core service and funding.

The management vacuum at the heart of the health service must be addressed urgently. We believe that national management of the health service would best be delivered outside the structure of the Department of Health and Children and are recommending the establishment of an Executive at national level (hereinafter called "the Executive") for this purpose. This would allow the Department of Health and Children to focus more fully on health policy.

The key function of the new Executive will be to provide the country's health service with quality management, analysis and evaluation of existing resource allocation mechanisms built around evidence based needs assessment. The new Executive must reduce, not increase, the levels of bureaucracy within the system and confront problems of fragmentation. Cutting the number of national executive agencies through consolidation and rationalisation will increase accountability for the performance of the health service and is also the key to beginning the process of reforming many of the management systems.

If the Executive were given responsibility to manage the health service, the Department of Health and Children would then be able to concentrate on the development of national health policy.

This Chapter also deals with governance issues for the restructured health system. In very basic terms, clarity is required on a number of key questions including: who does what?; where does the responsibility lie?; and what are the lines and structures of management accountability?

3.2 CURRENT ROLE OF THE DEPARTMENT OF HEALTH AND CHILDREN

The role of the Department of Health and Children is to advise the Minister on the development of health policy. In carrying out that role, it acts as a regulator and controller in respect of service provision. It does **not** manage the health service nor does it have any executive function in that regard. The management of the service is devolved to various national executive bodies, the health boards and other statutory and voluntary agencies. Any organisation which is multi-layered and fragmented has substantially weakened financial management and control. As a result, there is no one carrying explicit responsibility for the executive management and evaluation of the health system as a national service.

Despite the fact that accountability for the delivery of services is located at regional and local level, the Department of Health and Children frequently finds itself drawn into the details of health service provision without having executive control over the service i.e. the Department of Health and Children is being held accountable (wrongly) for service delivery issues without having the authority to directly address the management of the service at local level. The Department of Health and Children is frequently drawn into "fire fighting" and is therefore unable to create the space to carry out the necessary evaluation of core spending nationally.

3.3 THE NEED TO EVALUATE CORE EXPENDITURE

In terms of spending on health services, the estimates process (*see Appendix 4*) is based on historical expenditure trends and is incremental in nature, although some allowance is made for demographic changes. It has a disproportionate focus on the planning and implementation of new developments at the expense of ongoing systematic evaluation of baseline expenditure. Within the current structures, at national level there is no one in the health service carrying out this continual systematic evaluation of core service and funding.

To get the best returns from the investment of taxpayers' money in the health service, there should be a systematic process of monitoring and evaluating performance in terms of spending and activity at regional/service delivery level. At present the system does not have the capacity, as a matter of routine, to accurately cost and explore options. An analysis of core funding would:

- Permit evidence-based decision-making;
- Provide more accurate estimates of the true cost of providing health services;
- Promote closer monitoring and evaluation of the returns achieved for the resources invested; and
- Show where best value and best practice is to be found.

As presently constituted, the Department of Health and Children is focused on policy development. Its engagement in the estimates process is almost entirely aimed towards securing development monies for new initiatives at the margin of overall health spending. Simply put, the main focus of the Department of Health and Children is on the 3%, or so, of development funding without sufficient regard to how the 97% of core funding is being spent.

The fact that the primary emphasis of the work of the Department of Health and Children is on the development of policy and services, rather than the executive management, analysis and evaluation of overall performance, is symptomatic of an inherent structural problem in the health service.

3.4 MANAGING THE HEALTH SERVICE NATIONALLY - SEPARATING POLICY MAKING FROM THE MANAGEMENT OF SERVICES

Having regard to the foregoing, we have concluded that there is a managerial "vacuum" at the centre of the health service. Consistent with our core principle that the health service should be managed as a national service, we believe that a clear and unambiguous structural separation of the policy and management functions at national level is necessary to create the environment for the proper day-to-day management of the service as a whole.

Our view of the structure of managerial accountability for the total health care system can be simply explained.

- Firstly, the person responsible for the national management function should be accountable for the performance of chief executive officers (CEOs) of the regional health boards.
- Secondly, the CEOs of the various regional health boards should, in turn, be responsible for the performance of their General Managers (in health board hospitals, community care, etc.) and the CEOs of voluntary hospitals and statutory agencies within the health board's functional area.

This would simplify the structure and clarify accountability.

However, given that this national management function is not currently being carried out, the question arises:

Can executive management functions at national level be performed successfully while located within the Department of Health and Children, or, would they be better performed in an agency outside the Department of Health and Children?

The challenge is to find the best structure within which these executive management functions are executed while retaining Ministerial accountability.

This is a highly complex matter that overlaps with work being carried out elsewhere under the "Audit of Structures" as part of the Health Strategy (*see Appendix 6*). We took account of a number of factors when examining the respective merits of the national executive management function being performed by the Department of Health and Children or by an outside agency.

These included:

Management Experience: We have concluded there is a lack of management experience and culture in the Department of Health and Children of the type that is needed to manage the health service on a day-to-day basis – as noted above, executive functions have traditionally been carried out by a multiplicity of statutory agencies rather than by the Department.

Quality Management: A system as complex as the health service needs to be, at its topmost levels, staffed by the highest quality managers. It is imperative to attract and retain top class managers.

Management Remuneration: To ensure that the appropriate skills are attracted to the new organisation it is necessary to set the level of remuneration to achieve this objective. This requires different remuneration levels and conditions of service than in the civil service at present. In particular, the remuneration of the post of CEO should be determined by the process that currently applies to setting the salaries of CEOs in the non-commercial sector i.e. it should be determined by the Review Body on Higher Remuneration.

Open and Competitive Recruitment: Posts should be filled by competition that is "open" in the very widest sense. This will allow recruitment of senior managers from both the public and private sectors, domestically and internationally. This is fundamentally different to the arrangements that currently apply in the civil service.

Following consideration of these issues we have concluded that national management of the health service would best be delivered outside the structure of the Department of Health and Children. However, in reaching this conclusion we consider that there are a number of essential pre-conditions to the establishment of an independent Executive.

- Firstly, it is essential that a national Executive should **not** become an additional layer of bureaucracy.
- Secondly, the creation of such an Executive **must** involve the consolidation of many of the existing agencies within its functions with the result that there is a very significant reduction of the number of agencies – not to do so would simply perpetuate the unsustainable fragmentation of accountability and financial control.
- Thirdly, accountability and authority for management of the health service as a national entity must be explicitly devolved to the CEO of the Executive.

As regards the organisational consolidation, we believe that a major rationalisation of existing executive agencies in the health service is required if the establishment of the new Executive is to be recommended. We are aware that an audit of structures is already taking place *(see Appendix 6)*. While we do not wish to prejudge, we would not recommend a new agency:

- Unless the new Executive is made responsible for the functions now carried out by a large number of existing statutory bodies.
- Unless the functions of some existing bodies are subsumed into the Executive (examples include the Eastern Regional Health Authority, the Health Service Employers Agency and Comhairle na nOspidéal). This avoids multi-layering in the health services which dilutes financial control.

Recommendations on the National Management of the Health Service

R3.1 We recommend that the national management of the health service should be carried out by an "Executive" outside the Department of Health and Children.

R3.2 Establishment of the Executive must involve the consolidation of many of the existing agencies within its functions.

R3.3 There should be no net increase in staffing levels within the health service to give effect to recommendation R3.1.

R3.4 Staff of the Executive should be recruited by way of open competition and not restricted to the civil or public service.

R3.5 Recruitment of the CEO of the Executive should be by means of an international search and selection process.

Recommendations R3.1 and R3.2 will involve very substantial changes in the governance arrangements that apply to the health service.

We recognise that the establishment of an Executive will take some time in terms of legislation, rationalisation of existing structures, staffing, etc. Throughout this report we make recommendations to improve the health service that can be implemented immediately. Pending the establishment of the Executive, we take the view that these "quick-wins" should, in the short-term, be addressed by the Department of Health and Children and the Implementation Committee recommended in Chapter 11.

We would also emphasise that references to health boards and agencies elsewhere in the report should in no way be taken as an endorsement of existing structures or numbers of these agencies. As indicated above, we would be strongly of the view that many of the statutory agencies should be subsumed within the Executive.

3.5 RESTRUCTURED ROLE OF THE DEPARTMENT OF HEALTH AND CHILDREN

Within a restructured health service the Department of Health and Children will continue to be the chief advisor to the Minister for Health and Children and to the Government on health policy and financing of the health service. It is imperative that the new structures we are recommending do not diminish the quality of service available to the Minister and the Government. Indeed, it would be our wish that the proposed reorganisation should create an environment in which that service would be improved.

Under our proposals, the Executive will be assuming significant functions now carried out by the Department. For instance, responsibility for industrial relations, for approving annual Service Plans, for monitoring the spending of all health agencies and for overseeing the implementation of health policy will pass from the Department to the Executive.

As a result, the Department will no longer have direct access to sources of information about the services that currently comes from ongoing daily contact with the health boards. While, as indicated below, we envisage very close cooperation between the Department and the Executive at all levels, the loss of immediate contact with those responsible for delivering the

services could impact adversely on the quality of the advice that will be available to the Government from the Department. There is also a risk that, when the Department is formulating advice on financing, policy and legislation, the Executive could dominate it.

As a consequence of the changes we are recommending, the Department will also have to be restructured. The most important objective in this restructuring is to ensure that the Department has an increased capacity to carry out policy analysis and formulation. This role must go beyond simply promoting policy proposals put forward by the Executive. In carrying out its finance function, in particular, a key task will be to form its own view of the health services, based on ongoing critical analysis of service effectiveness and efficiency, so that the Government can be satisfied that the maximum output is being achieved for the resources being made available. It will also be vital that the working relationship that we outline in section 3.7 below proves effective.

The role, responsibilities and functions of the Department of Health and Children within a restructured health service will relate to the development of national health policy. The health policy function covers all those areas that specifically relate to supporting the political process at national level (the Minister, Government and the Oireachtas) and includes the legislative, international representative and estimates functions.

Recommendations on the Restructured Role of the Department of Health and Children

R3.6 The role of the Department of Health and Children should include:

- (i) Acting as advisor to the Minister and the Government;
- (ii) Developing and costing policy responses and strategies to achieve the necessary reform to address identified problems arising from existing policy;
- (iii) Developing and costing policies for future service developments;
- (iv) Dissemination and active sponsorship of best practice;
- (v) The Estimates process;
- (vi) Management of the legislative agenda as it relates to the health service;
- (vii) Acting as "regulator" in respect of national health care standards;
- (viii) International representation of the Irish health service (at the OECD, WHO etc.);
- (ix) Research and identification of ongoing developments in international best practice in the health area and consideration of the extent to which they may be adapted for implementation in an Irish context;
- (x) Risk assessment/management; and
- (xi) Issues relating to public sector pay policy.

3.6 THE ROLE OF THE EXECUTIVE

The role of the Executive should be focused on overall organisation and management of the health service as a national system – as indicated above, this is not currently being done with in the existing structures.

The work of the Executive must be to plan, organise and manage the total system in the same way that a corporate HQ manages the context in which each business unit operates. Functions would include:

- Analysis of the changing patterns of need for different types of medical and social services.

- Systematic review of the supply and provision of services to meet demand, including evaluation of changes in medical and related technologies and their potential to improve the range, quality and cost effectiveness of the services provided.
- Strategic planning and management of changes and improvements in the overall form, pattern and configuration of hospital and specialist services and balancing the provision of national, regional and local services.
- Systematic planning of medical and other manpower needs and the ongoing negotiation of employment contracts and terms and conditions to match the changing pattern of need for human resources to the changing pattern of demand for services.
- Costing and funding of training of medical students in public hospitals, continuing medical education and furthering medical research and development.

To perform this work the Executive will be required to subsume the functions and authority of a range of national executive agencies (e.g. Comhairle na nOspidéal, Health Services Employers Agency etc.) as, specifically, it will require authority to perform the following functions:

- To plan and manage the organisation of Consultant-led specialist services/hospitals throughout the State.
- To decide on the number and type of Consultant posts in each specialist service/ hospital.
- To plan and organise the provision of primary medical services (General Practitioner services) and to integrate primary medical services into the overall health system.
- To coordinate the management of the various interdependent support functions necessary to run the health service as a total unified health system e.g. manpower planning and recruitment, procurement, systems of funding and resource allocation, etc.
- To provide corporate governance of the total system in accordance with the principles and practices of best forms of governance.

Early tasks of the new Executive will include:

- Putting in place the new budgetary and accountability systems which we have recommended.
- Managing the investment in information systems which are necessary.
- Negotiating the changes necessary for the effective management of the health service with key stakeholders.
- Putting in place performance management and management development programmes.
- Reviewing resource allocation within the health service with a view to maximising efficiencies (e.g. to eliminate inappropriate use of expensive acute hospital beds by providing alternatives for the long stay patients who occupy them; and to reorganise the Accident and Emergency services so as to protect elective beds, thereby eliminating waste of Consultant time through cancellation of elective cases).

Capita Consulting found that this last problem is especially difficult in a number of Dublin hospitals, where as many as 20% of acute care beds are occupied at all times by delayed discharge of patients. They further found that over half of the large county hospitals and smaller urban hospitals visited by them reported that 7% or more of beds were occupied by these patients. [1]

[1]National Review of Bed Management Function, 27 January 2003.

Recommendations on the Role of the Executive

R3.7 We recommend that the role of the Executive should include:

(i) Strategic planning and management of change in the health system, including location of services, aimed at improved service delivery;

(ii) Managing the delivery of health services within budget;

(iii) Manpower planning and needs assessment;

(iv) Managing staff relations;

(v) The resource allocation process;

(vi) Analysing health spending annually by:

(a) Programme/care group (childcare, hospital services, disability services etc.),

(b) Health board region;

(vii) Under each of the headings at (vi)(a) and (vi)(b) above, the following actions should be undertaken:

(a) A comparison of performance, productivity, quality of care and value for money,

(b) Summary results of the comparative analysis undertaken at (vii)(a) above should be published, in a standardised format, within 6 months of the end of the relevant accounting period;

(viii) Identifying the problems and issues highlighted by the comparative analysis undertaken at (vi) and (vii) above;

(ix) Research and identification of ongoing developments in international best practice in the health area and consideration of the extent to which they may be adapted for implementation in an Irish context; and

(x) Risk assessment/management.

R.3.8 In regard to recommendation R3.7(vii)(a), we recommend that the existing National Performance Indicators Project Team define appropriate measurable definitions and indicators of "performance", "productivity" and "value for money". This group should submit its recommendations to the Secretary General and Minister for Health and Children.

3.7 RESTRUCTURED GOVERNANCE ARRANGEMENTS FOR THE HEALTH SERVICE

Relationship between Department and the Executive

In order to effectively discharge its responsibilities – on drafting legislation, developing policy and as principal advisor to the Government on health issues – it will be essential that the Department of Health and Children be closely in touch with the on-the-ground reality of policy implementation. This will require close contact between officials at all levels of the Executive and the Department of Health and Children in order that Departmental officials will have a clear understanding of the practical issues and challenges related to health service delivery.

Furthermore, the aims and objectives of the Department and the Executive will both be focused toward the same end – maximising efficiency, effectiveness and output within the health service. These congruent interests make a close working relationship between the two organisations essential. If the relationship between the two parties does not work properly, it could substantially compromise the capacity of the health system to deliver on its objectives. One of the key tests of the practical success of the organisational structure we propose will be the ability of both the Executive and the Department to forge an effective working relationship and build appropriate synergies.

In this context, we see the relationship between the Secretary General of the Department of Health and Children and the CEO of the Executive working along the lines of that which exists currently between CEOs of non-commercial State bodies and their respective Secretaries

General. Neither party is accountable to the other, nor do they formally report to each other, but of necessity they must have a close working relationship to deliver the best health service.

We envisage a "functional" relationship (rather than a formal reporting relationship) existing between the CEO of the Executive and the Secretary General of the Department. The CEO of the Executive will be responsible for providing the information necessary to support the Secretary General of the Department in his role as accounting officer for the health system overall. This information exchange will also be necessary to allow Government independently monitor the performance of the Executive against its objectives and to ensure that services are being delivered in line with Government policy.

We are convinced that this functional relationship can work. Similar "functional reporting" models already operate successfully in the public service, for example between the Revenue Commissioners and the Department of Finance and between IDA Ireland and the Department of Enterprise, Trade and Employment.

The Executive

We have recommended the establishment of an Executive to manage the Irish health service as a unitary national service.

The new Executive should have a corporate board with responsibilities and accountabilities that are consistent with those of a normal corporate/commercial board. However, the Minister for Health and Children will remain the ultimate accountable person, accountable to the Dáil and Oireachtas for the performance of the health service. It is therefore vital that there is strong accountability to the Minister by those responsible for the health service. For this reason, the Chairman of the board of the Executive will have a direct personal reporting relationship to the Minister. The Minister for Health and Children will also appoint the Chairman and members of the board of the Executive.

The CEO of the Executive should be accountable to the board of the Executive. Thus, the board of the Executive should have the power of hiring and firing its CEO (the ultimate test of accountability). The CEO of the Executive should be an accounting officer in his/her own right.

We have made recommendations earlier in this Chapter on the role and function of the Executive. Complementing these recommendations, are recommendations below on the role of the corporate board and CEO of the Executive. These recommendations on the board of the Executive cover accountability to the Minister, strategic and financial responsibilities, and responsibility for the performance of the CEO of the Executive.

Recommendations on the Role of the Executive Board, Chairman and CEO

R3.9 The Executive board should be statutorily responsible for the execution of national health policy and should be formally accountable for its performance to the Minister for Health and Children.

R3.10 The Executive board at R3.9 above should assume the functions associated with the management of the health service. These would be similar to the normal functions exercised by any corporate board and would include:
- (i) Implementing the overall strategic direction of national health policy for the health service;
- (ii) Approval of the annual regional Service Plans;
- (iii) Monitoring performance against objectives and ensuring that corrective action is taken when necessary;
- (iv) Ensuring that services are delivered within budget/determination;
- (v) Appointment of the chief executive officer (CEO) of the Executive;
- (vi) Establishment of an audit committee; and
- (vii) Approval of the Annual Report and Financial Statements.

R3.11 The board of the Executive should be accountable to the Minister for Health and Children.

R3.12 The CEO of the Executive should be accountable to the board of the Executive.

R3.13 The CEO of the Executive should be an accounting officer.

R3.14 The CEO of the Executive should be responsible for the provision of financial and other information necessary to support the Secretary General of the Department of Health and Children in his/her role as accounting officer and policy advisor to the Government.

Membership of the Executive Board

As the board of the Executive will have ultimate responsibility for implementation of health policy and driving reform within the health service, it is critically important that members be of a high calibre and bring an appropriate mix of experience and expertise, both from within and without the health sector, whether from Ireland or abroad.

Recommendations on Membership of the Executive Board

R3.15 The Executive board should have not more than 12 members made up as follows:
- (i) An independent Chairman drawn from outside the health sector;
- (ii) Ex-officio, the CEO of the Executive;
- (iii) Ex-officio, the Director of Finance of the Executive;
- (iv) A nominee of the Department of Health and Children; and
- (v) Not more than 8 non-executive members, reflecting the balance of expertise required, appointed by the Minister for Health and Children.

R3.16 In appointing the non-executive members at R3.15(v) above, the Minister should have regard to the appropriateness of each candidate's skills and experience.

Regional Health Boards

We considered the issue of whether regional health boards should remain a feature of the health service. There was a consensus that regional health boards currently deliver advantages in terms of local democratic representation within the health service. We were concerned that proposals to replace the regional health board structure might compromise accountability for the health service and the important corporate governance roles being carried out. However,

we acknowledge the need to review the number and functional areas of health boards.

Our recommendations aim to retain the best aspects of regional health boards, while making the changes necessary to create a unified national management structure.

Under current arrangements, around half of health board members are elected by county councils with the balance drawn from professional interests and three nominees of the Minister for Health and Children. We are not proposing any changes to these arrangements. However, with the establishment of the Executive, we envisage a strong reporting relationship between the health boards, at regional level, and the board of the Executive in respect of corporate governance functions. In practice, we would expect regional heath board chairmen to discuss important local issues with the Chairman of the Executive.

Role of the Boards of Regional Health Boards
At present the boards of regional health boards have a range of reserved functions, specified in legislation, including:

- Appointment and removal of chief executive officer (CEO);
- Adoption, supervision and amendment of a Service Plan;
- Adoption of notified amounts of indebtedness;
- Adoption of Annual Financial Statements;
- Adoption of Annual Report; and
- Establishment of committees of health boards.

All other functions are executive functions of the CEO.

We envisage a change in the role of regional health boards, such that they would no longer be required to approve the annual Service Plan nor would they have any role in relation to indebtedness – these would be executive functions. However, we believe that the boards of regional health boards must be consulted when regional Service Plans are being prepared. We also envisage that the appointment of the regional CEO will be a matter for the Executive.

Regional health boards should retain important corporate governance roles as discussed earlier and would continue to carry out valuable consultative, monitoring and representative functions. Thus, to ensure proper accountability, each regional health board should have a board with the role of:

- Monitoring the implementation of national policy within their region;
- Reviewing the arrangements made by the regional CEO to execute necessary work with in policy guidelines;
- Approving and adopting Annual Financial Statements and Annual Reports; and
- Establishing audit committees.

Regional CEOs and Chairmen
CEOs of regional health boards would be directly accountable to the CEO of the Executive (rather than to the board of their regional health board) for the implementation of national policy within their functional area. However, regional CEOs should continue to meet with, and report to, the boards of regional health boards on a regular basis to discuss local performance

within the national policy framework so that the board can carry out its functions as outlined above. Under this model, the regional CEO would be accountable upwards to the CEO of the Executive, and would report to his/her board at local level. This combination of accountability upwards, and reporting duties to a local board will, we believe, deliver maximum benefit in terms of accountability and corporate governance, in addition to greater efficiency and effectiveness.

With the formation of the Executive, we recommend that Chairmen of the regional health boards would report to the national level. We consider that the Chairman of each regional health board should have access to the Chairman of the Executive to raise issues of local concern and to comment on the performance of the regional CEO. This would allow the regional health boards to recommend changes in national policy to reflect local needs.

Recommendations on Governance of Regional Health Boards

R3.17 Functions of the regional health boards should include:
- (i) Advising on local and regional health service requirements;
- (ii) Representing local community and professional interests in terms of regional service provision;
- (iii) Advising and providing input in respect of the regions annual Service Plan;
- (iv) Monitoring performance within the regional area against national health care objectives;
- (v) Establishment of an audit committee; and
- (vi) Approval of the regional Annual Report and Annual Financial Statements.

R3.18 CEOs of the regional health boards should be accountable to the CEO of the Executive for the execution of their functions, including delivery of services within budget/determination, in respect of national service provision.

Accountability of Regional CEOs for Services Delivered in their Functional Area

The CEO in each regional health board area will be accountable for the performance of the staff employed by the regional health board, including the managers of health board hospitals.

In the case of the eastern region, a specific issue will have to be addressed following the anticipated transfer of functions from the Eastern Regional Health Authority to the new Executive. This relates to the accountability structure for those major teaching hospitals charged with the provision of a range of national services. We are of the view that because they deliver national services, the CEO of the new Executive (rather than the CEO of a regional health board) should be accountable for the chief executives of these hospitals. We acknowledge that specific and complex issues need to be addressed in the case of voluntary hospitals that, while funded by the State, are owned and managed through arrangements that reflect their history.

We believe that the relationship of accountability we are recommending between the new Executive and those hospitals delivering national services will greatly facilitate consideration, planning and implementation of the priority resource management tasks we have already identified for the Executive (e.g. the problems of "blocked" beds and of the Accident and Emergency services). We also believe that the role of these hospitals in providing national services (e.g. organ transplant services) and major regional services (e.g. vascular surgery) positions them in a key role to assist in formulating proposals for rationalisation of the general hospital service. In this regard, they can assist in balancing the national, regional and local

services they provide as well as their role in providing medical education and training and in research and development.

Recommendations on Accountability for Services Delivered in Regional Health Board Functional Areas

R3.19 CEOs of regional health boards will be accountable to the CEO of the Executive for the performance of all staff, including the managers of health board hospitals, employed by their health board.

R3.20 The CEOs of the major teaching hospitals providing national services would be accountable directly to the CEO of the Executive because of their role in the provision of national services and specialties.

Implementation

Significant changes will be required to existing legislation to give effect to the various recommendations above.

Recommendations on Implementation

R3.21 The necessary changes to the Health Acts 1970 and 1996 and the Eastern Regional Health Authority Act 1999 should be brought forward by the Department of Health and Children to give effect to the above changes.

3.8 CODE OF GOVERNANCE

In our view, it is important to codify and clarify precisely what governance in a health care environment means and thus ensure boards of all agencies understand and fully observe their responsibilities in this regard. A written code would also encourage boards to implement appropriate systems and structures in their organisations to meet the (specified) standards of good governance.

In this context, we would lay particular emphasis on the need to ensure that members are not placed in a position where a systematic conflict of interest could impair their ability to act solely in the best interests of the corporate entity.

The Department of Health and Children and/or the Executive should also develop appropriate corporate governance guidelines for hospitals. These guidelines should be mandatory for publicly owned hospitals and health service organisations. We believe that adoption of these guidelines should also be a condition for continued State funding of voluntary agencies/ hospitals.

Recommendations on a Code of Governance

R3.22 The Department of Health and Children should produce a written Code of Governance for all agencies in the public health sector. This code should enshrine the principles contained in the Department of Finance Code of Practice for the Governance of State Bodies.

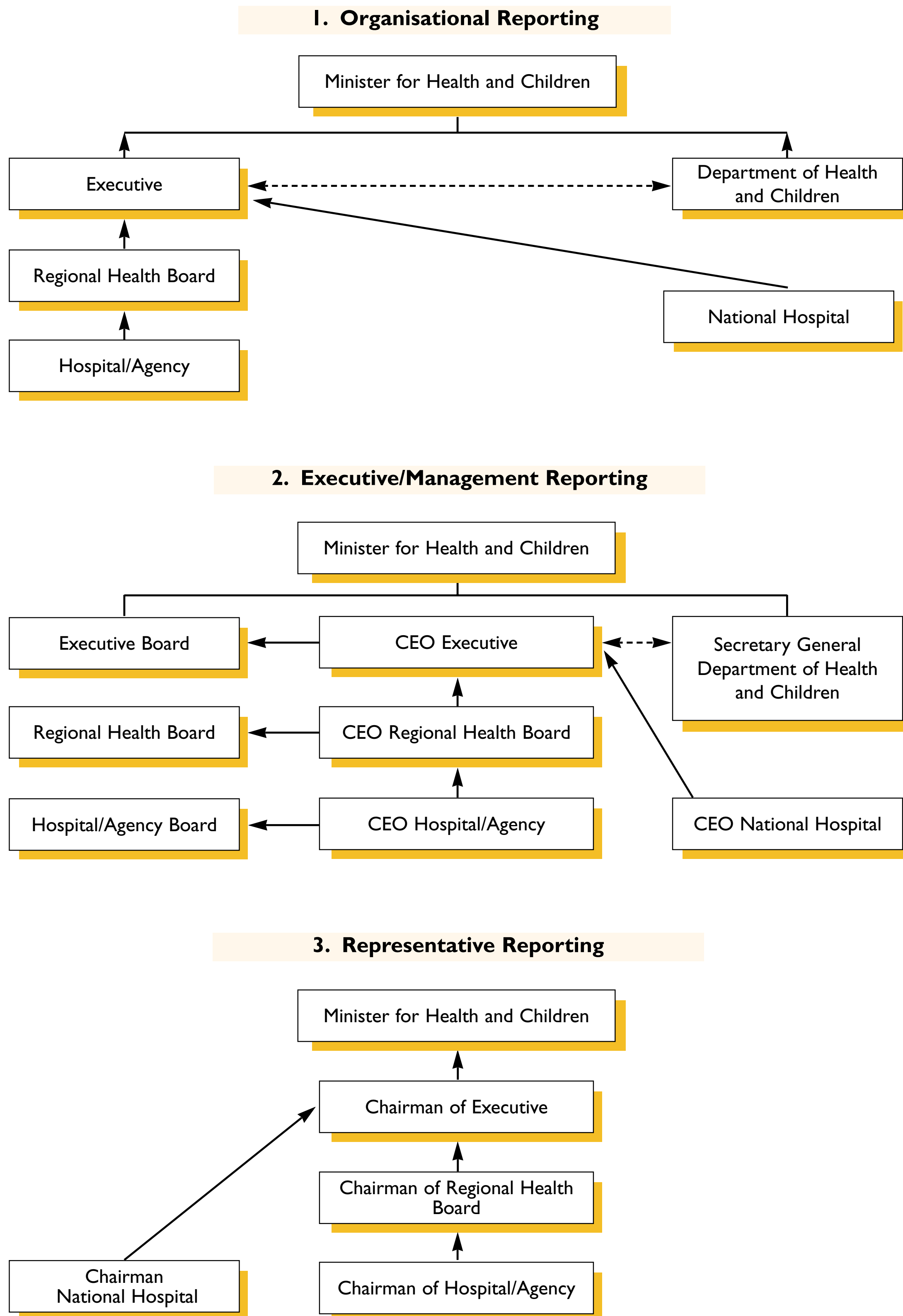
R3.23 All Executive board members should be independent and act solely in the interest of the board.

The recommendations on the proposed governance arrangements may be summarised as follows:

- The *Secretary General of the Department of Health and Children* should remain directly accountable to the Minister for Health and Children in respect of national health policy.
- The *board of the Executive* should be directly accountable to the Minister for Health and Children for delivery of services consistent with national policy.
- The *CEO* of the Executive should be accountable to the Board of the Executive.
- *CEOs of regional health boards* should be accountable to the CEO of the Executive for the delivery of services consistent with national policy priorities within their functional area.
- *Regional health boards* should have a role to monitor and advise on health service delivery within their functional area.
- The *Chairmen of the regional health boards* should report to the Chairman of the Executive on the performance of the regional CEO and other issues concerning local service delivery.
- The CEOs of the major teaching hospitals providing national services should be accountable directly to the CEO of the Executive.

Our governance model (see Figure 3.1), with a national Executive and regional health boards, can be characterised as being similar to that of parent company and subsidiary as it applies in the corporate sector.

Figure 3.1: Reporting Arrangements under new Structure



3.9 SUMMARY

In this Chapter, we have recommended the establishment of an Executive agency to undertake the national management of the health service. We have also made recommendations covering the governance arrangements to apply to the Executive and the consequent changes for other agencies within the system.

These changes are consistent with our core principle advocating the management of the health service as a unitary national system. We believe that a properly functioning national-level management is essential to the development of a more coherent planning framework. This is essential to the future avoidance of the kind of problems identified in Chapter 2 and where such problems do arise, to ensure their speedy identification and resolution.

CHAPTER 4
SERVICE PLANNING, BUDGETING AND SUPPLEMENTARY ESTIMATES

In this Chapter, we look at the issues involved and the reforms required in the important areas of service planning, budgeting and supplementary estimates. We outline how the provision of Service Plans must be reformed in a way that will facilitate an enhanced role for front-line decision-makers in the chain of accountability. At present, the process generally involves only limited input below the level of the hospital and this must change.

4.1 OVERVIEW

High-quality data is vital to facilitate informed decision-making. At present, the preparation of Service Plans is an important process in identifying where and why the health service plan to use resources, funded by taxpayers.

We believe the entire health service must take a new approach to service planning. The existing system (*see Appendix 4*) needs to be refined so that it is consistent with our core principle of accountability for resources expended being devolved to those making the decisions that affect resource consumption and income generation.

As well as outlining the symptoms of the current difficulties, we recommend how to deal with the issues involved. We also look at rebalancing health boards' financial allocations, multi-annual budgeting and supplementary estimates.

4.2 SERVICE PLANNING - SUPPORTING THE MANAGEMENT FUNCTION

The system of service planning is described in *Appendix 4*. Under the Health (Amendment) (No.3) Act, 1996, annual Service Plans must be prepared by health boards in response to the Letter of Determination issued by the Department of Health and Children. Under this legislation, health boards are required to adopt and submit an annual Service Plan to the Minister for Health and Children, outlining the planned activity which they will deliver for the funding they have received.

Improved information flows on health service activities and their associated costs will be necessary to underpin the proposed changes in the business focus of the Department of Health and Children and the Executive. Fundamental to this will be the further development of the service planning process.

Standardising Service Plans

We acknowledge that there has been an ongoing development and improvement of Service Planning since its introduction. However, currently Service Plans:

- Differ substantially in format and content;
- Concentrate primarily on plans for service development (i.e. new) money; and
- Have very weak or no links between activity and funding.

As such, they are inadequate to provide all the information necessary to underpin our recommendations on the structure and role of the Department of Health and Children and the Executive. Furthermore, Service Plans, as currently constituted, do not adequately penetrate through the system to those people making the spending decisions at the service delivery point. While there are examples of good practice in terms of involving staff at all levels in the service planning process, Service Plans need to be further developed so that they are consistent with our core principle of accountability for resources expended being devolved to those making the decisions that affect resource consumption and income generation.

We have concluded that a fundamental reappraisal of the Service Plan and related reporting arrangements represents the best means of supporting a changed business focus within the Department of Health and Children and the Executive. The Service Plan should constitute a clear statement of the quantity and quality of health and social care provision to be provided by each health board with reporting systems being focused on showing progress against these stated objectives. It is imperative that standardised service planning should involve the staff delivering care and treatment so as to bring those making the financial decisions on the ground into the planning process. This reflects two of our core principles; firstly, that accountability for resources expended should rest with the decision maker and, secondly, that good financial management and control should not be seen solely as a finance function. We are aware that a joint health board and Department of Health and Children project team is currently undertaking significant work on the development of the service planning framework.

Such a system would have benefits for both the providers (health boards) in terms of clarity as to their objectives and basis for accountability as well as for Government in terms of providing a more solid basis for measurement of output and value for money and an empirical framework within which to consider future policy development.

The developments that we are recommending are significant initial steps towards activity-based systems (costing, management etc.). The international literature shows that activity-based management systems are evolving in countries around the world as examples of best practice. However, while the notion of providing cost and performance information to clinicians is generally seen as desirable, most jurisdictions are, as yet, in the early stages of producing this information in terms of process and output measurement systems.

Recommendations on Service Planning

R4.1 A single, comprehensive and standardised template for Service Plans should be adopted. This should cover Service Plans at all levels: clinical Consultants, hospitals and non-hospital General Managers at sub-health board level, as well as regional health boards and the Executive. Higher level Service Plans should be derived from lower level Service Plans (e.g. hospital from the aggregate of individual Consultants).

R4.2 Pending establishment of the Executive, a working group, including representation from the the Department of Health and Children, Department of Finance and the regional health boards, should be established to devise an appropriate standard template and to make recommendations to the Secretary General and Minister for Health and Children.

R4.3 The terms of reference for the working group recommended at R4.2 above should, having regard to the data improvements afforded by the investment in information technology recommended in Chapter 10, include consideration of how best the Service Plans could be structured to provide:

- (i) Clear statements of projected service provision analysed by the main care groups (including each specialty in hospitals), linked to funding (both pay and non-pay elements);
- (ii) Integrated financial and non-financial data. Formal and clear inter-connections are needed between cost (approved determination) and activity (level of service being provided); and
- (iii) Pay and employment data.

R4.4 The working group at R4.2 above should also consider how existing reporting arrangements might be restructured to provide, again in a standardised format, an ongoing report on progress against targets and objectives set out in the Service Plan (see also Chapter 9 recommendations in this regard). In particular:

- (i) Monthly Integrated Management Reports should be closely linked to the Service Plan.
- (ii) Quarterly Performance Indicator Reports should continue to be explicit on delivery of targets and should also be linked to the Service Plan.
- (iii) Annual Reports and Financial Statements should specifically link back to financial and activity performance envisaged in the Service Plan. This would provide the final link between the Letter of Determination, Service Plan, Integrated Management Reports, Annual Financial Statement and Annual Report.

Drafting Service Plans

The predominance of core service delivery means that the Service Plan is largely drafted before the Letter of Determination (which details new developments) is received by the health boards. Under current arrangements, as described in *Appendix 4*, letters of determination issue following Budget day in early December and Service Plans are not finalised and approved until the middle of January each year (and, indeed, later than that in the case of those agencies within the Eastern Regional Health Authority area).

However, to prepare high quality Service Plans, health service providers need more preparation time. We believe that an effective planning and budgeting system requires activity and expenditure profiles for the coming year to be in place before the year commences and the budgetary timetable should be designed to accommodate this. A December Budget day is an impediment to achieving this objective. However, we accept that the Government must take account of issues other than the efficient management of the health service in deciding on Budget day. While we consider that an earlier budget day is desirable we recognise that it may not be a deliverable proposition.

Recommendation on Service Planning (cont'd)

R4.5 Service Plans of the Executive and the health boards should ideally be agreed and in place before the commencement of the year to which they relate.

4.3 REBALANCING FINANCIAL ALLOCATIONS

One consequence of the incrementally based estimates process is that individual health board allocations are largely a reflection of their historical funding positions. There have been significant demographic and social changes over the years that have implications for health service delivery and needs but are not reflected in the Letters of Determination (e.g. changes in the size and age profile of the population within each health board region). While we recognise that the lack of investment in information systems over the years has led to a situation where this information is not always readily available, we consider that funding should be determined in a manner that captures these changes in society.

This means examining the relative size of each health board allocation taking account of factors such as population size, age profile and so on. We recognise that before such a system could be implemented, it would be necessary to track and account for flows of patients between health board areas. Where necessary, the Executive should reallocate funds to those health boards that have greatest objective need. Such changes may need to be made over a phased period.

Recommendations on Rebalancing Financial Allocations

R4.6 Funding of regional health boards should be evidence based and prioritised across identified needs. In particular, in allocating budgets between health boards, the Executive should take account of a number of nationally agreed key factors, as they apply across health board regions, such as:

Demographics	Specialities	Client Profile	Capacity
Services	Activity	Infrastructure	Socio-economic profiles

R4.7 Pending establishment of the Executive, a working group representative of the Department of Health and Children, the Department of Finance and the regional health boards should be established:

(i) To conduct advance development work on defining the appropriate factors under R4.6 above;

(ii) To determine the relative weighting which should be ascribed to each factor in determining each health board's allocation; and

(iii) To examine the phasing arrangements that are appropriate to ensure a smooth transition to the new arrangement.

4.4 MULTI-ANNUAL BUDGETING

The current estimates process, being incremental and annual in nature, is not conducive to longer-term service planning, although there is a multi-annual planning framework in place for capital expenditure. Funding is sought on the basis of the expenditure to be incurred in the relevant year only and does not adequately capture the full cost implications of many developments.

We accept that a multi-annual system of budgeting would improve the planning process and, if appropriately structured, would improve financial management within the health service and contribute to the delivery of greater value for money. The current planning horizon (through health strategies, for example) is five to ten years but there is a notable absence of financial plans to underpin these strategies. Some system of multi-annual planning, identifying the source of the necessary funding, would support implementation of these health strategies.

The introduction of multi-annual budgeting was one of the main proposals for change in the submission we received from the CEOs of health boards. Before addressing this request it is important to be clear about what multi-annual budgeting is. It does not provide an absolute guarantee that funds will be available whatever the budgetary circumstances. Rather, it involves taking a strategic view of service planning and development on the basis of an indication of the funds which are likely to be available. It should more accurately be regarded as a multi-annual financial and service planning framework.

Under existing arrangements, the "Ireland Stability Programme December 2002 Update", submitted to the EU Commission, is based on a three-year allocation of gross public expenditure for 2003-05. We recommend that the Department of Health and Children issue the Executive with indicative 3-year planning totals consistent with the Stability Programme, which the Executive should break down between its major organisational units. These units should then be required to submit 3-year financial and service plans for approval to the Executive.

Recommendation on Multi-Annual Budgeting

R4.8 Service Plans should be framed on a 3 year multi-annual basis.

Speedier completion of each years Service Plans, to support recommendation R4.5 above, could be achieved by structuring the proposed multi-annual Service Plans to allow for annual adjustments to the funding base. Each year's Service Plan could then be more readily adjusted to fit the Letter of Determination.

4.5 SUPPLEMENTARY ESTIMATES

Supplementary estimates have been used over the years to cover certain categories of expenditure that are deemed to be outside the control of budget holders or CEOs within the health boards (*see Appendix 4*). Supplementary estimates in the health area equated to an annual average of ¤207 million or 4% of budget (current plus capital) over the four years from 1999 to 2002, varying from 5.8% of budget in 1999 to 3.0% in 2002.

We are concerned that the availability of supplementary estimates could undermine budgetary discipline. In this regard, we are aware of the comments of the Minister for Finance, in his Budget speech for 2003 that "*Ministers and their Management Committees will be required to manage strictly within the allocations given to them*". We also note that, for 2003, the Letter of Determination to the health boards specifically stated "*there will be no consideration given to a Supplementary Estimate for Health and Children in 2003, without exception*"[1].

Nevertheless, we make recommendations to tighten controls in this area in the event that

[1]Source: Department of Health and Children.

supplementary estimates are reintroduced. We recognise that, under current arrangements, there are certain categories of expenditure incurred, which are outside the control of budget holders. Fluctuations in these categories of expenditure may place an unsustainable burden on those agencies if they must be met from within their own resources in any given year. However, we are strongly of the opinion that every step should be taken to ensure that supplementary estimates are never used to cover normal budgetary costs. As a matter of general principle, we believe that automatic or easy access to supplementary estimates can undermine budgetary discipline. We consider that the tighter controls recommended below and adoption of the risk assessment procedures recommended in Chapter 8 should ensure that recourse to supplementary estimates is greatly reduced in the future.

Recommendation on Supplementary Estimates

R4.9 If, notwithstanding the statement of the Minister for Finance in his Budget speech delivered in December 2002 that Ministers and their Management Committees will be required to manage strictly within the allocations given to them, there are to be supplementary estimates in the future, we recommend that the Department of Finance and the Department of Health and Children should:

(i) Review the appropriateness and coverage of "allowable supplementaries";

(ii) Make recommendations to the Minister for Finance in this regard; and

(iii) Thereafter conduct biennial reviews by reference to the volume and content of supplementary estimates allowed in the intervening period.

4.6 SUMMARY

In this Chapter we have looked at tightening the budgetary and planning processes, particularly in relation to service planning.

The changes recommended are necessary to support the national management function that we have proposed in Chapter 3 be conducted by an Executive agency. The comprehensive use of standardised Service Plans at all levels throughout the system will also be essential to support the personal accountability framework which we adopted as one of our core principles in Chapter 2 and which is addressed further in Chapters 5 and 6.

A system of planning and then reporting on performance, financial and otherwise, against plan will help inculcate a culture of financial management through all levels, again consistent with our core principles identified in Chapter 2. External reporting is dealt with in more detail in Chapter 9.

CHAPTER 5
ACCOUNTABILITY – HOSPITAL AND NON-HOSPITAL PROGRAMMES

In this Chapter, we examine the changes most necessary to deal with the lack of clear accountability throughout the health system for service planning, budgeting and expenditure control. The main focus is on the Consultant-led specialist services.

5.1 OVERVIEW

In Chapter 3, we recommended the establishment of an Executive to address the management vacuum in the health service. The second major structural weakness of the system is the lack of clear accountability. In this Chapter, we will examine weaknesses in the structure of accountability within the hospital and non-hospital services for budgeting, costing, activity planning and management and cost control. Our views on how to address these problems will be guided by our core principles of reform, identified in Chapter 2, particularly as regards personal accountability – i.e. that accountability for resources expended should rest with those who have the authority to commit the expenditure.

We believe that accountability for spending should be devolved to the lowest and most appropriate decision-making level. There is a need to:

(a) Identify where and by whom decisions affecting expenditure are made;
(b) Define the areas for which these individual decision makers have responsibility; and
(c) Engage the identified individuals fully in the planning, managing and control processes.

Each year the general hospital sector accounts for almost 50% of national health expenditure. The role of clinical Consultants and their staff must be widened to include financial accountability as well as clinical accountability so as to develop a more accountable, cost-effective health service. In the non-hospital areas of the health system, the individual responsible for the budget, whether clinical or non-clinical personnel, should be held formally accountable for financial performance.

The health system is financed by the taxpayer. We believe that full costs of treating private patients in public hospitals should be both transparent and publicly available, as part of the culture of improved accountability.

5.2 GENERAL HOSPITALS

Identifying the Decision Makers

A general hospital is a location where clinical (i.e. admitting) Consultants conduct their medical practices. It is for the individual clinical Consultant to decide whether his/her patient requires admission and to decide and manage the patient's investigation, treatment and discharge. The work of other (non-admitting) Consultant colleagues (radiology, pathology, etc.) as well as the work of other hospital services (nursing, laboratories, therapy, administration) derives from the decisions of the clinical Consultant.

Analysis of the nature of specialist services provided by clinical Consultants through the general hospital programme budget illustrates the role they can play in the process of reform. An estimated ¤3.8 billion was spent on general hospital services in 2002 on non-capital services. This represents almost 50% of total estimated health expenditure of ¤8.0 billion for 2002 (see Table 2.3).

The Role of the Clinical Consultant

The clinical Consultant makes clinical decisions independently and free from the direct control or supervision of hospital management, medical administrators or other Consultant colleagues (see section 5.2 of the Consultants' common contract in *Appendix 7*). This concept of clinical independence exists for the benefit of the patient who can obtain a personal medical service from the individual Consultant. If the hospital operated in a commercial market, all costs would be assigned to patients to establish a break-even price for services. The clinical Consultant would be the key cost centre.

It is evident from this analysis that that the individual clinical Consultant is fundamental to the structuring of accountability for the management and control of resources in the general hospital programme. This reflects two of our core principles from Chapter 2: (i) that accountability for resources expended should rest with those who have the authority to commit the expenditure and (ii) that good financial management and control should not be seen solely as a finance function.

Recommendation on defining Units of Accountability

R5.1 We recommend that clinical Consultants and their practices in individual clinical specialties be designated as the primary unit of accountability in the general hospital programme.

The key question is: how can the health services contract with individual clinical Consultants in ways that make it possible to negotiate with them, in a systematic way, the resources they need for their practices without interfering in any way with their clinical independence in the treatment of their patients?

Past attempts to hold clinical Consultants accountable for managing and controlling the resources they use in treating their patients have focused on a variety of initiatives from "Clinicians in Management" to "Diagnostic Related Group" (*see Appendix 5*) based systems of information and funding. These initiatives are reported to have had limited success in some instances.

Experience has shown that where clinicians have been successfully engaged in management and planning within the hospital, benefits flow to all concerned. St. James' Hospital in Dublin is one location where a Clinical Directorate system has been successfully instituted. We note that the Review Body on Higher Remuneration suggested that lessons could be learned from locations where the Clinicians in Management initiative has been implemented.[1]

The international literature indicates that clinicians are interested in and wish to have access to information on the cost of clinical activity, clinical performance and the outcomes of clinical

[1] Review Body on Higher Remuneration, Report No 38, page 84.

activity. Case studies performed in a number of jurisdictions highlight the positive repercussions of providing this information to clinicians, in a way that is appropriate and sensitive to medical practice.

During their meeting with us, representatives of the Irish Hospital Consultants Association indicated their support for initiatives to have their members play a meaningful role in hospital management structures.

Clinical Independence and its Implications for Clinical Budgets

The major obstacle experienced to date in creating a financial planning, management and control model to 'fit' services provided by clinical Consultants appears to have been the interpretation put on clinical independence of Consultants. This is covered in section 5.2 of the Consultants' common contract (*see Appendix 7*) which states that "*being a Consultant involves continuing responsibility for investigation and for the treatment of patients without supervision in professional matters by any other person.*"

In the absence of agreed mechanisms for planning and managing resources, attempts to introduce cost reductions or to increase efficiency may be met with resistance because they are perceived to interfere with the clinical autonomy of Consultants. Clinical independence or autonomy appears to be the distinctive feature of general hospital services which has defeated the application of conventional financial and management accounting systems to hospital expenditure in the past.

The difficulty lies in being able to describe the nature of the accountability of Clinicians for the resources they use in making clinically independent decisions. It also lies in being able to agree within the terms of the Consultants' contract how that accountability can be discharged in a way that is acceptable to both parties.

Consultants' Common Contract

We consider clinical Consultants to be the key decision makers affecting expenditure in hospitals. We believe that, even though resource management is already part of the Consultants' common contract (*See Appendix 7, section 6.2*), resource management responsibilities are not being systematically and uniformly discharged because of the absence of appropriate mechanisms for planning outputs and budgets and monitoring expenditure. We find the wording in the contract relating to Consultants' responsibilities for resource management to be somewhat vague and lacking in explicit detail. For example:

> "*agreeing with management the details of the service levels and mix to be provided with in the scheduled commitment*" *(Sn 6.2(v))*
>
> "*providing information to (the employing authority) including data for hospital information systems and service planning and for such other purposes as (the employing authority) and you agree are appropriate.*" *(Sn 6.2(ix))*

The individual contracts of Consultants give them the right to the resources they need to practice in their respective hospitals. As a consequence, we believe that the management of these resources needs to be grounded on individual accountability for how they are used. The Consultants' common contract as it currently stands contains inherent weaknesses that

impede the full application of general principles of financial accountability by clinicians. Specifically:

- Consultants are not required to account for the cost of resources consumed as a direct consequence of their clinical decisions.
- Existing arrangements allow Consultants to pursue both public and private practices (including during the 33-hour scheduled commitment under the Consultants' public contract[2]).
- The mixing of public and private treatments also restricts the time available to clinicians to pursue resource management issues.

Issues surrounding the public/private mix are discussed in more detail later in this Chapter.

We are concerned at the lack of explicit detail in the Consultants' contract concerning their time commitment to public patients. For example, the contract does not require an individual Consultant to discharge his responsibilities to public patients personally (see section 5.2 of the contact and 2.11.2 of the Memorandum of Agreement in *Appendix 7*):

> *"The consultant may discharge this responsibility directly in a personal relationship with his patient, or, in the exercise of his clinical judgement, he may delegate aspects of the patient's care to other appropriate staff". (Sn 5.2)*
>
> *"A consultant's time commitment, which will be personally discharged, will be scheduled in sessions during the hours normally worked within the Monday to Friday working week. The requirement to personally discharge all of the commitment does not preclude the consultant from delegating aspects of his scheduled work while the time commitment to (the employing authority) is being personally discharged elsewhere." (Sn 2.11.2 – Memorandum of Agreement)*

We acknowledge that individual Consultants personally carry "*the continuing responsibility for his patients so long as they remain in his care*". However, we note that the State pays up to 90% of the professional indemnity insurance for Consultants with a contract, so the risk when procedures go wrong is substantially carried by the taxpayer, and not by the consultant personally. The opportunity to earn additional monies through private practice, combined with the ability to delegate public work to other staff, is not in the best interests of the Irish taxpayer.

At present, 47 Consultants have a contract, which commits them to work exclusively in the public sector. However, this option was withdrawn under the 1997 common contract. We understand the Review Body on Higher Remuneration (Report No. 36) recommended abolition of this category of contract. We also understand that this was not a popular contract option among Consultants (hence the small numbers exercising the option).

[2]See Appendix 7, section 5.2 and section 2.11.2 of the Memorandum of Agreement to the Consultant Common Contract.

Recommendation on the existing Consultants' Common Contract

R5.2 The Consultants' common contract should be reviewed, for existing Consultants, to ensure that the following principles are explicitly reflected in the contract:

- Formal recognition and agreement by Consultants, as the key decision makers, of their responsibility to manage resources to which they are entitled to conduct their practice[3] within agreed budgets at department, specialty and individual Consultant level.
- Participation in arrangements for collective representation of Consultants at hospital management committee level.
- Agreement of core hours of attendance.
- Active management and optimisation by Consultants of resource allocation against agreed practice, specialty and department Service Plans and budgets.
- Cooperation with arrangements for measurable and transparent systems of continuously monitoring adherence to public and private practice contractual commitments.
- Where there are competing public and private practice demands on Consultants' time and resources, the former should have priority call on such time and resources at all times.

The progressive implementation of the EU Working Time Directive over the coming years is likely to give rise to recruitment of a large number of additional Consultants. This presents a unique opportunity to recruit a substantial proportion of Consultants on a "public-only" contract. This would go a substantial way towards addressing the conflict of interest issue identified above and make sufficient time available to Consultants to fully engage in financial management and practice budgeting.

In this context, we would emphasise that such a move would be consistent with Government policy, as reflected in the health strategy, to target public resources towards public patients. In particular in the health strategy[4], the Government has decided that there will be a progressive reduction in the proportion of private to public beds in the public hospital setting. It has decided that **all** new general hospital beds under the Bed Capacity Programme will be designated as exclusively for the use and treatment of public patients. Seven hundred beds are currently being put in place in public hospitals on this basis.

Recommendation on Contract for New Consultant Appointments

R5.3 All new Consultant appointments, covering new posts and the replacement of existing Consultants, should be on the basis of contracting the Consultants to work exclusively in the public sector.

Executive Management Committee

If clinical Consultants are to become central to the structuring of accountability for the management and control of resources in the general hospital programme, it will be essential to have appropriate management structures and processes to enable them exercise that accountability in ways that will benefit their patients through the more effective use of resources. It is imperative that all hospital management structures include an Executive Management Committee that involves representation of clinical Consultants in the management of the hospital. The Executive Management Committee will provide a forum for clinicians to have an input into, and be accountable for, managing the hospital resources and to discuss clinical and management concerns.

[3]Section 6.4.4. - Consultant Common Contract 1997 (See Appendix 7).
[4]"Quality and Fairness – A Health System for You" (page 107).

We believe that the maximum benefit from these committee structures will be delivered when a system of individual accountability for practice budgets is in place.

Recommendations on of Hospital Management Structures

Executive Management Committee

R5.4 Where they do not already exist, chief executive officers in all hospitals should immediately establish an Executive Management Committee.

R5.5 The role of the Executive Management Committee should include:
- (i) Agree the hospital Service Plan;
- (ii) Monitor performance against budget;
- (iii) Agree corrective measures; and
- (iv) Advise on policy matters that may arise from time to time.

R5.6 The membership of the Executive Management Committee should include, at a minimum:
- (i) The hospital CEO/manager (as Chairman);
- (ii) The head of the hospital's finance function;
- (iii) A clinical Consultant; and
- (iv) The Director of Nursing.

Service Planning in General Hospitals

The system of service planning is described in *Appendix 4*. Under the Health (Amendment)(No.3) Act, 1996, annual Service Plans must be prepared by health boards in response to the Letter of Determination issued by the Department of Health and Children. Under this legislation, health boards are required to adopt and submit an annual Service Plan to the Minister for Health and Children, outlining the planned activity which they will deliver for the funding they have received.

Engaging Consultants in Service Planning

While examples of good practice exist, there are currently no system-wide mechanisms in general hospitals to engage clinical Consultants in the service planning process, in the preparation of associated budgets or in the evaluation of results against budget.

In structuring clinical budgets, a distinction must be made between (i) admitting Consultants (who have the primary responsibility for the care of patients) and (ii) non-admitting Consultants. While recognising the differences between the specialties, we believe that similar procedures for planning, managing and reporting should be put in place for both admitting Consultant practices and non-admitting Consultant-led hospital departments.

In addition to the direct costs of their practice, the indirect costs (of management/ administration, overheads etc.) should also be apportioned on an agreed basis to the individual practices. The rationale for this approach is that hospitals exist to provide services to patients - all costs of running the hospital should therefore be attributable to the patients through the clinical Consultants who decide on their admission, treatment and discharge. In teaching hospitals the costs attributable to medical education or research will not be attributable to services and need to be deducted in deriving the true cost per patient.

We believe that there is a need for practice, specialty and department-level Service Plans and budgets within general hospitals. These should be subsets of the hospital Service Plans and, in turn, the health board Service Plans – aggregating the Service Plans from all the sub-units should give the costs and activity set out in the health board Service Plan. All Service Plans, from the individual clinical Consultant's practice to the health board, should have a standardised format and content. These Service Plans would replace the operational plans prepared, under the existing arrangements, in support of health board's Service Plans.

Doctors are a valuable resource; the more time they devote to the treatment of patients the better. Involving Consultants in planning and management requires that hospital management provide appropriate support, through the provision of a business manager, to Consultants to assist them in preparing their annual budgets. This would create the space to ensure that Consultants can continue to focus on medical services rather than spending an inordinate amount of time on administrative matters. The business manager would be responsible for the preparation of cost and activity budgets, practice profiles, monthly expenditure reports, etc.

Consultant budget holders must then be accountable for their actual expenditure and activity and how this compares against budget. We believe that such a system would create opportunities for improving value for money within the health service without compromising clinical independence. We are of the view that business manager support can be found from within the existing resources of the hospitals and from within different disciplines. It requires a refocusing of existing resources on to a different way of doing business i.e. by reformatting budgeting systems and expenditure control reports around the patient and the clinical Consultant.

The introduction of hospital costing systems to patient level will require the development of sophisticated activity based costing systems to fully integrate financial and activity data. Development of such systems should be undertaken within the IT investment programme envisaged in Chapter 10.

Recommendations on Service Planning in the General Hospitals Programme

R5.7 In the case of admitting Consultants who assume clinical care for a patient, the following steps should be taken:
- (i) Hospital/health board CEO, as appropriate, identify all individual clinical practices within each specialty;
- (ii) Hospital/health board CEO, as appropriate, identify a lead clinician as Head of Specialty;
- (iii) Hospital/health board CEO, as appropriate, should agree with the Head of Specialty the assignment of a member of staff as business manager to prepare cost and activity budgets, practice profiles and monthly expenditure reports for the specialty and each individual clinical Consultant's practice within the specialty.

R5.8 In the case of non-admitting Consultants (e.g. radiology, pathology, etc.), the following steps should be taken:
- (i) Hospital/health board CEO, as appropriate, identify all non-admitting hospital departments;
- (ii) Hospital/health board CEO, as appropriate, identify for each department a Head of Department;
- (iii) Hospital/health board CEO, as appropriate, should agree with the Head of Department the assignment of a member of staff as business manager to prepare cost and activity budgets, practice profiles and monthly expenditure for the department.

R5.9 All costs incurred by the non-admitting hospital departments identified at R5.8(i) above should be allocated back to the admitting specialties identified at R5.7(i) above in order to allow the calculation of full costs incurred by specialty and patient.

R5.10 A working group, under the aegis of the Department of Health and Children, should be set up to agree a common national methodology to be applied to the allocation of the indirect costs referred to at R5.9 above.

R5.11 The business managers recommended at R5.7(iii) and R5.8(iii) above:
- (i) May cover more than one specialty/department, depending on the particular needs and demands of that specialty/department; and
- (ii) Should be made available from within existing resources as part of a reorganisation by hospital/health board CEOs of existing duties and responsibilities.

Format and Content of Service Plans

Consistent with our conclusion from Chapter 4 that Service Plans at all levels should be standardised, we consider it appropriate that sub-hospital level Service Plans should have a format and content similar to standard health board Service Plans.

Recommendations on Service Planning in the General Hospitals Programme (contd.)

R5.12 The annual practice/specialty/department Service Plan should include:
- (i) Clear statements of projected activity, linked to funding (both pay and non-pay elements);
- (ii) Integrated financial and non-financial data. Formal and clear inter-connections are needed between cost and activity; and
- (iii) A clear analysis between public and private patients in respect of (i) and (ii) above.

R5.13 Clear reporting arrangements and responsibilities must be put in place such that:
- (i) Business managers are responsible for gathering and presenting management data on costs and activities; and
- (ii) Clinical Consultants/Heads of Department are responsible for providing explanations to the hospital/health board CEO of variances from budget and how such variances will be brought back into line.

R5.14 Routine reports (monthly, quarterly, annual) should be submitted in the format and within the timescales envisaged in recommendation R9.1.

Training Needs

In addition to the information technology requirements necessary to give effect to the above recommendations (see Chapter 10), it will be necessary to provide a range of ongoing training and assistance to the main participants in the process to assist in the implementation of the above recommendations.

Recommendations on Implementation in the General Hospitals Programme

R5.15 Business managers should receive continuous relevant training to ensure they have the requisite skills, training and experience in medical and clinical work as well as finance and management to perform their duties.

R5.16 The health board/hospital CEO should be responsible for determining the appropriate level and quantum of training and for putting in place the mechanisms necessary to ensure that training is delivered.

R5.17 The Executive should liaise with educators to prepare/train clinical Consultants/Heads of Department on an ongoing basis to understand and to work with new financial management information systems.

R5.18 The Department of Health and Children should liaise with the Higher Education Authority to introduce a requirement for medical schools to develop programmes to ensure that every medical student receives at least one module on health economics, technology assessment and financial management and control issues.

R5.19 A working group under the aegis of the Executive, in consultation with the Department of Health and Children, should examine and make recommendations on appropriate incentives for those clinical Consultants/ departments that successfully implement recommendations above.

Public/Private Mix in Public Hospitals

The existing arrangements for mixing public and private treatments are inherently unsatisfactory from a management and control perspective. They result in a conflict of interest for Consultants between meeting clinical obligations to public patients on the one hand and, on the other, the prioritisation, treatment and the use of publicly provided infrastructure and resources in public hospitals for private patients. They also raise issues of fair competition with private hospitals in that the resources used are not charged for fully. They severely limit the time the majority of clinicians have to pursue resource management. Ultimately, these issues can only be resolved fully by completely separating public and private practices.

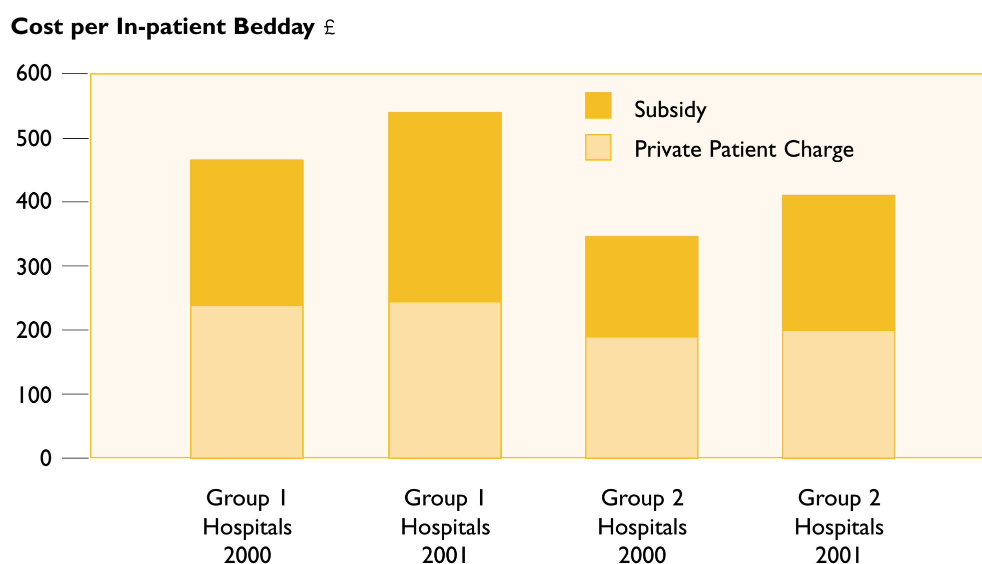
Table 5.1 and Figure 5.1 give some indication of the levels of subsidy from the taxpayer towards the cost of treating private patients.

Table 5.1: Cost per Inpatient Bed Day Compared with Private Patient Charges, 2000 and 2001

	Cost Per Inpatient Bed day	Private Patient Charge	Subsidy
	¤	¤	¤
2000: **Group 1 Hospitals**[5]	465	232	233
Group 2 Hospitals[6]	347	192	155
2001: **Group 1 Hospitals**	546	239	307
Group 2 Hospitals	409	197	212

Source: Department of Health and Children

Figure 5.1: Cost per Inpatient Bed Day in Group 1 & Group 2 Hospitals split between Subsidy and Private Patient Charge, 2000 and 2001



[5]Group 1 hospitals are the major academic training hospitals (i.e. Beaumont Hospital, Cork University Hospital, James Connolly Memorial Hospital, Mater Hospital, St. James' Hospital, St. Vincents' Hospital and University College Hospital Galway
[6]Group 2 hospitals are non-teaching hospitals (i.e. all hospitals other than those categorised as Group 1).

The table above illustrates that for the larger (Group 1) hospitals, the economic cost per bed day increased by ¤81 from 2001 to 2002 (from ¤465 to ¤546). However, the private patient charge for that bed day increased by just ¤7. As a result, the inpatient bed-day subsidy increased by ¤74 in just one year (from ¤233 to ¤307). The table shows that there is a similar outcome in the smaller (Group 2) hospitals with the nominal subsidy increasing by ¤57 year on year. This outcome for 2000/2001 is inconsistent with Government policy.[7]

Transparency

We believe that the taxpayer is entitled to know how much of his/her contribution to tax revenues is being spent on private patients in public hospitals. The full costs of treating private patients in public hospitals should be both transparent and publicly available. This reflects our core principle on patient costing i.e. that all costs incurred should be capable of being allocated to individual patients.

The benefit of making this information publicly available is that it would inform the policy debate and allow consideration of the real costs and State subsidies associated with the public/private mix. A further argument for making any subsidy explicit is that significant hidden subsidies of the treatment of private patients in public hospitals may inhibit the development of private facilities that may be competing with private medicine carried out in public hospitals.

Recommendations on Public/Private Mix in Public Hospitals

R5.20 All Service Plans, Practice Plans and monthly, quarterly and annual reports should include a clear breakdown between public and private costs and activities.

R5.21 A coding system should be put in place in all cases (e.g. outpatient activity, private patients having tests in a public hospital etc.) and in all hospitals to explicitly identify all activity as relating to public or private patients, as appropriate.

R5.22 The coding system referred to at R5.21 above should allow for allocating of general overheads incurred by hospitals between public and private patients so that the full cost of treating public and private patients can be calculated. The objective should be to identify the costs of treating individual patients.

R5.23 The Executive should publish in its Annual Report a comprehensive analysis of the amount of public resources[8] consumed by private patients within the public hospital sector.

R5.24 Recognising that implementation of the information systems recommended in Chapter 10 will be necessary to produce accurate information in respect of R5.23 above and the lead in time for the establishment of the Executive, the Department of Health and Children should, on an interim basis, publish such information using the best estimates that are available to it.

R5.25 The provisions of Consultants' existing common contract should be enforced to ensure that the following is undertaken:
- (i) The setting of core times when a Consultant must be available to patients in the public hospital; and
- (ii) Formal active monitoring of work commitment in respect of public patients.

R5.26 The health board/hospital CEO should put mechanisms in place to ensure;
- (i) Consultants' sessional contractual commitments to the public hospital are met; and
- (ii) The cap on private activity in public hospitals is observed both with respect to inpatients and day-cases (i.e. agree with Consultants on the number of private patients to be treated in public hospitals).

[7]One of the recommendations of the "White Paper on Private Health Insurance" (1999) was that the gap between the charges for private patients and actual costs should be eliminated over a 5 to 7 year period.
[8]At a minimum this should include direct public expenditure within the health sector. The Department of Health and Children should consider the extent to which other costs, such as tax relief and medical teaching costs, should also apply.

5.3 OTHER (NON-HOSPITAL) PROGRAMMES

Approximately 50% of health service expenditure occurs outside the general hospitals programme. These expenditures relate to community care, mental health and a range of other services. Consistent with the principle that accountability for resources expended should be devolved to those making the decisions which affect resource consumption, there is a need for the health board CEO to assign formal responsibilities to personnel making financial decisions.

Within the context of these services, we consider that the appropriate level within the system to which accountability should be devolved is to that of the General Manager. The General Manager is the person in a health board responsible for managing and coordinating the delivery of health and social services provided by a health board within a community care area, in accordance with the board's policy.[9]

We stress that the health board CEO should remain the accounting officer for all health board expenditure and that nothing in our recommendations is intended to change or undermine this accountability.

Recommendations on Other (i.e. Non-Hospital) Programmes

R5.27 In all other areas of the health service (i.e. non-hospital), the individual responsible for the budget (whether clinical or non-clinical personnel) should be held formally accountable for financial performance.

R5.28 The CEO of the Executive and the health board CEOs should analyse the totality of non-hospital related health board activities into clearly defined care groups (e.g. community care, mental health etc.) that are consistent throughout the system.

R5.29 The health board CEO should identify a General Manager with responsibility for each care group identified at R5.28 above.

R5.30 Each General Manager should prepare an annual Service Plan and budget for their area of responsibility.

R5.31 Each General Manager's Service Plan should include:
(i) Clear statements of projected service provision, linked to funding (both pay and non-pay elements); and
(ii) Integrated financial and non-financial data. Formal and clear inter-connections are needed between cost and activity.

R5.32 General Managers should submit routine reports (monthly, quarterly, annual) to the CEO of their regional health board within the format and the timeframe envisaged in recommendation R9.2.

Implementation

R5.33 The Health (Amendment) (No. 3) Act, 1996 should be amended, as necessary, to permit the health board CEO to formally assign duties to the General Managers making them accountable to the CEO/line management for their financial decisions. *(The health board CEO should remain the accounting officer for all health board expenditure and nothing in our recommendations is intended to change or undermine this accountability.)*

5.4 SUMMARY

In line with our core principles on personal accountability and wider financial management responsibilities (see Chapter 2), in this Chapter, we have recommended devolving responsibility and accountability for resource management and planning to those with the authority to commit the expenditure – mainly Consultants in the case of the hospital system and General

[9]They may also have responsibility for the management of health board owned hospitals – in this case they will be the Chairman of the proposed Executive Management Committee for the hospital (see recommendations R5.4 to R5.6 above).

Managers in the case of other expenditure.

A more extensive system of planning and budgeting at the level of the cost unit or cost centre will improve planning and budgeting at a more aggregate level also. This should contribute to improved costing and planning thereby avoiding the kinds of problems identified in Chapter 2 relating to cost overruns and unauthorised expenditure being incurred. In line with our core principle on patient costing, we have recommended that systems should allow for all costs incurred to be allocated back to the admitting specialty and, thereafter, the patient.

Our recommendations on public/private mix will improve transparency in information flows generally, again supporting enhanced planning at central level.

CHAPTER 6
ACCOUNTABILITY – GENERAL MEDICAL SERVICES AND COMMUNITY DRUG SCHEMES

In this Chapter, we examine the accountability issues to be addressed in the General Medical Services (GMS) and the Community Drugs Schemes, particularly the Drugs Payment Scheme.

6.1 OVERVIEW

Primary care contractors are a crucial part of the health service infrastructure. In many instances, the General Practitioner (GP) and pharmacist link the service user to the health system. A modern, effective health service requires quality standards and value for money in all aspects of primary care.

The cost of the GMS has increased rapidly in recent years. In our view, action is required on a number of fronts. Accountability issues that must be addressed include the services required and provided by GPs within the GMS and the publicly funded drugs and medicines schemes as they currently operate.

We believe there is significant room for improvement. The increases in expenditure on the GMS, discussed in Chapter 2, are further examined in this Chapter. The figures make a compelling case for reform.

6.2 GENERAL MEDICAL SERVICES (PAYMENTS) BOARD

The function of the General Medical Services (Payments) Board is to make payments due under medical cards, drug subsidisation, long-term illness and dental treatment service schemes as well as a range of community-based services. It is the role of the Board to calculate, verify and make payments under the various schemes and to compile statistical information.

The greatest costs covered by the GMS (Payments) Board arise in respect of the medical card scheme and the Drugs Payment Scheme (Table 6.1). Of the population, 31% are covered by medical cards and the balance of 69% are eligible for the Drugs Payment Scheme.

Table 6.1: Grants to GMS (Payments) Board to cover the Medical Card and Community Drug Schemes

	1997 (¤ m)	1998 (¤ m)	1999 (¤ m)	2000 (¤ m)	2001 (¤ m)	2002[1] (¤ m)	% increase 1997-2002 (¤ m)
Medical card	361	400	543	551	653	922	155%
of which:							
-Drugs, medicines, appliances	*188*	*202*	*292*	*304*	*375*	*514*	*173%*
-Fees to GPs/pharmacists	*149*	*174*	*216*	*211*	*239*	*373*	*150%*
Drugs Payment Scheme	86	109	142	185	252	276	221%
Other drugs refund schemes[2]	37	52	50	60	74	76	105%
Total[3]	**483**	**561**	**735**	**795**	**978**	**1,274**	**164%**
% year-on-year increase		16%	31%	8%	23%	30%	

Source: Revised Estimates for Public Services, 1998 to 2002; Department of Health and Children

6.3 MEDICAL CARD SCHEME

As shown in Table 6.1, the costs associated with medical cards are the most significant element of those met by the GMS (Payments) Board. All persons aged 70 years and over, regardless of means, as well as persons under 70 years who are unable without undue hardship to arrange GP medical and surgical services for themselves and their dependants receive a free general medical service. Medical card holders are entitled to free GP medical and surgical services and to free prescription drugs, medicines and appliances through their local participating pharmacist.

Drugs, medicines and appliances supplied under the scheme are provided through retail pharmacies. In most cases, the GP gives a completed prescription form to a person, who takes it to any pharmacy that has an agreement with a health board to dispense GMS prescription forms. In rural areas the doctor may dispense for those persons who opt to have their medicines dispensed by him/her. This aspect is covered in more detail in the following section.

GP Capitation and Other Fees

The arrangements for paying capitation and other fees to GPs in respect of their medical card patients are summarised below. Fees and allowances fall into three categories:

- Standard capitation fee;
- Additional fees for outside hours work; and
- Additional fees for certain services.

Under their contract for service, GPs receive a capitation fee in respect of each medical cardholder registered with their practice. The fee is paid regardless of whether the medical

[1]Figures shown for 2002 are the allocation as per the Revised Estimates for Public Services 2002 plus an additional ¤ 191 million provided, by way of supplementary estimate (¤ 183 million in respect of medical card expenditure and ¤ 8 million in respect of the Drugs Payment Scheme). [2]Includes Long Term Illness Scheme, High Tech Medicines Scheme and Hardship Scheme. [3]Rounding may affect the totals.

cardholder consults the GP. In some cases the GP may have little or no contact with a registered patient, while in other cases the GP may have frequent consultations with a medical cardholder. Capitation fees per patient range from ¤36 per patient per annum to ¤670 per patient per annum, as shown below:

- Annual capitation fee for pre-existing (largely means-tested) cardholders: from ¤36 to ¤171 (range depends on patient's age, sex and distance from doctor's surgery).
- Annual capitation fee for newly-eligible (non-means tested) over 70s category: ¤462 or ¤670 (the higher rate is payable in respect of persons resident in nursing homes).

The standard GP capitation fee only covers GP services provided between 9am and 5pm, Monday to Friday. Although applying standard office hours to a service that requires (on occasion) a 24 hour a day, 7 day a week service seems to be a mismatch between service delivery and service demands, under their contract, GPs are entitled to additional payments for services provided outside this period, such as:

- Surgery: ¤35.
- Home visits: ¤35 to ¤70 (depending on the distance to patient's home).

GPs also get extra payments for certain additional services provided. These include:

- Suturing of cuts and lacerations/ECG tests and their interpretation: ¤22.
- Influenza vaccination: ¤30.
- Hepatitis B vaccination: ¤108.

The medical card scheme represents a major challenge and financial risk to the health service nationally. There are three broad but clearly interrelated areas of concern:

- As seen in Chapter 2, there have been serious failures in costing changes, monitoring operations and verifying expenditures.
- There is little or no evaluation of attendance patterns, prescribing rates, hospital referrals etc. amongst GPs within the medical card scheme.
- The increase in the costs associated with the medical card scheme is very high – the cost in 2002 (over ¤900 million, including the supplementary estimate) is some two and a half times greater than the 1997 figure.

In relation to the Medical Card Scheme, the choices faced by Government, on behalf of the taxpaying public, are stark. It can either:

- *accept that this system cannot be controlled and continue to meet the annual funding deficits of such an open ended scheme;*
  or
- *it can negotiate budget limits for the scheme and devise mechanisms whereby agreed outputs, in line with the Government's own Health Strategy, will be delivered for agreed budgets (e.g. in relation to reduction of inpatient admissions, treatment of more hospital Accident and Emergency cases through the primary medical service, etc).*

We believe it is in the public interest to increase the controls in this system.

Recommendations in respect of the General Medical Service

R6.1 The health board CEO should, in consultation with the General Practitioner (GP), draw up, consistent with national guidelines established by the Executive, a Practice Budget for each GP covering his/her patients registered as medical cardholders.

R6.2 The Practice Budget at R6.1 above should be broken down between:
- (i) Medical treatments; and
- (ii) Drug prescriptions.

R6.3 The Practice Budget at R6.1 above should be based on treatment costs having regard to:
- (i) The demographic profile of each GP's medical card patients;
- (ii) Attendance, treatment and prescribing patterns;
- (iii) Attendance of patients at Accident and Emergency clinics; and
- (iv) Referral patterns to general hospitals.

R6.4 In the event that a GP requires funding above the budget agreed at the start of the year, it should be necessary for him/her to submit a request for same to his/her health board CEO citing the clinical factors which have given rise to the overspend.

R6.5 Health boards should monitor individual versus normative patterns of referral of patients to hospitals. (This can be facilitated by appropriate identification of patients by source within the hospital coding systems recommended at R5.21.)

Implementation

R6.6 The Secretary General of the Department of Health and Children should take immediate steps to agree with GPs' representatives the necessary changes to GPs' Contract for Service to give effect to recommendations R6.1 to R6.5 above.

R6.7 The Secretary General of the Department of Health and Children should take immediate steps to devise a standard template for annual Practice Plans.

List of Registered Medical Cardholders

One problem identified in Chapter 2 (see Table 2.11) was inaccurate lists of medical cardholders for each GP with cases of duplicate registrations, where cardholders are registered with more than one GP, and the presence of large numbers of inactive cardholders, some of whom may have died. GPs continue to receive a capitation fee in respect of these registered cardholders.

Health boards are responsible for preparing centralised records of medical cardholders, with details of their addresses, which are then used to allocate medical cardholders to individual GPs. This list forms the basis for payment of the capitation fees by the GMS (Payments) Board. Nonetheless, it seems likely that the doctor, who will know many of his/her patients personally, would, in some cases, be aware that a patient has died and that the capitation fee paid in respect of such a patient was erroneously paid.

We are of the opinion that health boards should introduce new procedures to audit their medical cardholder lists on a systematic basis (including comparing them against other health board lists to check for duplications) to reduce the incidence of errors. We also believe that individual GPs should have responsibility for checking and verifying the accuracy of these lists. Where the health board discovers an overpayment to a GP, this overpayment should be

recovered by setting it against payments due to the GP in the following year.

Recommendations in respect of the General Medical Service (cont'd)

R6.8 GPs should be assigned responsibility for reporting to the health board on the accuracy of their list of registered medical cardholders annually.

R6.9 Health boards should introduce new verification and audit procedures to ensure their lists of medical cardholders are accurate.

R6.10 Based on an evaluation of the reports at R6.8 by the health board, overpayments made in a previous year (for example, where a patient dies or moves to another GP) should be automatically netted off by the health board against that GP's Practice Budget for the following year.

6.4 COMMUNITY DRUG SCHEMES

The main community drugs schemes are prescriptions under the medical card scheme, as described in the preceding section, and the Drugs Payment Scheme (DPS). There are more specialised schemes namely the Long Term Illness Scheme (for certain defined illnesses/ conditions) and High Tech Medicines Scheme (for certain high cost drug products).

Medical Card Scheme: provision of drugs, medicines and appliances

A medical cardholder is entitled to free drugs, medicines and appliances, as prescribed by his/her GP, chosen from a list of 4,536 licensed drugs, medicines and appliances, agreed between the Department of Health and Children and the Irish Pharmaceutical Healthcare Association. This list includes products of similar content but of (sometimes substantially) varying cost.

The retail pharmacist filling a prescription is entitled to a dispensing fee and reimbursement for the drugs, medicines and appliances dispensed on a cost of ingredients basis. We understand that, in accordance with normal commercial practice, retail pharmacies routinely negotiate discounts (in the form of rebates) with wholesalers in relation to the products they provide under the medical card scheme.

In all health board areas, on a voluntary basis, GPs are participating in initiatives designed to contain prescribing costs. In the case of the Indicative Drug Target Savings Scheme, operating since 1993, this has involved setting a nominal drugs budget for the GP practice based on his/her number of patients with medical cards and average prescribing rates for the country as a whole. Savings made under the scheme are made available by the health board for investment in the development of general practice (including infrastructure, equipment and computer costs).

In at least one health board area, we are aware that savings under this initiative have been used to co-fund the construction and equipping of a number of local health centres owned by the health board where the GP is a central figure within the team providing services from the centre. Significant investment in medical equipment, communications and computer systems for primary care has also been achieved. This is fully in accordance with Government strategy on primary care. The use of resources under the scheme may offer important lessons for use in a wider context.

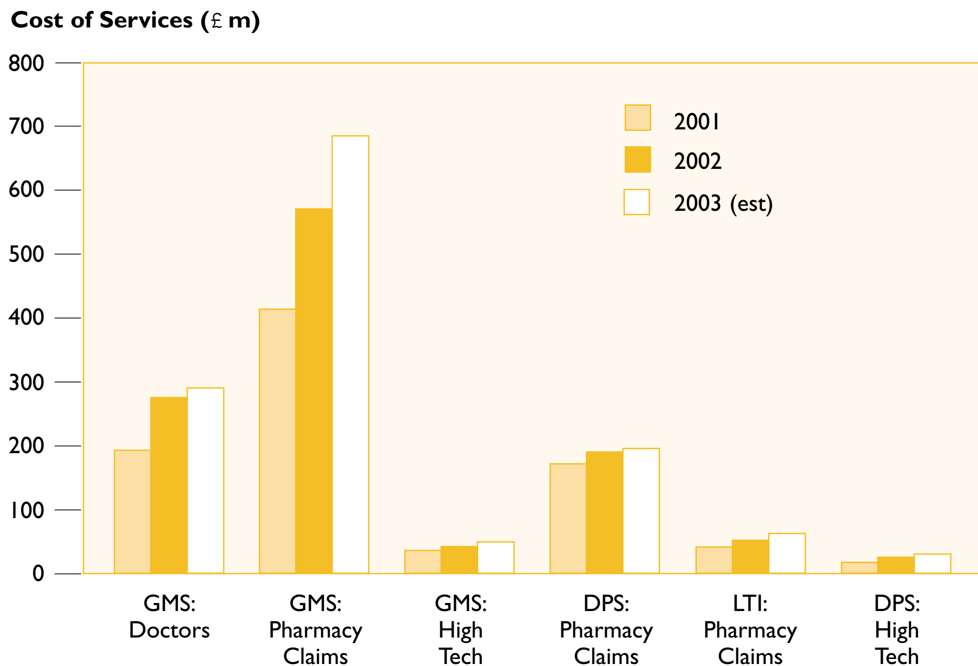
Drugs Payment Scheme

Under the Drugs Payment Scheme, individuals and families pay only the first ¤70 per calendar month of expenditure on approved items. Under the scheme, GPs, Consultants and Dentists may prescribe approved medicines of their choice from a list of licensed drugs, medicines and appliances, agreed between the Department of Health and Children and the Irish Pharmaceutical Healthcare Association. This list includes the 4,536 items from the medical card list above plus a further 3,673 items. It should, however, be noted that, in 2002, only 2.4% of the drugs prescribed/dispensed under the Drugs Payment Scheme (at a cost of ¤5.8 million) were from this supplementary list.

The retail pharmacist facilitating this service is entitled to a dispensing fee and a 50% mark up on the ingredient costs of the products dispensed. Again, it is understood that, in accordance with normal commercial practice, retail pharmacies routinely negotiate discounts (in the form of rebates) with wholesalers in relation to the drugs, medicines and appliances they supply under the Drugs Payment Scheme.

As Figure 6.1 below suggests, the cost of operating these publicly-funded drugs schemes has increased significantly in recent years.

Figure 6.1: Comparative Costs of Publicly-Funded Pharmacy Services, 2001 - 2003



Source: GMS (Payments) Board

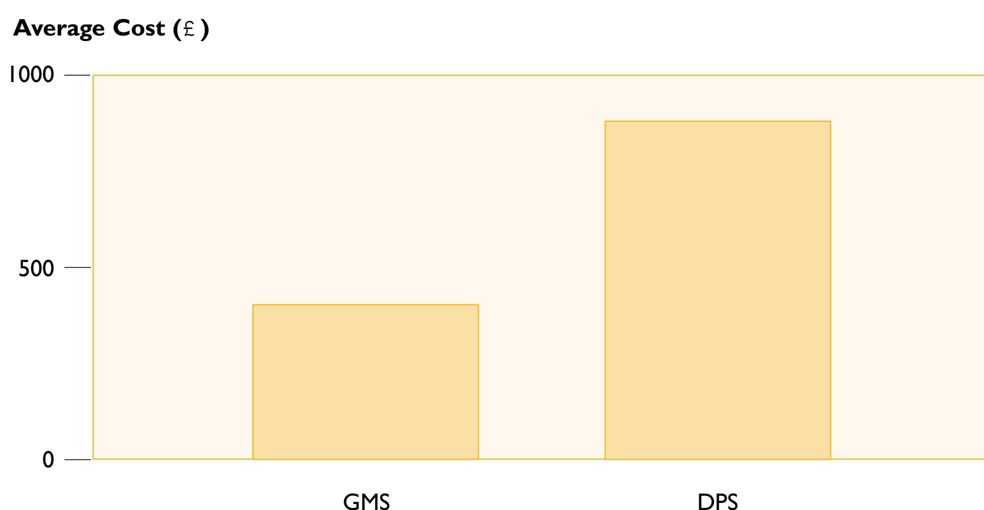
According to the 2001 Annual Report of the GMS (Payments) Board, the national average pharmacy cost per medical card holder was ¤371. The national average pharmacy cost per claimant under the Drugs Payment Scheme (DPS), was ¤890, not including the co-payment contribution per claimant (the gross figure is ¤1,314). As such, the pharmacy costs of the two main publicly-funded schemes, the medical card and the Drugs Payment Scheme, vary considerably.

Table 6.2: Pharmacy Costs (¤)

Medical Card	Drugs Payment Scheme
Average Pharmacy Cost per Cardholder (¤)	Net Pharmacy Cost per Claimant (¤)

Source: GMS (Payments) Board, Annual Report 2001

Figure 6.2: Average Pharmacy Costs in GMS and DPS Schemes

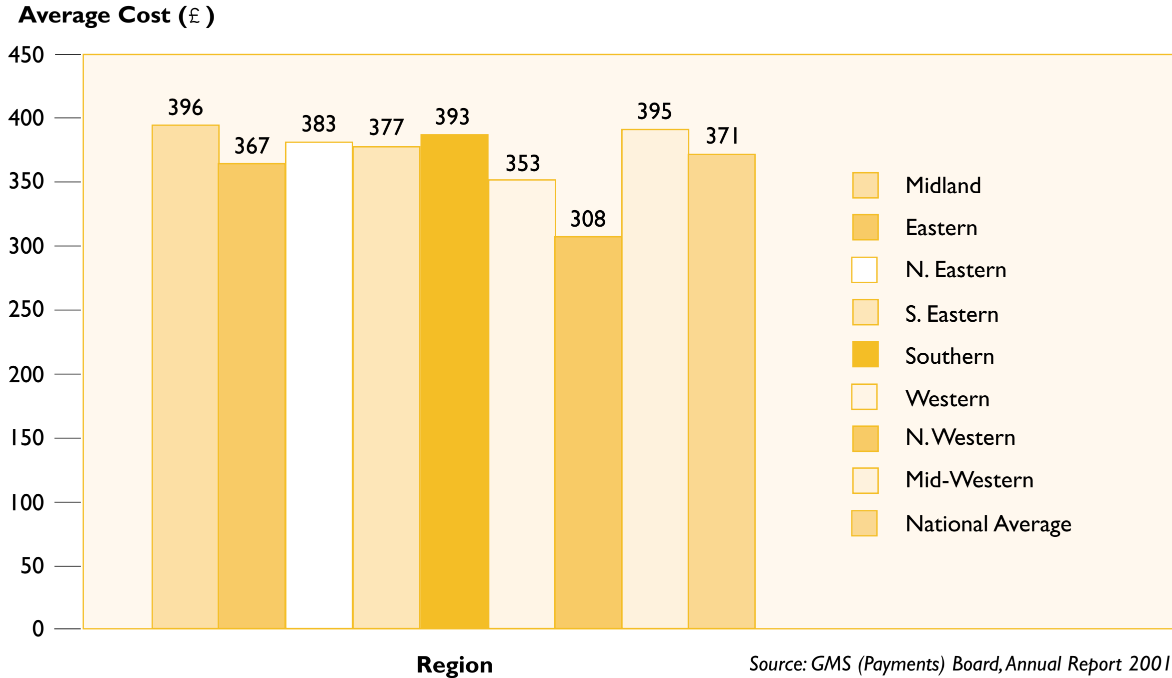


It should, however, be noted that there are legitimate reasons for variations across the two schemes:

- DPS claimants tend to be, by definition, heavy users of drugs and pharmaceuticals – only those using drugs costing in excess of ¤ 70 per month can claim under the scheme. Medical cardholders, on the other hand, are largely determined by reference to means rather than health status. The medical card population, therefore, will contain both healthy and sick people and, as such, can be expected to have a lower average cost.
- Different cost structures exist; pharmacists receive a 50% mark-up on prescriptions under the Drugs Payment Scheme compared to a flat-fee arrangement under the medical card scheme.
- The medical card and Drugs Payment Schemes do not share a common approved drugs list.

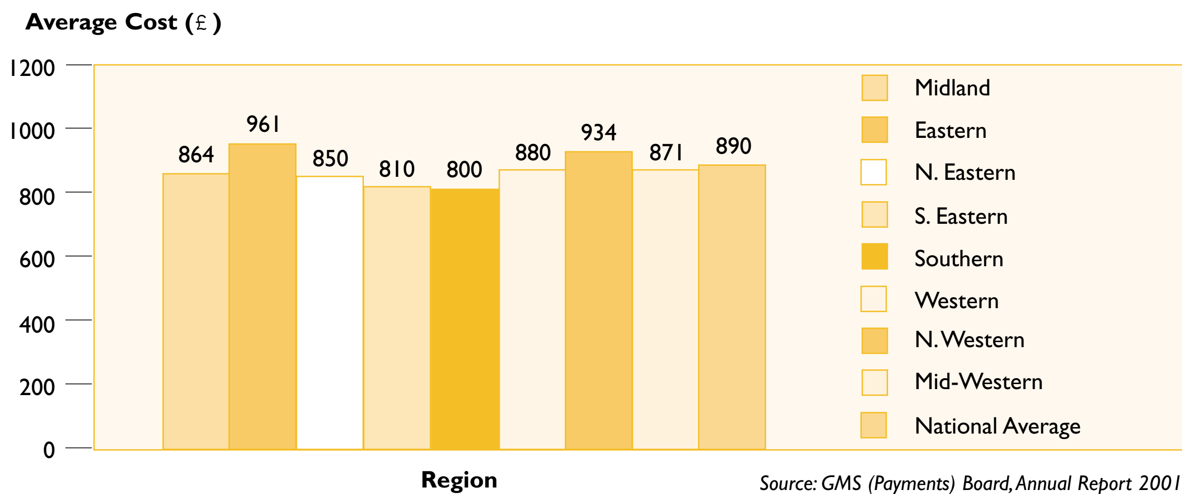
Nonetheless, we are concerned to learn that the significant cost variations across the various drugs schemes and between health board regions (see Figures 6.3 and 6.4 below), and the reasons behind those variations, do not appear to be the subject of ongoing systematic analysis and review.

Figure 6.3: Variation in Medical Card Pharmacy Costs (2001) by Health Board Region



Source: GMS (Payments) Board, Annual Report 2001

Figure 6.4: Variations in DPS Claimant Costs (2001) by Health Board Region



Source: GMS (Payments) Board, Annual Report 2001

In our view, the operation of the Drugs Payment Scheme needs to be urgently reviewed. At present there is no incentive comparable to the GMS to encourage the prescriber (GP, Consultant or Non-Consultant Hospital Doctor) to prescribe products that may be just as effective but considerably cheaper than high-cost brands. Furthermore, where a doctor prescribes the more expensive product, the profits of retail pharmacies are increased.

We recommend that a review be undertaken to ensure that this expenditure is economic, cost effective and provides value for money. Controlling pharmaceutical costs is an important, though complex, management process and will require collaboration between the Department of Health and Children, health boards and medical/pharmacy professionals. Key features of this review will include:

- Influencing/incentivising positive prescriber behaviour;
- Minimising inappropriate prescribing;
- Maximising the prescription and dispensing of generic products;
- Negotiating cost competitive drug prices at national level; and
- Implementing common hospital/primary care drug formularies.

We consider that this review should apply across all publicly-funded drugs and medicines schemes – medical card scheme, Drugs Payment Scheme, Long Term Illness Scheme and High Tech Medicines Scheme.

We believe that a flat-fee basis for reimbursement of drug costs by the GMS (Payments) Board to pharmacists should apply across all national drug schemes. In addition, the State should only reimburse at the rate of the lowest cost for therapeutically equivalent products in all schemes.

Recommendations relating to the Drugs Payment Scheme

R6.11 Current arrangements for reimbursing pharmacists under the medical card scheme – i.e. reimbursement on a cost of ingredients basis (without mark-up) plus a flat-rate prescription fee – should be extended to the Drugs Payment Scheme.

R6.12 The operation of the Drugs Payment Scheme should be reviewed immediately by the Department of Health and Children, in consultation with the Department of Finance, the GMS (Payments) Board and the health boards. The review should actively examine:

(i) Introducing a system whereby health boards would actively monitor and evaluate prescribing patterns by individual GPs, Consultants or Dentists and reimbursement patterns by individual pharmacists, having regard to relevant demographic and epidemiological factors;

(ii) Introducing incentive schemes for reducing levels of prescribing and drugs costs;

(iii) In recognition of the influence of hospital generated prescribing on community drugs budgets, each health board/hospital CEO should immediately establish Drugs and Therapeutics Committees, comprising Consultants, GPs from the hospital catchment area, supported by pharmacy and financial management expertise, to agree clinically cost-effective common drug formulary; and

(iv) Relevant international experience and the lessons from this in containing drug costs and the rate of growth.

R6.13 The existing agreement between the Department of Health and Children and the Irish Pharmaceutical Healthcare Association should be evaluated against international experience with similar agreements (particularly in countries of the European Union). The results of this evaluation should be used in the negotiation of any further agreement so as to assure value for money.

New products continually come on the market. These products are usually more expensive than existing treatments and are patent-protected so that generic substitution is not possible. If prescribed in substitution for existing, lower priced drugs, they will have an escalating impact on the drug budget. Products of differing price may have similar content.

We recognise that since 1998 work has been ongoing on economic evaluation of pharmaceuticals. Economic evaluations have been conducted on a number of medicines, and the national centre has negotiated a framework for economic evaluation with the pharmaceutical industry. The centre has provided information to prescribers through the medical press, highlighting expenditure trends in the community drug schemes, and suggesting improvements in regard to the cost-effectiveness of prescribing.

Recommendations relating to Drugs Assessment

R6.14 The Irish Medicines Board should have its remit extended to not just examine new drugs for their efficacy and effectiveness, but also to:
- (i) Assess their cost effectiveness; and
- (ii) Approve the drug product for reimbursement under the community drugs schemes (including specifying the conditions under which it may be made available, for example restricted to named patients or in respect of defined clinical treatment regimes).

R6.15 The Irish Medicines Board should also be charged with the responsibility to monitor the continuing effectiveness of existing drugs and to delist those which are no longer considered appropriate or clinically cost-effective.

R6.16 Where the Irish Medicines Board determines that a cheaper, but equally effective, alternative exists, only the cost of the cheaper drug should be reimbursed by the GMS (Payments) Board. Where a GP prescribes the more expensive branded drug, the cost difference arising should be regarded as entirely private prescribing.

6.5 SUMMARY

In this Chapter, we have identified the medical card and community drug schemes as the area showing the greatest cost escalation in recent years.

Mirroring the approach taken in Chapter 5 in respect of Consultants and General Managers, we have recommended that, again consistent with our core principle of personal accountability, GPs be designated as the fundamental unit of accountability in relation to the medical card scheme.

We also make recommendations to address the gaps in evaluation, benchmarking and management of the various drugs schemes from a value for money perspective. Some of these problems were illustrated in our description of inaccurate costings and records within the General Medical Services in Chapter 2.

CHAPTER 7
ACCOUNTABILITY - EMPLOYMENT AND PAY

In this Chapter, we focus specifically on health service employment. We detail the increase in health service pay and employment in recent years and we examine how factors including overtime and allowances are affecting the overall pay bill. We consider the systems for setting authorised staff numbers and how these operate in practice. We make recommendations in relation to negotiating and implementing pay agreements and the operation of the Common Recruitment Pool.

7.1 OVERVIEW

Pay is the single biggest cost driver in the health service. It accounts for over two-thirds of total non-capital health expenditure. In absolute terms, pay costs have risen by a cumulative ¤2.1 billion or 69% over the four-year period, 1999 to 2002.

Numbers employed in the health service increased by 37% between 1997 and 2001 – from 68,000 to 93,000. For a number of groups in the health sector, gross pay rates (i.e. with overtime, call-out payments, etc. included) are significantly higher than basic pay.

We believe the health service does not have adequate information to facilitate proper costing and control on issues of employment and pay.

There is a lack of co-ordination in the health service in the collection and validation of basic information on national employment levels and pay patterns.

There is an absence of manpower planning at national level on issues including conditions of employment, recruitment policies, rostering arrangements, flexibility requirements etc.

The methods used to negotiate pay agreements have sometimes produced expensive knock-on consequences and this aspect of the system needs to be urgently reviewed.

At present vacancies within many areas of the health service can only be filled by a system known as the Common Recruitment Pool. This agreement, dating back to 1970, was designed to preserve the promotional outlets of certain employees within the Pool. This blocks access for applicants from such areas as the private sector, voluntary hospitals, mental handicap agencies and the civil service. We believe these arrangements are not appropriate and should be changed.

We also recommend the introduction of effective performance management systems and an accelerated management development programme for senior managers in the health service.

7.2 PAY

Expenditure on Pay

As can be seen below (Table 7.1 and Figure 7.1), pay is the single biggest cost driver in the health system. There are, essentially, three variables that drive pay costs:

- Numbers in employment;
- Number of hours worked; and
- Rate at which those hours are paid (basic pay, overtime/premium rates etc).

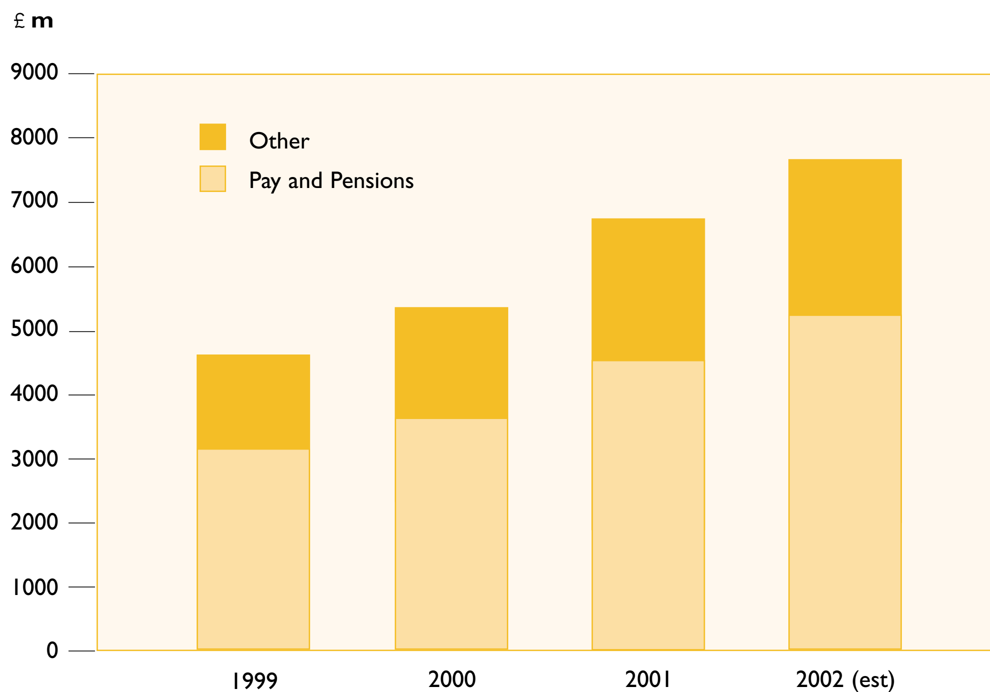
In absolute terms, pay costs have risen by a cumulative ¤2.1 billion, or 69%, over the period from 1999 to 2002.

Table 7.1: Expenditure on Health Service Pay and Pensions, 1997 - 2002

Year	Total Pay and Pensions[1] (¤ m)	Year-on-Year Increase (¤ m)	Gross Non-Capital Health Expenditure (¤ m)	Pay and Pensions as a % of total Non-Capital Health Expenditure
1999	3,116		4,600	68%
2000	3,677	561 (18%)	5,362	69%
2001	4,572	895 (24%)	6,704	68%
2002 (est)	5,251	679 (15%)	7,692	68%

Source: Department of Health and Children

Figure 7.1: Pay and Pensions as a Proportion of Gross Non-Capital Health Expenditure, 1999-2002



Source: Revised Estimates for Public Services 2000 – 2002; Department of Health and Children

[1]This includes pay costs for direct State employees as well as "pay-related" costs associated with voluntary bodies/agencies funded through the health boards and GP and pharmacy fees under the General Medical Service. These "pay-related" costs are not available for years prior to 1999.

Numbers Employed

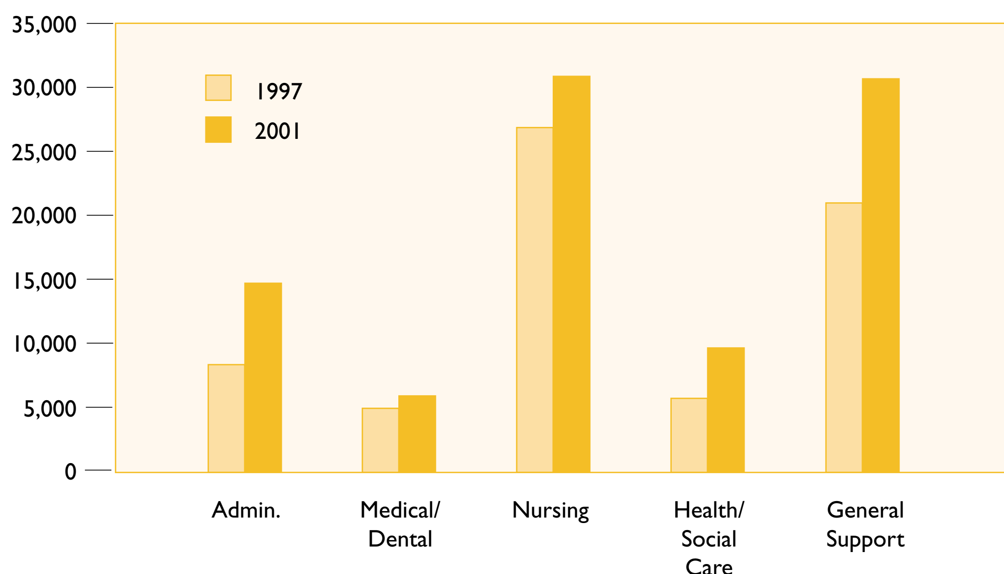
As Table 7.2 and Figure 7.2 show, the numbers employed (based on whole time equivalents) in the public health service have also increased – by 37% between 1997 and 2001, from 67,939 in 1997 to 92,996 in 2001.

Table 7.2: Numbers Employed in the Public Health Service (WTE), 1997 and 2001

Category[2]	1997	2001	Increase	Increase as % of total
Management/Administration	8,308	14,714	6,406	26%
Medical/Dental	4,976	6,285	1,309	5%
Nursing	27,346	31,429	4,083	16%
Health and Social Care Professionals	5,969	9,228	3,259	13%
General Support Staff and Other Patient and Client Care	21,339	31,340	10,001	40%
Total[3]	**67,939**	**92,996**	**25,057**	**100%**

Source: Department of Health and Children

Figure 7.2: Numbers Employed by Category, 1997 and 2001



Source: Department of Health and Children

[2]Numbers within each grade category may not be directly comparable from 1997 to 2001 due to some minor reclassifications that have not been taken into account. However, the broad level of increases and breakdowns across categories are valid.
[3]Rounding may affect totals

There has been ongoing comment during the course of our deliberations that the vast majority of increased employment in the health sector has been taken up by administrators - i.e. that administrative staff, rather than those providing a direct patient service, have consumed the additional resources allocated. We have not found evidence to support this perception.

In October 2001, health boards were asked by the Department of Health and Children to carry out a comprehensive analysis of the primary roles and functions of the staff classified as "Management/Administration". The result of this analysis is set out in Table 7.3 below.

Table 7.3: Total Health Service Staffing 2001 (including a breakdown of the Management/Administration Category)

GRADE CATEGORY		2001	As % of Category Total
Management/Administration		**14,714**	
of which			
	Payroll etc.	*1,324*	*9%*
	Human Resource Management (including training)	*736*	*5%*
	Service Managers	*441*	*3%*
	IT Staff	*441*	*3%*
	General Management Support	*1,619*	*11%*
	Legislative and Information Requirements	*736*	*5%*
	Direct Patient Services	*9,417*	*64%*
Medical/Dental		**6,285**	
Nursing		**31,429**	
Health and Social Care Professionals		**9,228**	
General Support and Other Patient and Client Care		**31,340**	
	Total	**92,996**	

Source: Department of Health and Children

Of those falling within the category of "Management/Administration" in 2001, 64% are staff engaged in direct service to the public. These include Consultants' secretaries, out-patient department personnel, medical records personnel, telephonists and computer personnel who are engaged in front-line duties. These personnel are recorded generically at clerical officer/grade 3 level on the basis of their rates of pay as distinct from the functions they perform. While there is no directly comparable figure for 1997, applying that same ratio and extrapolating from that category's 26% share of the total increase indicates that of the order of 10 out of every 11 additional employees recruited since 1997 are engaged in duties of direct service to patients and the public.

Rates of Pay

Table 7.4 shows the average pay levels for selected representative grades in the public health

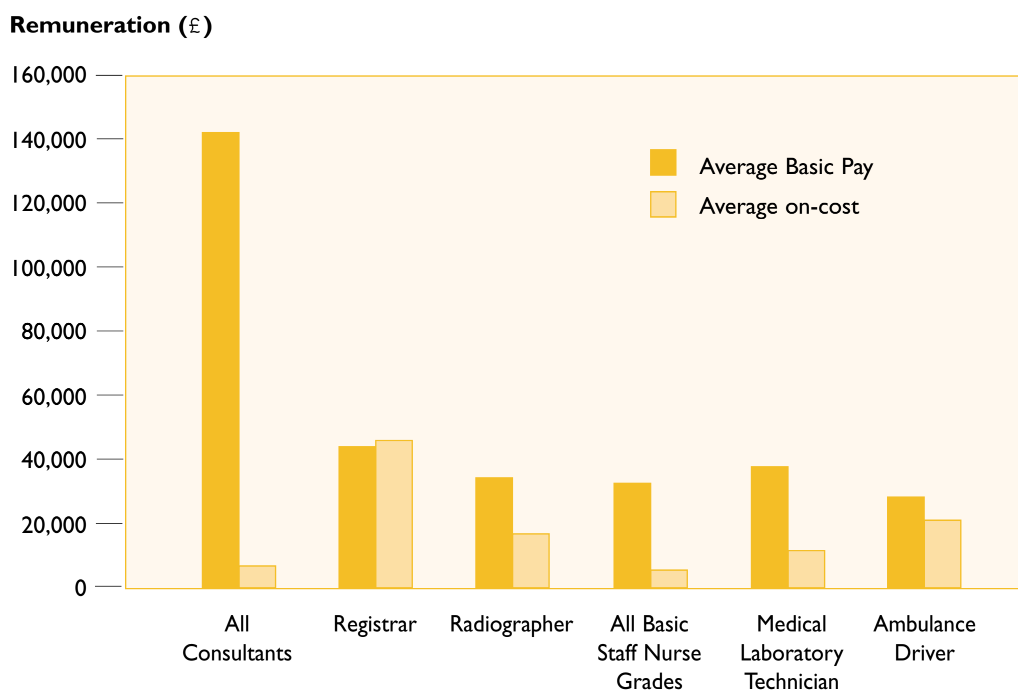
service. The table includes details of average basic pay and average gross pay (i.e. inclusive of overtime and any on-call or other allowances available). The figures reflect the pay levels within the health service and how, for a number of sectors, the difference between gross pay and basic pay is significant.

Table 7.4: Selected Average Pay Rates, 2002

Grade	Average Basic Pay (¤)	Average Gross Pay (¤)	Ratio of Gross to Basic Pay
All Consultants	143,388	151,694	106%
Registrar	45,993	92,939	202%
Radiographer	33,146	50,298	152%
All Basic Staff Nurse Grades	32,060	39,584	123%
Medical Laboratory Technician	37,137	49,122	132%
Ambulance Driver	28,254	49,796	176%

Source: Department of Health and Children

Figure 7.3: Breakdown of Average Gross Pay for Selected Grades, 2002



Source: Department of Health and Children

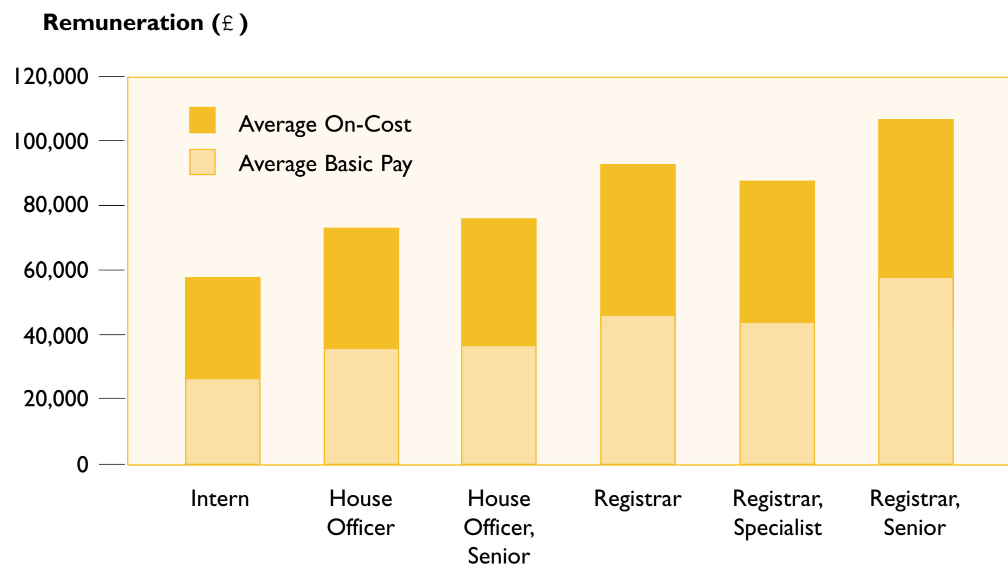
Table 7.5 and Figure 7.4 (below) show how on-cost earnings (overtime, shift allowances etc.) are now a significant factor for the 4,000 Non-Consultant Hospital Doctors (NCHDs) as a whole. The average ratio of gross to basic pay across six grades of NCHDs is approximately 200%. We recognise that such high levels of additional pay indicate lengthy hours working and/or on-call. But the situation raises questions about the efficiency of manpower planning arrangements, particularly given the requirements of the EU Working Time Directive which will necessitate a phased reduction over the coming years in the number of hours worked by NCHDs.

Table 7.5: Average Basic and Gross Pay for Non-Consultant Hospital Doctors 2002

Grade	Average Basic Pay 2002 (¤)	Average Gross Pay 2002 (¤)	Ratio Gross to Basic Pay
Intern	26,996	57,920	215%
House Officer	37,134	73,172	197%
House Officer, Senior	38,516	76,744	199%
Registrar	45,993	92,939	202%
Registrar, Specialist	44,409	87,532	197%
Registrar, Senior	58,517	108,355	185%

Source: Department of Health and Children

Figure 7.4: Average Remuneration of NCHDs, 2002, in terms of Basic Pay and Overtime etc.



Source: Department of Health and Children

Consultants' average pay (¤ 151,694), as shown in Table 7.3, refers to remuneration in respect of their 33-hour public contract only. Consultants often work on-call and/or for lengthy periods outside their core hours as part of their public contract commitment. Many Consultants also have income from private practice. The Department of Health and Children estimates payments to Consultants from private insurers in respect of private practice in 2002 amounted to some ¤ 192.5 million. Averaging this over an estimated 1,515 Consultants with private earnings, including those engaged solely in private practice, suggests an average gross fee income (before practice and other expenses) from private practice in excess of ¤ 127,000 per Consultant per annum (this figure does not include fee income paid directly to the Consultant by the patient in the context of out-patient visits). Of course, some Consultants have little or no private practice while others will earn a multiple of this average.

International comparisons of pay rates are fraught with difficulty due to a wide variety of factors such as differing job specifications and terms of contract. However, we consider that it is nonetheless instructive to give some indication of how the reward structure in Ireland compares with, for example, the UK. Consultants in the UK earn a basic salary in the range of ¤ 80,000 to ¤ 105,000 (Stg£52,640 - £68,505)[4]. A small proportion of Consultants in the UK can earn in excess of this through a complex system of distinction/merit payments and awards. This can bring pay rates up to around ¤ 204,000 (Stg£133,585) based on an A+ distinction award. However, considerably less than 1% of Consultants employed in the UK's National Health Service receive payment at the A+ distinctions level – in 2001, just 36 consultants.[5]

Having regard to the foregoing, we fully acknowledge the long and unsocial hours worked by health care staff in caring for patients. Patients have no control over the time at which they become ill and are entitled to expect treatment out of hours when they need it. Equally, staff are entitled to be recompensed for working unsocial hours.

Nevertheless, we believe that the payment of overtime and other on-cost remuneration on the scale shown in the preceding tables is unsustainable. A significant proportion of the work of the health service is planned, non-emergency work. It should be possible to organise and manage this work within core hours. In addition, it has been suggested to us that a much greater proportion of hospital work could be undertaken in day facilities, for example.

We consider that a key task for the proposed Executive will be to examine the drivers of pay costs with a view to achieving more efficient working arrangements and cost savings through strategies to reschedule work within core hours and tighter control of basic pay costs through the introduction of improved systems of manpower deployment and control.

7.3 NEGOTIATING AND IMPLEMENTING PAY AGREEMENTS

The Health Service Employers Agency (HSEA), on behalf of health employers, takes the lead role in negotiations with trade unions and representative bodies on the pay and conditions of employment of health service personnel and in solving industrial relations problems in the health sector. The HSEA was established in 1996. It is a representative body for all publicly-funded health service employers. Its membership includes the health boards, public voluntary hospitals, intellectual disability agencies and such other corporate bodies in the health sector as are admitted to membership. The HSEA provides its services through a Board that is appointed by the Minister for Health and Children. The Board consists of nine persons drawn

[4]Source: UK, Department of Health (April 2002). Euro/Sterling exchange rates as at 31 January 2003.
[5]Source: Advisory Committee on Distinction Awards, Annual Report 2001, page 6.

from the health boards, voluntary hospitals, the Department of Health and Children, joint boards hospitals and intellectual disability agencies. The HSEA has acquired particular expertise by recruiting to its staff experts from outside the civil service.

As indicated in Chapter 3, we would see the HSEA as one of the bodies whose functions would be subsumed within the human resource function of the proposed Executive.

There have been instances where the costs of special pay awards were underestimated, some times substantially so. Frequently, this is caused by the "spill-over" effects of pay agreements with particular groups not being anticipated at the time negotiations are being finalised by the HSEA. The pay deal concluded with childcare workers, as detailed in Chapter 2, is such an example. Originally estimated to cost ¤4.7 million, it turned out at ¤11.4 million in respect of childcare workers alone and is expected to cost some ¤45 million to ¤50 million per annum once the knock-on effects have fed through to linked grades.

Pending the establishment of the Executive, we consider that there should be some level of responsibility with the HSEA for the costing of awards negotiated by them while accepting that ultimate responsibility in this regard must rest with the Department of Health and Children. Our recommendations on risk assessment (see Chapter 8) are also relevant to this issue. We are also aware that there have been past instances of differing interpretations of pay agreements and, consequently, a lack of consistency between health boards in how agreements have actually been implemented on the ground. In order to ensure clarity and coherence between the various agencies involved, it is important that each party have a clear understanding of their role during the negotiation stage and, subsequently, during the implementation stage.

Recommendations on Costing of Pay Awards

R7.1 Pending transfer of functions to the proposed Executive, the CEO of the Health Service Employers Agency (HSEA) should report to the Secretary General of the Department of Health and Children and be accountable to him for the financial consequences of pay negotiations and the interim costing of agreements conducted by the HSEA.

R7.2 Prior to any agreement being concluded, the final costing of pay agreements negotiated by the HSEA should be prepared by the Department of Health and Children, drawing on the comprehensive dataset proposed at recommendation R7.6 below.

7.4 COLLECTION AND VALIDATION OF BASIC INFORMATION

At present, the principal data source on employment in the public health sector is the annual Census of Health Service Employees. This is a snapshot of employment, conducted by all health boards, on the instruction of the Department of Health and Children, over the last two weeks in each calendar year.

The Census is a count of all health service personnel. It includes information on employment contracts, such as temporary, full-time, locum etc. Employee numbers are reported on by the absolute number employed and are also expressed as whole time equivalents (WTEs) – i.e. converting the number of part time workers into an equivalent number of full time employees, by reference to the average length of the working week.

As an important tool to facilitate the management of the health service, the Census has a number of weaknesses:

- The Census for any one year is not usually available until well into the succeeding year. By that time significant changes in employment may have taken place. For example, the 2001 data, only published in November 2002, is already one year out of date.
- The Census does not record staff employed in voluntary bodies/agencies that are grant-funded by health boards. Pay awards to health service personnel usually apply to staff at these bodies/agencies, many of whom are paid at health service rates.
- The Census does not provide details of vacancies.
- The Census is taken at the year-end when employment patterns are atypical.
- The Census does not record the number of agency personnel employed. Agency nurses, for instance, are qualified nurses who, while they work on hospital wards alongside staff nurses, are not directly employed by the hospitals. They are used to fill vacancies in hospitals or temporarily substitute for absences.
- There is no method for validating the accuracy of the returns.
- The data contained in the Census is not consistent over time - i.e. ongoing refinements to the data are not carried into returns for earlier years.
- It is not clear if uniform, accurate and relevant methods are being used throughout the health service, when carrying out the Census, for matters including the estimation of whole time equivalents.

Because the health service is the biggest employer in the State, high quality information on employment and pay is essential for effective management of the system.

We have concluded that, once the appropriate information systems are in place (see Chapter 10 recommendations), a formal annual Census coordinated by the Department of Health and Children will no longer be necessary. Rather, such information should feed up from the employing body based on existing records, such as payroll information etc. Responsibility for the provision of employment information should reside with those organisations, principally the health boards, responsible for directly employing staff or funding their employment – as a condition of grant payment, voluntary bodies/agencies have a duty of accountability back to the State to provide the data necessary to manage national pay policy.

Pending roll out of the necessary information technology systems, the Census will have to remain in place.

Recommendations on Employment Information and Reports

Responsibilities for provision of Employment Information

R7.3 The CEO of each health board should be responsible for the provision of employment information both for their own direct employees and for employees of all agencies funded by the health board.

R7.4 Health boards should afford appropriate priority and resources to ensure the compilation of timely, accurate and verifiable employment data.

Employment Information to be included in Monthly Reports

R7.5 Health board CEOs should report employee numbers and pay cost data to the Executive on a monthly basis within the revised Integrated Management Reporting structure recommended at R9.3.

R7.6 The specific details of the pay and employment data to be provided in the health boards' Monthly Integrated Management Reports should be determined by the working group referred to in recommendation R4.4. At a minimum, these should include:
- (i) Detailed information on gross pay costs, by grade code;
- (ii) Details on the elements comprising pay (i.e. basic pay, overtime, shift allowances etc.), by grade code;
- (iii) Details on costs of agency working;
- (iv) Identification of approved vacancies and progress in filling new posts to support service development as set out in the annual Service Plans;
- (v) Comprehensive listing of voluntary bodies/agencies funded by each health board; and
- (vi) Similar detail as at (i) to (iv) above in respect of these voluntary bodies/agencies.

R7.7 National employment data should be reported by the Executive to the Department of Health and Children within the revised Consolidated Integrated Management Reporting structure referred to at recommendations R9.4 and R9.5.

7.5 CONTROLLING STAFFING LEVELS

The requirement to live within budgetary allocations is, and will remain, the primary means of expenditure management. However, Governments have traditionally chosen to underpin budgetary allocations with an employee numbers control framework as an integral part of the overall management structure for the public service.

The most recent example of this came in the announcement by the Minister for Finance in his Budget speech delivered on 4 December 2002 that "*the Government has decided that numbers employed across all sectors of the public service are to be capped at their present authorised levels with immediate effect. In addition, the Government has decided that there will be a reduction of 5,000 in those numbers over the next three years*"[6]. This announcement was made as part of wider efforts "*to move our expenditure, pay and cost levels onto a lower growth trajectory*" given the changed economic and financial circumstances.

We consider that there is, at least in the short to medium term, a place for an employee numbers ceiling, consistent with the overall budgetary allocation, as an additional tool in budgetary management. This is particularly the case within the health sector given the scale of employment engaged at a multitude of different levels and in a wide variety of working time arrangements. We also note the conclusion of the Independent Estimates Review Committee that "*centralised control of health service employment needs to be re-established by the Department of Health and Children as a matter of urgency*"[7].

Under current arrangements, the Department of Finance authorises the overall staffing

[6]Financial statement of the Minister for Finance, 4 December 2002.
[7]Paragraph 9.3, Estimates for Public Services 2003 - Report of the Independent Estimates Review Committee to the Minister for Finance, December 2002.

numbers. This sanctioned total, expressed in wholetime equivalents, is intended to relate to 31 December of the year in question and, hence, is verifiable by reference to the annual Census of Health Service Employees, which the Department of Health and Children takes on that date each year.

The Department of Finance indicated to us that it views the mechanism it uses for deriving the ceiling for authorised staffing levels as crude. The authorised numbers are not analysed by either employing source (e.g. health boards, hospitals etc.) or by grade. However, the underlying weaknesses of the methodology are substantially compounded by the inadequacies of the base data used to determine the sanctioned level of staffing (i.e. the annual Census of Health Service Employees).

While recognising the serious weaknesses in the methodology used to calculate the employment numbers ceiling, we are, nonetheless, concerned at the significant breaches of this officially endorsed figure by the health service employers, as illustrated Chapter 2.

Ultimately, however, an employee numbers ceiling is a crude tool that does not reflect the complex management decisions on use and substitution of resources, whether labour or otherwise, which influence output and value for money. In the longer term, we see active manpower planning (including recruitment policies, rostering arrangements etc.) as part of the ongoing function of the Executive proposed in Chapter 3. This should render crude, high-level employee numbers ceilings unnecessary.

In the meantime, a numbers ceiling must recognise the reality of service delivery if it is to be useful as a control tool – it is the number of hours worked, and when they are worked, that drive pay rather than the number of people that work them. There may, accordingly, be instances where it can be cheaper to take on extra staff on a temporary basis rather than deliver services through overtime etc. We accept, however, that until accurate data on manpower hours is available, a numbers policy must act as a proxy.

We consider that the following actions are essential to strengthen the employment control function in the health service, consistent with the regulatory role of the Department of Health and Children.

Recommendations on Staffing Limits

R7.8 The Department of Health and Children, in consultation with the Department of Finance, should obtain from the health board CEOs accurate numbers and associated costs of employment (in respect of both their own employees and employees funded by the health boards) to inform the appropriate authorised limit.

R7.9 The Department of Finance and the Department of Health and Children, with expert assistance as required, should fully review the existing methodology applied by the Department of Finance in calculating the numbers ceiling. The methodology should be based on data from health boards and have regard to the lessons learned from costings produced as part of the "benchmarking" process and to the potential future information flows generated by investment in information technology (see Chapter 10 recommendations on PPARS).

7.6 THE COMMON RECRUITMENT POOL

A "Common Recruitment Pool" operates for administrative grades (Grades IV to VII) within the local authorities, health boards and certain other health bodies and vocational educational committees[8]. Under this arrangement, any vacancies at the relevant administrative grades can only be filled from within the Pool. The Common Recruitment Pool was an agreement made in 1970 and was aimed at preserving the promotional outlets of certain employees within the Pool.

The operation of the Common Recruitment Pool means that staff in the private sector, voluntary hospitals, mental handicap agencies and the civil service are not eligible to compete for certain positions in health boards.

We consider that these arrangements are not appropriate in a modern business environment and are not conducive to achieving cost effectiveness and value for money. In particular, good financial management and control systems require appropriately qualified personnel.

The availability of skills in specific areas such as information technology, finance and human resource management will be a prerequisite to the successful implementation of our recommendations. The Common Recruitment Pool arrangement does not provide sufficient flexibility to enable these specialist posts to be filled by appropriately qualified and experienced personnel.

We note that the public sector unions and employers have agreed during the recent partnership negotiations to conduct a cross-sectoral review of pertinent recruitment issues in the health sector[9]. We believe that this provides the opportunity to introduce the necessary flexibility in recruiting the appropriate expertise.

Furthermore, at present there is no dedicated formal career structure for the finance function in health boards. This has militated against the creation of a professional finance team in health boards and has been a factor in the accounting weaknesses identified in this report.

The nature of the activities and the complex technology involved requires the finance function to be resourced with specialist finance personnel. Such staff will not just contribute to a professional finance function but will facilitate the development of a financial ethos and culture amongst operational management.

Recommendations on the Common Recruitment Pool

R7.10 The recruitment of certain key financial, human resource management and information technology personnel, necessary to the successful implementation of the recommendations of this report, should be by means of open competition i.e. from outside the Common Recruitment Pool.

R7.11 In order to develop and retain suitably qualified personnel in the areas of finance, human resource management and information technology it will be necessary to create appropriate career structures for these personnel.

R7.12 The operation of the Common Recruitment Pool should be reviewed having regard to its appropriateness to a modern public service environment, the inflexibilities it engenders and the capacity of the system to attract graduate, professional and other managers to the health service.

[8]The "Pool" consists of the health boards, local authorities, vocational education committees, General Medical Services (Payments) Board, St. James' Hospital, Beaumont Hospital, An Bord Altranais, and the Local Government Computer Services Board.
[9]Sustaining Progress; Social Partnership Agreement 2003-2005, page 101

7.7 PERFORMANCE MANAGEMENT

We believe that an effective performance management system is essential if an organisation as complex as the health service is to be managed efficiently. In this report, we have identified areas in which the management of the health services needs to be improved and accountability strengthened. To achieve this, effective performance appraisal systems are essential. It is important that good performance is rewarded and poor or underperformance is confronted – a recent Finnish study concluded that acceptance of financial reporting in the healthcare field may be accelerated by aligning the incentives of medical practitioners to the economic performance of the entity under their control[10]. An important and basic element of performance management is that an effective management information system is put in place and that reporting deadlines are met.

We strongly support the early implementation of the performance management scheme agreed in the recent national partnership negotiations as a means of achieving this goal. The text states:

"A model of performance management, integrated with service planning and human resource planning, is currently being developed for the health service. This process will be expedited and the rollout of a performance management scheme accelerated to successfully align effective utilisation of human resources with strategic and operational performance priorities. The parties will work energetically to develop and agree an appropriate national uniform system of performance management for the health service"[11]

We also believe that there is a need to develop the management skills of those charged with running the health service.

Recommendation on Management Development in the Health Service

R7.13 An accelerated management development programme should be put in place for senior managers in the health service.

7.8 SUMMARY

In this Chapter, we have noted the difficulties which exist in relation to management and costing of the pay budget, aspects of which were also referred to in Chapter 2. We have made recommendations to improve the information flows consistent with the wider reporting framework recommended in Chapter 9. This is necessary to provide a more accurate basis for manpower policy considerations going forward – as the pay bill accounts for almost 70% of current expenditure in the health service, manpower management is an essential component of the overall management framework discussed throughout the report.

We have made recommendations to improve the skills mix and management performance across the health service. This will help to maximise value for money and can also play a role in changing the culture so that good financial management is not seen solely as a finance function, in line with our core principles from Chapter 2.

[10]Kurunmaki, L., Making an Accounting Entity: The Case of the Hospital in Finnish Health Care Reforms, The European Accounting Review (1999) 8:2 pp219-237.
[11]Sustaining Progress; Social Partnership Agreement 2003-2005, page 102.

CHAPTER 8
AUDIT REFORM

In this Chapter, we look in detail at a range of issues related to audit functions and responsibilities in the health service.

8.1 OVERVIEW

A wide range of internal and external auditing reforms are necessary so that expenditure is controlled and assessed in a manner consistent with modern commercial practice. Given the scale of on-going investment in the health service, reforms will be required in the accounting standards throughout the health service. The improved systems of checks and balances will have to include changes in risk assessment and management. We also recommend that the new systems of control for the health service should include measures to protect against fraud.

Consistent with modern commercial best practice, it is imperative that the health service, as part of its general governance arrangements, ensure that strong audit committees exist, appropriate external and internal audit arrangements are in place and, in terms of enforcement, that there is a clear and unambiguous policy on fraud.

8.2 AUDIT COMMITTEES

Legislation governing health boards provides for reserved functions of the boards, with all other functions being executive functions of the CEO. Health boards may not issue a direction to the CEO in relation to executive functions but the CEO must give the board of the health board information sought by them in relation to these functions.

Best practice requires organisations to establish audit committees chaired by an independent non-executive Chairman. External auditors and internal auditors should report to the audit committee. If necessary, legislation should be amended to ensure that the reserved functions of health boards and health board CEO executive functions support implementation of best practice in relation to audit committees of health boards. However, we believe that health boards could voluntarily adopt many aspects of best practice in relation to audit committees without a change in legislation.

All health boards should establish an audit committee. These audit committees should:

- Comprise at least three non-executive directors.
- Have written terms of reference dealing clearly with authority and duties.
- Duties should include reviewing:
  - Scope and results of audit;
  - Cost effectiveness of audit; and
  - Independence and objectivity of auditors.

Members of management are not normally members of audit committees but frequently are required to attend meetings to provide the committee with any information required. The powers and functions of the audit committee, as set out in its charter or written terms of reference, should be adopted by the board.

The main function of an audit committee is to reassure the board on the system of internal

control and other relevant matters. The audit committee should report on a regular basis to the health board. In addition, the audit committee should prepare an annual report on its activities for presentation to the health board. The minutes of the health board audit committee should be available to the audit committee of the Executive and a nominated member of the Executive board should have a right of attendance at health board audit committees.

The audit committee and the board should take whatever steps are considered necessary to carry out the board/audit committee functions to the highest standards of corporate governance.

The Department of Health and Children should prepare a charter for audit committees in the health sector that sets out their powers, functions, details of membership and procedures. The audit committee charter should ensure that the detailed external and internal audit process and the consideration of external and internal audit reports should be functions of the audit committee.

In making recommendations on the establishment, and workings, of audit committees, it is important that such recommendations be responded to in a meaningful way. Recent global corporate scandals have shown that the mere existence of an audit committee is not sufficient. A necessary condition to the successful operation of audit committees is that they adopt best practice in a substantive and meaningful way.

The principles outlined for audit committees of health boards should extend to (i) the Department of Health and Children, (ii) agencies and other bodies under the remit of health boards and (iii) other statutory agencies in the health services.

When making the necessary legislative amendments, to facilitate the recommendations throughout this report, consideration should be given to making audit committees a mandatory feature of boards' revised governance arrangements.

Recommendations on Audit Committees

R8.1 The Secretary General of the Department of Health and Children, the board of the Executive, boards of the regional health boards, boards of agencies and other bodies under the remit of health boards and boards of other statutory agencies should all establish an audit committee.

R8.2 The audit committee of the Department of Health and Children, of the Executive, of the regional health boards, of boards of agencies and other bodies under the remit of health boards and of other statutory agencies should:
- (i) Be chaired by:
  - (a) an independent outside person in the case of the Department of Health and Children;
  - (b) a non-executive member of the board in all other cases.
- (ii) Comprise at least three members, all of whom should be:
  - (a) independent outside persons in the case of the Department of Health and Children;
  - (b) non-executive members of the board in all other cases.
- (iii) Report on a regular basis to the Secretary General/board;
- (iv) Prepare an annual report for the Secretary General/board, which, inter alia, should include a copy of its charter.

R8.3 The audit committee should be required to follow best practice in ensuring independence and effectiveness in relation to internal audit, risk management and external audit (including managing relations with the external auditor).

R8.4 If necessary, legislation should be amended to facilitate these recommendations.

8.3 EXTERNAL AUDIT

The annual financial reporting cycle is not completed until the external auditor signs off on the statutory accounts. We are aware that the audit of health board accounts has, on occasion, not been completed until more than 18 months after the end of the year to which they refer. This is highly unsatisfactory.

It is clear from the Comptroller and Auditor General's management letters that timeliness is a problem across the health service. This has already been discussed under problem 5 in Chapter 2.

Timeliness of Audits

It is a fundamental principle of accounting that information should be available in a timely manner. Legislation reflects this by specifying deadlines within which health boards are required to report. There are two key deadlines:

- Health board Annual Financial Statements to be approved by the board of the health board and available "ready for audit" no later than 1 April in the year following the year end.
- The audit of these Annual Financial Statements by the Comptroller and Auditor General to be available not later than 30 September in the year following the year end.

Table 8.1 shows the actual audit completion dates for the eight health boards[1] for the accounting years 1998 to 2000. In no case were audited financial statements of the health boards available by the statutory deadline of 30 September. Breaches ranged from one month to ten months. By January 2003, only two audits had been completed for the health boards in

[1]Prior to the formation of the Eastern Regional Health Authority (ERHA) and its three area health boards, there were only eight health boards – there are now 10, not including ERHA.

respect of 2001. The Comptroller and Auditor General indicated to us that the Eastern Regional Health Authority and its three area health boards, established in 2000 to replace the Eastern Health Board, experienced significant difficulties in producing accounts for 2000 to an auditable standard. Fundamental questions about these accounts were not resolved until relatively recently and certification is expected shortly.

Table 8.1: Dates of Health Board Audit Certificates

	Audit Certificate Date (no. months late)					
Accounts Year Ended 31.12	**1998**		**1999**		**2000**	
Health board	Date Audit Completed	Months Late	Date Audit Completed	Months Late	Date Audit Completed	Months Late
Eastern Health Board	29/2/00	5 months	9/7/01[2]	7 months	Still incomplete	
Midland Health Board	7/2/00	4 months	18/12/00	3 months	17/1/02	4 months
Mid-Western Health Board	17/12/99	3 months	17/1/01	4 months	26/3/02	6 months
North Eastern Health Board	23/12/99	3 months	3/1/01	3 months	8/2/02	4 months
North Western Health Board	16/3/00	5 months	9/11/00	1 month	24/1/02	4 months
Southern Health Board	23/12/99	3 months	15/12/00	2 months	1/2/02	4 months
South Eastern Health Board	23/12/99	3 months	28/2/01	5 months	20/2/02	5 months
Western Health Board	23/12/99	3 months	12/12/00	2 months	30/7/02	10 months

Source: Department of Health and Children

The Comptroller and Auditor General explained why this situation had arisen as follows:

- Firstly, the Office of the Comptroller and Auditor General had experienced staff shortages arising from difficulties in retaining appropriately qualified personnel in his Office.
- Secondly, health boards appear to concentrate on meeting their own legal requirement to have Annual Financial Statements approved by their boards. Once this is done, senior management in health boards appear to attach little priority to securing audited financial statements.
- Thirdly, lack of preparedness for audit, delays in responding to requests for information necessary for the completion of audits and changes in key staff in health boards have all been identified as causes of delay in completing audits.

Arising from staffing difficulties, and in an effort to meet his statutory auditing deadlines, the Comptroller and Auditor General has outsourced some of his audits of health agencies (but not health boards) to private sector firms. This exercise met with mixed results, suggesting that even when adequate audit resources were available (whether from within his Office or from

[2] As part of the transition to the Eastern Regional Health Authority, the accounting period for this year ended on 29/2/00.

outsourcing) some agencies were unable to facilitate an expeditious audit.

We were also informed that, for the majority of health boards, despite the delay between draft approval by health boards and final audit certification by the Comptroller and Auditor General, there are only minor amendments from the draft financial statements to the final financial statements, which would suggest that, at least in some cases, health boards accounts are "ready for audit" following approval by the health board in April.

Table 8.2 below shows that two health boards/authorities failed to meet the deadline of 1 April 2002 by which they were required to have their 2001 accounts certified. Such delays contribute to the delay in completion of the external audit. In the case of every health board/authority the statutory deadline of 30 September 2002 for completion of the 2001 external audit has not been met. At the time of completing this report (31 January 2003) only two external audits have been completed for health boards/authorities in respect of the 2001 financial year.

Table 8.2: Dates of Health Board Approval of Annual Financial Statements and Audit Certificates for the Year Ending 31 December 2001

Health board	Date Annual Financial Statements Certified by Health Board (no. months late)		Audit Certificate Date (no. months late)	
Eastern Regional Health Authority	02/05/02	1 month		Still incomplete
Midland Health Board	21/03/02	On time	17/01/03	3 months
Mid-Western Health Board	25/03/02	On time		Still incomplete
North Eastern Health Board	25/03/02	On time		Still incomplete
North Western Health Board	28/03/02	On time		Still incomplete
Southern Health Board	28/03/02	On time		Still incomplete
South Eastern Health Board	28/03/02	On time	23/12/03	2 months
Western Health Board	04/11/02	7 months		Still incomplete

Source: Department of Health and Children

In the case of companies incorporated under the Companies Acts, the Director of Corporate Enforcement has the function of investigating and prosecuting breaches by companies of their statutory obligations. Consideration should be given to the establishment of similar sanctions for bodies corporate in the public sector. In the meantime, we believe that it is important that failure to meet deadlines is made public and repeated breaches of these obligations carry sanctions for the CEO.

Recommendations on Monitoring Timeliness of Financial Reports

R8.5 The draft statutory accounts must be approved by the health board by 1 April following year end and the audited statutory accounts must be completed by the C&AG and laid before the Houses of the Oireachtas within 9 months of year end in accordance with current statutory requirements. Where this requirement is not met, the CEO should be required to provide a written explanation to the Secretary General, for inclusion in his report referred to at R8.6(v), setting out the reasons why these statutory deadlines have not been met.

R8.6 The Department of Health and Children should publish on its website details of the performance of health boards/agencies in terms of meeting their financial accounting responsibilities, including:
- (i) Year end date;
- (ii) Date financial accounts/statements are finalised/submitted;
- (iii) Date audit completed (including section 6(4) reports, if any, on the accounts);
- (iv) Details of organisations failing to meet their deadlines should be highlighted in an appropriate manner; and
- (v) Publish and widely circulate a report with commentary on performance annually by 1 January each year i.e. 12 months after the period to which the report relates.

We recognise that the Comptroller and Auditor General has complete constitutional independence and is accountable only to the Dáil for the performance of his functions. Nonetheless, we believe that the Comptroller and Auditor General fully supports efforts to improve standards of accountability in the health services and the public sector generally. In particular, we believe the Comptroller and Auditor General would welcome any steps to deal with persistent breaches of statutory accounting and auditing obligations. For these reasons, we believe that the Comptroller and Auditor General should be required to make an annual declaration by 1 January of each year to the Public Accounts Committee certifying (i) the bodies which he has audited / caused to be audited in accordance with statutory obligations and (ii) the bodies which he has been unable to audit. His report should state the reasons for the latter inability, distinguishing between (i) delays caused by the auditee and (ii) delays caused by lack of resources or other aspects of the operation of his own Office. In the latter case, the Comptroller and Auditor General should indicate the steps required to remedy the problems leading to such delays.

Recommendation on a Declaration by the Comptroller and Auditor General

R8.7 The Comptroller and Auditor General should lay before the Public Accounts Committee a report (with commentary) on performance in meeting accounting and auditing deadlines annually by 1 January each year i.e. 12 months after the period to which the report relates.

Audit by the Comptroller and Auditor General

The Comptroller and Auditor General provides up to two possible outputs of his audit: a "section 6" report and a management letter.

Section 6(4) reports: Where significant issues arise during an audit these are referred to in the Comptroller and Auditor General's section 6(4) reports. Such reports allow the Comptroller and Auditor General to report on matters he deems appropriate to report, following his examination of the system of internal control operated by health boards. Such reports are unsatisfactory. Section 6(4) reports that do not refer to any specific items are clean

audit reports. A number of examples of section 6(4) reports are set out in Chapter 2.

Management letters: This is a letter from the auditor setting out issues arising from the audit but which were not of such significance as to merit mention in the audit report. The normal procedure followed is for the auditor to draft the management letter and send it to management (i.e. the CEO/chief financial officer) for their comment and responses to the items and issues raised. The final version of the letter contains management responses to the auditor's points.

The management letter refers to a small number of minor areas where some improvements can be made. It would be unusual for there to be many items referred to in such letters or for these items to relate to fundamental issues. We examined the management letters from the Comptroller and Auditor General to the health boards. A number of aspects of these management letters, though not significant enough to substantially affect the overall veracity of the audited financial statements, are worth drawing attention to:

- Firstly, the kind of items and issues being raised reflect basic errors and problems that suggest poor standards of accounting and weaknesses in administration procedures in some health boards.
- Secondly, we noted that, while all points raised by the Comptroller and Auditor General were responded to, in some cases the Comptroller and Auditor General had to write one or more reminders requesting the health board CEO/chief financial officer to respond to the management letter points.
- Thirdly, we noted that in almost all cases, responses to the management letter were not provided for at least six months.
- Lastly, we were surprised at some of the comments by management to what appeared to be very valid points raised by the Comptroller and Auditor General. In some instances, points raised were not treated with the seriousness that they deserved.

8.4 INTERNAL AUDIT

The Comptroller and Auditor General reported[3] that all eight health boards (then existing) had an internal audit unit. Three aspects of the internal audit function are of concern to us (i) resourcing of internal audit, (ii) powers and duties of internal audit and (iii) reporting lines.

Resourcing Internal Audit

A review of the role of internal audit in the health boards in 1995 found that internal audit was at that time "*underdeveloped and generally regarded as a backwater operation.*"[4] The Comptroller and Auditor General reported[5] that the scope of internal audit varies in the eight health boards examined, <u>depending on the remit given to it.</u> In his 2000 report, he noted that"*many Boards lack specialist personnel in these areas*" and that "*lack of resources is a problem in a number of units which militates against the proper organisation of the unit*". Since then, progress has been made with many boards now having fully qualified internal audit teams, staffed to approved levels.

However, we believe the internal audit function in the Department of Health and Children is underresourced. The report *Internal Audit Review* prepared by the Department of Finance in September 1999, indicates that only one member of staff (a Higher Executive Officer) was assigned to the internal audit unit. We are aware that since then the unit has been increased to

[3] *Internal Audit in Health Boards,* Comptroller and Auditor General, August 2000, p.4.
[4] *Internal Audit in Health Boards,* Comptroller and Auditor General, August 2000, p.5.
[5] *Internal Audit in Health Boards,* Comptroller and Auditor General, August 2000, p.4.

two staff headed by an Assistant Principal. The Department of Finance expressed the concern that internal audit units should have the capacity to enable them to operate effectively and to be well placed to bring to the accounting officer issues arising from inadequate or ineffective systems. The internal audit function in the Department of Health and Children concentrates only on the ¤30 million or so administrative spending incurred directly by the Department. Pending the establishment of the Executive, we consider that internal audit systems should be put in place to cover the entire ¤9 billion of health service spending.

Recommendations on Internal Audit

R8.8 The Secretary General of the Department of Health and Children, the board of the Executive, boards of the regional health boards, boards of agencies and other bodies under the remit of health boards and boards of other statutory agencies should ensure that there is an adequately resourced internal audit function. Where it is considered inefficient, for reasons of scale, for an agency to have a dedicated internal audit unit, the regional health boards should either provide the service centrally or have the function outsourced.

R8.9 The internal audit unit should report directly to the non-executive Chairman of the audit committee.

R8.10 The audit committee should determine powers and duties of the internal audit unit.

R8.11 Internal audit reports should be made available to the external auditor.

8.5 RISK ASSESSMENT AND MANAGEMENT

During the course of our work, we encountered a number of examples where the assessment of risk associated with policy decisions (and the management of those risks) was not adequately undertaken. For example, in Chapter 2, we highlighted the outcome of the negotiations relating to the extension of the medical card to all people over 70 years. In this case, the full risk, for a range of reasons, was not identified nor arrangements made for the management of the risk at the time the decisions were being taken.

We believe that the Department of Health and Children must have a strong, proactive risk assessment role in relation to the development and monitoring of national policies. This would cover two broad areas; risk assessment at policy design stage and risk management at operational/executive levels. We recommend that the Department of Health and Children substantially enhance its capabilities in this area.

Policy Risk Assessment

A professional assessment of the risks associated with national service development, building in the necessary control measures in advance of the introduction/extension of new services, is essential. In this national policy context, risk assessment involves systematically (and at the very earliest stages of policy development) analysing, evaluating, monitoring and communicating the risks associated with planned activities so that potential losses are minimised and opportunities are exploited in the best interests of the taxpayer.

Risk Management

In this context, we refer to "risk management" as the ongoing monitoring and review of systems and procedures in place in all bodies responsible for service delivery (the Executive, regional health boards, hospitals, voluntary agencies etc.). As such, we see the risk management function

as relating to operational matters – the implementation, as opposed to the development, of Government health policy. All agencies, at all levels, need to have effective risk management procedures in place.

The Department of Health and Children should take the lead role in approving the overall risk policy and tolerance for the health service. They will have to satisfy themselves on the effectiveness on the overall risk management framework and that the key risks are managed to an acceptable level. The risk management function in the Department of Health and Children should implement and communicate risk management strategy, policy and procedures across the health service. In terms of its development of risk management capabilities, the Department of Health and Children should adopt best practice standards.

It would then be a matter for the internal audit function in the Executive and in each health board/agency at local and regional levels to ensure that effective risk management procedures are in place. The internal audit function will be responsible for the ongoing review of the overall effectiveness and suitability of the risk management framework at regional and agency level in the context of Departmental policy. The internal audit unit should report regularly to the audit committee in that regard while the Department of Health and Children would have an oversight role at national level.

Recommendations on Risk Assessment and Management

R8.12 A systematic assessment of all risks (including financial, operational and clinical risks) must be a central and integral part of all policy development and ongoing operational activity.

R8.13 A Risk Assessment Unit should be established with immediate effect by the Secretary General of the Department of Health and Children with the task of:
- (i) Supporting policy makers; and
- (ii) Driving the implementation of risk management policy and procedures down to local and agency levels.

R8.14 In respect of R8.13(i) the role of the Risk Assessment Unit should be to:
- (i) Support in an integral and ongoing way national policy developments and negotiations;
- (ii) Provide technical support and advice to individual officers/sections on the identification and management of risks at policy design stage;
- (iii) Advise on the design and execution of control measures to minimise risks; and
- (iv) Review the conduct of risk assessment procedures on new services/schemes within the Department of Health and Children.

R8.15 In respect of R8.13(ii) the role of the Risk Assessment Unit should be to:
- (i) Develop, implement and communicate risk management strategy, policy and procedures across the health service;
- (ii) Develop and co-ordinate risk management information requirements, reporting thresholds and mechanisms for determining priorities;
- (iii) Develop, promote and maintain common methodologies for identifying and assessing risk and determining adequacy and cost effectiveness of controls;
- (iv) Identify and assess accumulations of risk across the health service and interdependencies; and
- (v) Co-ordinate risk management activity, training and technical support, across the health service.

R8.16 A working group should be established to bring forward a report on best practice in terms of risk assessment and risk management in the health sector.

R8.17 The Risk Assessment Unit should make half-yearly reports to the Management Advisory Committee of the Department of Health and Children on the ongoing effectiveness of, and compliance with, national risk management policy.

R8.18 Internal audit units in all health service agencies should make half-yearly reports to the Chairman of their local audit committees on the effectiveness of the risk management procedures in place in their organisation. Any legislative amendments to facilitate this should be implemented.

8.6 FRAUD

It is essential that all staff in the health services be aware of the possibility of fraud and be conscious of their individual duties and responsibilities in preventing fraud. The health services have a budget of almost ¤ 9 billion in 2003. In view of the wide range of operations in the health services it is possible that fraud may occur. In order to give assurance to the Irish taxpayer, to patients and consumers and to staff, it is important to have a clear policy on fraud that should be communicated and applied consistently throughout the health services.

There are a number of elements that assist in preventing fraud. These include:

- Staff awareness of the potential for fraud;
- Strong internal controls built into all operations;
- Consideration of internal control and risk management in designing new developments, schemes etc;
- Strong internal and external audit functions;

- Penalties for fraud, including policies for prosecuting fraud, for staff found to have committed fraud; and
- Opportunities for staff to report suspicions of fraud in confidence and without fear of reprisals or other adverse consequences of carrying out their duties to their employer and the Irish taxpayer. On the contrary, such staff should be rewarded for taking steps to reduce fraud in their organisation. Such reports should go to someone other than management (who may be implicated in or compromised by the finding of fraud) such as the internal auditor.

Recommendation on Fraud Policy

R8.19 The health board CEOs should submit, for approval by the Secretary General of the Department of Health and Children, a written fraud policy statement covering all health boards and all organisations under their aegis.

8.7 SUMMARY

In this Chapter, we have made recommendations to improve the timeliness and content of financial reports and audits, problems with which were previously described in Chapter 2.

We have also made recommendations to bring internal audit procedures into line with best practice generally and to introduce a comprehensive risk assessment and risk management function. Progress in these areas would provide assurance that systems are operating properly and, thus, help ensure that the kind of problems described in Chapter 2 (for example, the over-70s medical card extension, the childcare workers pay deal, unauthorised expenditure being incurred and due charges not being imposed) are not repeated.

CHAPTER 9
EXTERNAL REPORTING PROCEDURES

In this Chapter, we look at the information which financial and management reports "up-the-line" should contain and the reporting deadlines that should apply.

9.1 OVERVIEW

Monitoring and management information is essential to the efficient functioning of any complex organisation. In this regard, all budget, financial and non-financial reports must be (i) relevant, (ii) clear and concise, (iii) up to date and (iv) available as early as possible. Reporting systems must be geared to deliver these objectives. We conclude that some of the current arrangements between service providers and the Department of Health and Children are not adequate. The essence of our recommendations is that the reporting mechanisms should be designed to provide regular updates (monthly, quarterly and annual) on performance against Service Plans at all the levels identified in Chapters 4 and 5. We have set out the changes that are necessary to address these issues.

9.2 MANAGEMENT REPORTING

Each health board is required to submit an Integrated Management Report to the Department of Health and Children on a monthly basis (*see Appendix 4*). Reports are to be submitted by the 25th day of the month following the month under review. This report derives from the aggregation of internal reporting on activity and financial performance by each of the micro-units (hospital, community care areas etc.) and funded agencies that fall under the aegis of each health board. The Department of Health and Children in turn prepares a consolidated report covering all the health service providers, which they then provide to the Department of Finance.

The monthly Integrated Management Report sets out the health board's current financial position, identifying variances from budget. This numerical information is aggregate information only and variances are not analysed by programme or care group. A CEO commentary must accompany the monthly Integrated Management Report as this allows the board and the CEO to discharge their specific responsibility as required under the 1996 legislation.

In Chapter 4, we highlighted the inadequacies as we see them of the existing service planning arrangements for the management of a modern health service. These inadequacies include (i) differing report formats between agencies, (ii) a concentration on plans for service development money (i.e. an inadequate focus on core funding/activity) and (iii) weak links between activity and funding. These inadequacies have direct consequences for the quality and content of reporting against Service Plan.

In addition to this, we are aware of delays that have arisen in respect of the submission of the Integrated Management Reports from the health boards to the Department of Health and Children. In *Appendix 8* it can be seen that some health boards may exceed the 25 day reporting deadline by several weeks on some occasions. As a result the consolidated reports

from the Department of Health and Children to the Department of Finance, which are supposed to be made monthly, are only submitted intermittently.

We have concluded that existing reporting arrangements between the service providers and the Department of Health and Children fail to meet some or all of the criteria mentioned at section 9.1 above. Reports are being submitted in a variety of formats, many of them late, and containing no links between activity and expenditure.

It is not possible at the national level for the Minister for Health and Children and the Minister for Finance to plan or determine important and timely responses to emerging spending and service pressures without comprehensive financial and activity data being provided each month by health service providers. While the financial data in the Integrated Management Reports are largely reported on time, there appears to be an acceptance that reporting on non-financial performance to the national level is given lesser priority by health service providers when considered against their own management requirements on the ground. Furthermore, the fact that late submission of reports has been allowed to persist by the Department of Health and Children and the Department of Finance gives rise to some questions as to the usefulness and use made of the management information gathered for the Departments. Elsewhere in this report (Chapter 10), we make recommendations in respect of the IT investment necessary to support financial management in the system. We believe that this investment must be accompanied by fundamental change in the culture described above and that there be a commitment to produce timely and accurate financial and activity reports.

We understand that, from the point of view of the health boards, their bottom line is the delivery of their own regional/local Service Plan within budget. From their point of view, the monthly Integrated Management Report is simply a consolidated position of boards' financial, human resource and activity performance used for reporting to the Department of Health and Children. Its submission, late or otherwise, does not hinder the process of internal reporting in the health board area or the taking of corrective action by health boards to deliver a balanced budget.

However, we take the view that the monthly Integrated Management Reports (appropriately developed) are cornerstones of the overall management of health expenditure at the national level. They are an imperative and the health service providers should regard them as an integral part of their own internal reporting and management structures. In this regard, mirroring the recommendations for service planning, reporting mechanisms must penetrate the internal systems of the health boards right down to the level of those responsible for making decisions on expenditure. This is consistent with our second core principle articulated in Chapter 2.

We believe that all routine reports should be built around the various Service Plans. Consistent with our recommendations in Chapter 4 on standardising the format and content of Service Plans throughout the system, we consider that monthly, quarterly and annual reports at all levels should also, as far as possible, follow a standardised format (see recommendation R4.4 in this regard).

For each of the recommendations R9.1 to R9.5 below, the "reports" cover all routine reports (monthly Integrated Management Reports, quarterly Performance Indicator Reports and Annual Reports/CEO commentary).

Recommendations on Reports from Health Service Providers to Health Boards

R9.1 With regard to general hospital expenditure:

(i) The Head of Specialty/Head of Department/business manager should prepare standardised reports containing:

(a) The plan for the month (financial and activity) as set out in the specialty/department Service Plan;

(b) Performance against plan;

(c) Details of variance against plan;

(d) Clear explanations for variance; and

(e) Action to be taken (if any) to bring performance back in line with plan.

(ii) All reports should follow the same format as the Service Plan and measure performance against this benchmark.

(iii) The Head of Specialty/Head of Department/business manager should provide reports to hospital CEO within 10 days of the end of the period to which they refer.

(iv) The hospital CEO should provide the health board CEO with consolidated reports within 15 days of the end of the period to which they refer.

R9.2 With regard to non-hospital expenditure:

(i) The General Manager should prepare standardised reports containing:

(a) The plan for the month (financial and activity) as set out in his/her Service Plan;

(b) Performance against plan;

(c) Details of variance against plan;

(d) Clear explanations for variance; and

(e) Action to be taken (if any) to bring performance back in line with plan.

(ii) All reports should follow the same format as the Service Plan and measure performance against this benchmark.

(iii) The General Manager should provide the health board CEO with reports within 10 days of the end of the period to which they refer.

It will then be necessary for CEOs of the regional health boards to consolidate the reports from the various programmes and hospitals within their area and provide a consolidated report to the Department of Health and Children and, in time, the Executive. As already indicated in recommendation R7.5, these reports should also contain data on employee numbers and pay costs.

Recommendation on Reports from Health Boards to Department of Health and Children/Executive

R9.3 Reports should be:

(i) Prepared in a standardised format across health boards/agencies.

(ii) Contain information on:

(a) The plan for the month (financial and activity) as set out in the health board Service Plan;

(b) Performance against plan;

(c) Details of variance against plan;

(d) Clear explanations for variance;

(e) Action to be taken (if any) to bring performance back in line with plan; and

(f) The health board balance sheet.

(iii) Submitted by the health board CEO to the Department of Health and Children/Executive within 20 days of the end of the period to which they refer.

Similarly, it will be for the Executive to consolidate reports from the health boards and from those hospitals providing a national service that report directly to the Executive and provide this consolidated information to the Department of Health and Children. As already indicated in recommendation R7.7, national employment data should be included in these reports. This completes the chain and ensures consistency of reporting (formats and content) across all agencies and levels while taking due account of their differing needs in terms of the level of detail required.

Recommendations on Reports from the Executive to the Department of Health and Children

R9.4 Reports from the Executive to the Department of Health and Children should provide information on performance against budget. This analysis should be provided:

(i) By health board and care group (e.g. child care, disabilities (intellectual and physical), general hospital services etc.);

(ii) Include supporting data detailing activity/output measured against benchmarks set in the Service Plans; and

(iii) Include corrective measures to be taken (as necessary) to bring expenditure back on budget.

R9.5 Reports should be submitted by the CEO of the Executive to the Department of Health and Children within 25 days of the end of the period to which they refer.

9.3 POLICY REVIEW PROCESS (EXPENDITURE REVIEW PROGRAMME)

The Expenditure Review Programme operates across all Government Departments. Its objectives are to analyse in a systematic manner what is being achieved by Exchequer spending and to provide a basis on which more informed decisions can be made on priorities within and between programmes. Reviews are usually undertaken by the relevant Department, under the aegis of a joint steering group representing both the Department and the Department of Finance.

A Central Steering Committee chaired by the Secretary General of the Department of Finance oversees the process. Expenditure Review topics are approved by Government on a rolling basis; most recently in April 2002 for the first year of the current three year planning horizon of 2002 to 2004.This process needs to be developed further in the Department of Health and Children.

Expenditure reviews should, of their nature, be based on more in-depth information than that available through the routine monitoring reports recommended above. It is important that the reviews, as a matter of best practice, should always involve the participation of the Department of Finance and other relevant Departments/agencies as appropriate. The standard terms of reference[2] for each review include:

- Identifying programme objectives;
- Examining their continued validity;
- Examining the effectiveness and efficiency with which these objectives have been achieved;
- Evaluating the degree to which the objectives warrant the ongoing allocation of public funds;

[2]Source: Department of Finance

- Measuring the outputs associated with programme activity, examining scope for alternative approaches; and
- Defining performance indicators.

This process would have benefits for both the Department of Health and Children's policy function, in terms of improved policy information/input, and the Executive, in terms of ensuring continuing value for money in expenditure by facilitating a regular cycle of in-depth programme reviews to complement their more routine, ongoing evaluation role.

Recommendation on Health Policy Reviews

R9.6 The Secretary General of the Department of Health and Children should proactively promote the expenditure review process on a continuous and systematic basis within his Department by:

(i) Setting up and chairing a steering group to oversee reviews; and

(ii) Through the forum of the steering group, and consistent with Government requirements in this regard, identify and propose on a continuing basis those areas of expenditure that would benefit most from

9.4 ANNUAL FINANCIAL STATEMENTS AND ANNUAL REPORTS

We noted in Chapter 2 that health boards have to prepare statutory financial accounts that comply with the accounting standards laid down by the Minister for Health and Children for the purposes of audit by the Comptroller and Auditor General. The format and content of these accounts are very significantly different to the monthly Integrated Management Reports and Service Plans prepared by the health boards and it is not possible to make a link between them.

The Annual Financial Statement need to be transformed into a document which reflects the governance arrangements in health boards and become more relevant to the services that are being delivered. A tripartite approach involving the health boards, the Department of Health and Children and the Comptroller and Auditor General should advance this by working on linking the Financial Statements with the Annual Report and integrating non-financial data with the Annual Financial Statements.

Recommendation on the Annual Financial Statement

R9.7 The Annual Financial Statement prepared by the health boards should be tied in more clearly and in a more relevant manner to the services that are being delivered. In this regard, the CEO should prepare a reconciliation document that makes it clear how the figures in the final (i.e. December's) Integrated Management Report of the financial year have appeared in the Annual Financial Statement and Annual Report.

At present health boards must, no later than 30 June in each year, prepare and adopt an Annual Report in relation to the performance of its functions during the preceding year. This report must include a statement on the services provided by the board in the preceding year and any other particulars (including financial statements) that the board considers appropriate or that the Minister specifies (*see Appendix 4*). However, Annual Financial Statements must be adopted by each health board and submitted to the Comptroller and Auditor General by

end-March following the previous year-end. We believe that best practice should require that the deadlines for the preparation and submission of the Annual Report and the Annual Financial Statement should be the same.

Recommendation on the Annual Report

R9.8 The Annual Report prepared by the health boards should be adopted by health boards at the same time as the Annual Financial Statement which is by 31 March following the previous year end.

9.5 SUMMARY

In this Chapter, we note that current management reporting arrangements, right up to Department level, are unevenly applied. We have made recommendations to introduce a standardised reporting framework, detailing what we consider to be appropriate content and timescales. We have recommended a format consistent with that recommended for Service Plans in Chapter 4. This facilitates comparison of output/outturn with the original plans/ budgets. Effective reporting mechanisms are essential if we are to hold those spending the money accountable for their performance, as proposed in Chapter 5 and Chapter 6 and consistent with our core principles from Chapter 2.

CHAPTER 10
INFORMATION SYSTEMS

In this Chapter, we look at the information technology (IT) implications of our recommendations for the health service. The various recommendations made by us throughout the report require the integration of financial, human resources/personnel and clinical activity information down to patient level.

10.1 OVERVIEW

There has been under development of information systems throughout all aspects of the Irish health service from policy-making through to implementation. There needs to be an accelerated programme of investment in information systems to extend SAP and PPARS to all major spending agencies.

SAP is a fully integrated software package with available modules including financials, materials management, human resources, payroll, asset management and asset maintenance. PPARS (Personnel, Pay, Attendance and Recruitment System) is the human resource module of SAP. SAP financials are in use in the Eastern Regional Health Authority, Midland Health Board and North Eastern Health Board. PPARS is a national project and the first phase is in operation in five health boards and St. James' Hospital. Current developments will see the remaining boards and larger hospitals developing specifications to implement SAP financials and PPARS.

10.2 THE CASE FOR IT INVESTMENT

Clinicians need to have access to cost, performance and clinical outcome information in order to provide quality health care in an efficient and effective manner. The international literature indicates that throughout the world countries/jurisdictions are striving to improve the quality of health care information. This requires significant State investment in information systems and human resources.

The case for increased investment is twofold. Firstly, at a health board/agency level, IT investment will deliver more process efficiency. IT facilitates the re-engineering of business processes from inefficient manual processes to the most efficient automated processes. A common system for the differing processes also allows the development of shared services to optimise efficiencies and concentrate expertise.

Secondly, the real gain will be in the quality of information that becomes available to managers at all levels to enable more timely and effective decision making as well as benchmarking across similar hospitals, departments and services to deliver a more effective, optimum service.

We note that the Independent Estimates Review Committee said *"the strengthening of information systems should command a higher priority and implementation of improved personnel systems should be accelerated so that value for money can be better assessed"* [1]

The main benefits of increased IT investment can be characterised as strategic and operational.

[1]Paragraph 9.4 Estimates for Public Services 2003 - Report of the Independent Estimates Review to the Minister for Finance, December 2002.

Strategic benefits include:

- Enhanced performance evaluation, planning and monitoring;
- Devolved budgetary control and management;
- Benchmarking and comparative analysis based on best practice; and
- Improved financial transparency.

Operational benefits include:

- Systems and processes which allow users to focus on service delivery;
- Regular, timely and accurate financial information and reporting;
- Financial and related activity analysis;
- Reduction in resources involved in financial transaction processing;
- Increased focus on value for money and greater transparency in resource use; and
- Improved budgetary control and financial management of resources.

10.3 CONDITIONS

We have no doubt that there is an IT deficit in the health sector and that significant investment is overdue. However, it has to be understood that investment (of many millions of euro) in IT will not, of itself, solve the problems of the health service. Spending additional resources on IT systems without fundamental changes to the health system will not deliver the value for money benefits that are regularly cited to support such expenditure. The amount of money involved is substantial and for this reason the greatest of care must be taken to ensure that the expenditure takes place under conditions that will deliver on the value for money expectations.

Resources and skills in change management will be needed to gain full value from the proposed investment in information systems. We have seen what has been achieved in the Midland Health Board in terms of management information generated by new IT systems (*see Appendix 9*). On the other hand, it was suggested to us that where there had been expenditure on IT in the health services, the expected benefits were not always achieved because personnel had not changed their pre-existing practices and had not adapted to the new IT environment. Commensurate with the expenditure on IT, a change management programme is needed to ensure that the transition from old to new ways of running services takes place.

It is normal practice when seeking sanction for investment in IT systems that management draw up a comprehensive business case indicating the value added by the proposed systems – to do otherwise risks wasting public funds. The standard business case in this instance covers:

- The business context: why it is being done and its fit with strategic priorities;
- The expected benefits: strategic, process effectiveness and efficiency;
- The costs: including staff, consulting, licensing, support, maintenance, managed service, hardware, software; and
- Risks/challenges: culture change required, commercial risk, project management and governance, change management.

We believe that it is imperative that the business case made should be expanded to provide greater assurance that the proposed IT expenditure will deliver the outcomes specified. In

particular, we believe that it should be an essential pre-condition of investment in IT that the business case include specification of:

- Staff (including their skills and qualifications) that will operate the new systems and/or design the outputs that will be drawn from the system;
- Specific organisational change that is necessary for the successful implementation of the project;
- Changes in information flows and use and the advantages that such information will provide vis-à-vis existing arrangements;
- Internal mechanisms to be put in place to make sure that the structural changes and the project are delivered on time and within budget;
- Involvement of internal audit and finance staff to ensure that internal controls are not compromised by the changeover to the new system; and
- A detailed programme for implementation.

A business case that does not contain this level of information should not be considered. If we are serious about getting the best value from significant public investment in IT then we must be provided with the greatest possible degree of certainty that that value will be derived from the investment.

Foremost among the conditions necessary to successfully implement and extract maximum value from IT investment is the need to invest in expertise (financial, IT and human resource management personnel) to analyse, evaluate and interpret the upgraded systems to fully exploit the benefits they can offer. The barriers to recruitment of appropriately trained and qualified staff must be addressed as a matter of urgency. In this regard, we noted in Chapter 7 that the public sector unions and employers have agreed, in recognition of the nature of the Common Recruitment Pool system, to conduct a cross-sectoral review of pertinent recruitment issues in the health sector. We believe that this provides the opportunity to introduce a new flexibility in recruiting the necessary expertise.

The implementation of a programme of investment must also be placed within the wider context of the process of structural and cultural reform set out in this report. If the deficits we have identified are not addressed or if there are no substantive changes in the pervasive culture of the system of financial reporting examined in Chapter 9, investment on its own will change very little. Information systems are simply a tool, not an end in themselves. As such, the full benefits of investment in IT systems can only be realised within a restructured health service where the focus, at all levels, is on continuing to improve effectiveness and efficiency and where there is a willingness amongst all staff to account for their performance in this regard.

Recommendations on Information Systems

R10.1 The information systems necessary to support financial management and control systems recommended in this report should be built around SAP and PPARS.

R10.2 This investment should be subject to:
- (i) Prior arrangements being put in place to ensure that appropriate use can and will be made of new systems as evidenced in a detailed business case as outlined in the text above;
- (ii) Parallel implementation of the wider organisational changes we recommend throughout this report; and
- (iii) The recruitment of certain key financial, human resource management and information technology personnel, necessary to the successful implementation of the recommendations of this report, should be by means of open competition i.e. from outside the Common Recruitment Pool (see also recommendation R7.10).

R10.3 There should be an acceleration in investment so as to achieve the early implementation of the following:
- (i) SAP financials installed in all health boards and the major teaching hospitals[2];
- (ii) PPARS (Phase 1) fully implemented in the outstanding sites (South Eastern Health Board, Southern Health Board, Beaumont, Mater, St Vincent's and Tallaght hospitals); and
- (iii) PPARS (Phase 2)[3] implemented in the health boards and the major teaching hospitals.

R10.4 Roll out of PPARS should continue to be driven by the National PPARS Office, to ensure a consistent and uniform national approach, and that Office should liaise on a monthly basis with the Implementation Committee referred to at R11.2.

R10.5 Hospital information systems which provide information on patients and their procedures (i.e. number of tests, x-ray, lab time, theatre, drugs etc.) be rolled out to all acute hospitals and integrated with the financial and HR systems at R10.3 above.

R10.6 Funding for the IT strategy should be ring-fenced to ensure that:
- (i) The funding is solely for specified IT investment;
- (ii) There is increased transparency of where the investment occurs; and
- (iii) There is clear measurement of the improvements in management information resulting from such investments.

R10.7 Pending establishment of the Executive, the Department of Health and Children should have full control over how this funding will be allocated and should report the results of such investments to the Implementation Committee recommended at R11.2.

10.4 SUMMARY

While recognising the IT deficit, we consider that substantial expenditure in this area can only be justified if it is accompanied by a more comprehensive business case than has applied heretofore and by the parallel implementation of the wider structural reforms recommended throughout this report.

[2]St. James', Beaumont, Mater, St. Vincent's and Tallaght hospitals
[3]Phase 2 has not been implemented in any site.

CHAPTER 11
IMPLEMENTATION

In this Chapter, we set out our views on how the recommendations in this report should be implemented.

11.1 OVERVIEW

We do not underestimate the challenge of implementing our recommendations. The scale of the changes we envisage illustrates the size of the task. These include:

- The creation, re-organisation and consolidation of agencies;
- Changing staff conditions;
- Engaging clinicians in resource management in a meaningful way;
- Addressing the issues in their contracts to enable this happen;
- Addressing the control culture amongst some managers; and
- The legislative programme.

To ensure that the major changes we have recommended are implemented pending the establishment of the new Executive, we recommend that a National Implementation Committee under an independent Chairman be set up to drive the implementation process.

11.2 DECISIONS BY GOVERNMENT

In addressing our report, early decisions are needed by Government on the following:

- Whether to establish a new Executive agency and make the changes to the system of governance we have recommended.
- Which existing organisations will have their functions transferred to the new Executive.
- Whether to make funding available for the recommended investment in information technology systems.

11.3 MANAGING CHANGE

Once these decisions are taken and owing to the wide-ranging nature of the various recommendations and the multiplicity of groups required to give effect to them, it will be important that there is a single driving force at the centre to bring the various strands together.

Concentrate on Core Health Activities

In addressing the very substantial reform agenda we have proposed, it will be important to concentrate on core health activities. We are conscious that over the years the health system has been assigned responsibility for a number of what might be regarded as non-core health activities (income support, environmental health, food safety etc.). In this context, we believe that the Government should consider assigning some or all of these non-core health activities to other Government departments.

Recommendation on Core Activity of Health Service

R11.1 Government should give consideration to assigning non-core health activities, currently undertaken by agencies within the health service, to other bodies.

Implementation Committee

The most important task for the implementation of our recommendations is to put in place a plan and timescale that realistically takes into account the risks whilst seeking to minimise uncertainty in the system. Pending the establishment of the Executive, we believe that this task should be undertaken by a high level and well resourced Implementation Committee. To expedite matters, consideration should be given to appointing an interim board of the new Executive on a non-statutory basis.

We acknowledge that many of our recommendations require considerable work and further deliberation in order to tease out the detail and the mechanics of their application. With that in mind, we have, throughout the report, recommended the establishment of various working groups, primarily at Department of Health and Children and health board level in order to give further consideration to those areas where we considered it to be inappropriate to be overly prescriptive.

We acknowledge that a substantial amount of work, including consultation with relevant parties, will be required to progress these working groups. However, their successful completion is essential if the wider changes recommended throughout the report are to be implemented. Accordingly, we consider that appropriate priority should be attached to them to ensure their completion.

Recommendations on Implementation

R11.2 A National Implementation Committee should be established with the role of:
- (i) Ensuring the implementation of the recommendations;
- (ii) Driving the implementation process;
- (iii) Overseeing the establishment of the Executive and the consequent governance changes in Chapter 3; and
- (iv) Providing progress reports every 3 months.

R11.3 The Implementation Committee should, within 2 years of the publication of this report, be in a position to hand over responsibility for implementation of any outstanding recommendations to the CEO of the Executive.

R11.4 The Government should nominate an independent person to chair the Implementation Committee.

R11.5 Membership should also include the Secretary General of the Department of Health and Children, a Secretary General in the Department of Finance, a health board CEO and three persons from the private sector with appropriate expertise and experience in change management and financial management/audit functions.

R11.6 In the preparation of the reports referred to at R11.2(iv) above the Implementation Committee, and subsequently the Executive, will:
- (i) Identify the person(s), by name and/or position, responsible for the delivery of each recommendation (and the elements therein where applicable);
- (ii) Contact and formally assign responsibility to each person identified at (i) above;
- (iii) Agree with the person(s) identified at (i) above appropriate deadlines for implementation of each recommendation;
- (iv) Draw up a schedule of implementation deadlines for all recommendations based on agreements at (iii) above;
- (v) Audit progress of the responsible person(s) in giving effect to recommendations against the stated objectives; and
- (vi) Report progress with recommendations for corrective action as appropriate.

R11.7 In reporting on progress to the Implementation Committee, and subsequently the Executive, each person identified at R11.6(i) above should:
- (i) Identify the resources required to deliver the recommendations;
- (ii) Identify the critical success factors to deliver recommendations on time (and within budget); and
- (iii) Identify the barriers to success in delivering recommendations on time (and within budget).

Delivering Change

The major challenge for the Implementation Committee will be to prepare a plan to implement and deliver the change programme. This will require investment in IT and some changes in work practices. The investment recommended for information systems will involve very considerable expenditure that can only be accommodated by either (a) once-off additional allocations, perhaps over a number of years, or (b) a reallocation of funding from other areas within the overall system. However, we believe that full implementation of our recommendations will yield significant cost efficiencies within the system.

In relation to IT investment, we are aware that there is already a programme of investment in place for the roll-out of SAP and PPARS systems on a national basis and that work in this area is ongoing. The State has already invested in the region of ¤60 million to date in these systems and plans are well advanced for their further development across the health service.

We are of the view that there are potentially significant benefits and efficiencies to be gained from the already planned upgrading of systems that would justify the roll-out of the programme

being brought to completion as soon as possible. In this regard, we have noted the comments of the Independent Estimates Review Committee[1], set up by the Minister for Finance, which stated in relation to the health service that "*the strengthening of information systems should command a higher priority and implementation of improved personnel systems should be accelerated so that value for money can be better assessed*".

Given the number of agencies in the system and the key recommendation that these should be consolidated, there is scope for delivering many of the support services (payroll, accounting, information technology, systems development, procurement etc.) through a single shared services unit within the system or outsourced by way of public/private partnership. This would free up considerable resources for core activity including supporting the reorganisation and change programme.

In terms of changing working practices, the implementation of our recommendations poses a challenge to all health service employees. However, we would stress that the changes we propose are in the best interests of staff in the health service insofar as the reformed structures will support them in their efforts to provide the best possible service to patients.

We note that both unions and employers have already acknowledged, in the context of the recent partnership negotiations, that "*reform of healthcare requires ongoing change and development of services and the skills that are required to deliver them*". There is a shared acceptance of "*the requirement for system and structural change*"[2].

We also note, as agreed between unions and employers, that the payment of the final two phases of the benchmarking increase and the general round increases is dependent on verification of cooperation with flexibility, ongoing change and satisfactory implementation of the agenda for modernisation.[3]

We see this common purpose between both health service management and staff as the ideal environment within which to pursue the work practice changes proposed by our recommendations.

11.4 DETAILED GUIDANCE ON IMPLEMENTATION

In putting forward recommendations on improvements to the health services, we are conscious of the need for our report to deliver maximum benefits in as short a timeframe as possible and at minimum cost to the Irish taxpayer. Accordingly we set out in the Addendum to this Chapter a list of our 136 recommendations, indicating in broad terms our view of the IT systems implications of the recommendations and the timeframe for implementation. It will be a matter for the Implementation Committee to develop a detailed project plan.

Recommendation on Implementation (cont'd)

R11.8 The Implementation Committee and the Executive should have regard to the attached Addendum that summarises the various recommendations throughout the report – cross-referenced to the relevant chapters – showing, where appropriate, a timeframe for their completion.

[1]Paragraph 9.4(e), Estimates for Public Services 2003 - Report of the Independent Estimates Review Committee to the Minister for Finance, December 2002.
[2]Sustaining Progress, Social Partnership Agreement 2003-2005.
[3]Sustaining Progress, Social Partnership Agreement 2003-2005.

Timeframe for Implementation

While establishing an Executive on a statutory basis, as we have recommended, will take some time, many of our recommendations can be implemented, or at least begun, immediately by the Department of Health and Children, the Implementation Committee or an interim Executive board. Of our 136 recommendations, we would see the timeframe for implementation as being immediate or to commence immediately in the case of 52, sometimes interrelated, recommendations.

IT Systems implications of the Recommendations

Of our 136 recommendations, only 23 have IT implications. Of these 23 recommendations, 17 can be begun without any additional IT expenditure, although we acknowledge that, in these 17 cases, additional IT facilities are required to implement the recommendations fully. Finally, 6 recommendations will have significant IT implications.

11.5 Conclusion

We believe that an integrated implementation of our recommendations will create opportunities for financial transparency, greater accountability, increased value for money and, most importantly, help identify opportunities for treating more service users within the limits of available budgets. Futhermore, we believe that implementation will support the many dedicated people working in the health service in doing what they wish to do: offer the highest quality service to the public.

Appendix 1

COMMISSION MEMBER BIOGRAPHIES

Professor Niamh Brennan
Niamh Brennan, BSc, PhD (Warwick), FCA, a chartered accountant, is Michael MacCormac Professor of Management at *University College Dublin*. She is Academic Director of the *Institute of Directors' Centre for Corporate Governance at UCD*. Prof. Brennan is a non-executive director of *Ulster Bank*, and is a former non-executive director of *Lifetime Assurance*, Bank of Ireland's life assurance subsidiary, of *Coillte*, the State forestry company and of *Co-Operation Ireland*. She is also a member of the *Audit Committee* of the Department of Agriculture, Food and Rural Development. She has published widely in the areas of financial reporting, corporate governance and forensic accounting.

Dr. Sean Barrett
Sean Barrett is a graduate of *UCD* and *McMaster University*, Canada. He is a senior lecturer in economics and Fellow of *Trinity College, Dublin*. A member of the editorial board of the Journal of Air Transport Management, he has been extern examiner at the universities of Ulster, Loughborough, and Birmingham. He was a director of *Bord Failte* from 1984 to 1989 and was a member of the *Culliton Review Group on Industrial Policy* (1992) and the *Review Group on Harbour Legislation and Pilotage* (1992). He is a member of the organising committee of the annual Kenmare economic policy conference and is a board member of the *Alfred Beit Foundation*.

Dr. Donal de Buitleir
Donal de Buitleir is General Manager, *Office of the Chief Executive of AIB Group*. Prior to joining AIB, he was an Assistant Secretary in the Revenue Commissioners. He was Secretary to the *Commission on Taxation* 1980-85 and a member of the *Barrington Committee on Local Government Reorganisation and Reform* (1990). He was Chairman of both the *Advisory Committee on Third Level Student Support* (1993) and the *Review Committee on Post-Secondary Education & Training Places* (1999). He was also Chairman of *Comhairle* (2000-2002) and Chairman of the *Lord Mayor's Commission on the Funding of Dublin City Council* (2002). He is currently Chairman of the *Foundation for Fiscal Studies* and a Trustee of the *Eisenhower Fellowships in Philadelphia*.

Mr. Diarmuid Collins
Diarmuid Collins is an accountant (ACMA) currently working as Director of Finance with the *Midland Health Board*. He is a member of the Senior Management Team and is responsible for the financial function within the Board. He is a former Chairperson nationally of the Health Boards' Directors of Finance/Finance Officers' Group. He is also chairperson of the Midland Health Boards SAP project. He has previously worked at various levels in both the private and public sector, at home and abroad across a range of industries including manufacturing, retail, and telecommunications.

Mr. Pat Farrell
Pat Farrell MMII; Cert Dip in AF; is Head of Marketing and Communications with *EBS Building Society*. From 1975 to 1986 he worked in a variety of administrative and managerial roles in the

public health service including five years as Hospital Administrator at *Sligo Regional Hospital*. He served as CEO of *Galvia Private Hospital* in Galway from 1986 to 1991. From 1991 to 1997 he was General Secretary of *Fianna Fáil*. He is a Director of the *Irish Blood Transfusion Service*, and Chairman of the Audit Committee of VHI of which he is also a Director.

Mr. Tommie Gorman
Tommie Gorman is the Northern Editor of *RTE*, the national broadcasting service. He served as RTE's Brussels-based Europe editor from 1989 to 2001. His extensive experience of health care services in many EU member states featured in the television documentary "*Europe, Cancer and Me*." He was named Ireland's European of the Year in 2002.

Mr. John P. Greely
John P. Greely is a Chartered Accountant in practice in Co. Kildare and is a member of the *Council of the Institute of Chartered Accountants in Ireland* and is also a member of its Finance Committee. John is the Chairman of the *Institute of Chartered Accountants Benevolent Fund*. He is also currently a Director of *PFPC*, a company operating in the IFSC, and is formerly a Director of *Smurfit Finance Ltd* and *ACC Bank plc* (until its sale).

Mr. George Mansfield
George Mansfield is Chairman of *Ark Life Assurance Co. Ltd*. and is a Director of *AIB Finance & Leasing Ltd., Pettit Engineering Group Ltd* and *The Irish Guide Dogs Foundation*. He has held a number of executive positions with *AIB* and recently retired as General Manager of its Southern Area. Mr Mansfield is a Fellow of the *Institute of Bankers in Ireland*, Certified Member of the I.M.I. and is a former President of *Waterford Chamber of Commerce*. He is President Elect of the *Rotary Club of Cork*.

Mr. Jim McCaffrey
Jim McCaffrey recently retired as Assistant Secretary in the *Department of Finance*. He joined the Department of Finance in 1965. He has worked in all areas of the Department - including personnel, spending policy and taxation. For the last ten years, Mr. McCaffrey has been the Assistant Secretary responsible for social spending (health, education and social welfare) and for social policy advice generally in the Department.

Mr. Michael McLoone
Michael McLoone, Dip H.I., B.A. (Pub Admin) has been County Manager with *Donegal County Council* since 1994. He worked as an environmental health officer from 1966-74. He was appointed Industrial Relations Officer with the *North Western Health Board* in 1975, Personnel Officer with Midland Health Board in 1978 and Programme Manager with the North Western Health Board in 1982. In 1988 he was seconded to *Beaumont Hospital* as Chief Executive to set up the structures to run the new hospital - he was there for six years. In 1997 he was appointed Chairman of the governing body of *Letterkenny Institute of Technology*. In 1998 he chaired the *Donegal Employment Initiative Task Force* and was a member of the *Western Development Commission* from 1996 - 2001. He was appointed Chairman of the *Irish Blood Transfusion Board* in 2001.

Mr. Dermot Smyth
Dermot Smyth is an Assistant Secretary in the *Department of Health and Children*. His responsibilities include Finance, Planning, Management Information and Private Health Insurance.

He has held this position since 1996. He is currently Chairman of the Steering Group of the National Health Information Strategy.

Mr. Maurice Tempany
Maurice Tempany is a former President of *The Institute of Chartered Accountants in Ireland*. He was engaged in professional accountancy practice in Dublin until 1989. Since then he has held a number of non-executive company directorships and trusteeships of various pension schemes. He was a member of the Implementation Advisory Group on the establishment of a Single Regulatory Authority for the Financial Services Sector which reported to Government in May 1999.

Dr. Gerardine Doyle
Dr. Doyle's research interests are in the area of health care accounting and management and she has researched/examined modern costing technologies in the health sector internationally. She is also involved in an *EU Training and Mobility Network* (Accounting and Management in the Reform of European Health Care Systems) as the 'scientist in charge' of the Irish team and a member of the management committee of the network since its commencement in 1998. The work of Dr. Doyle on our behalf both assisted and informed us in reaching our proposals for the reform of systems in the Irish health service.

Appendix 2

GROUPS/INDIVIDUALS INVITED TO MAKE SUBMISSIONS

(* denotes that submission was received)

BUPA (Ireland)
Chartered Institute of Management Accountants
Chartered Institute of Public Finance & Accountancy
Deloitte & Touche*
Department of Health Services Management, Trinity College Dublin
Disability Federation of Ireland
Dr. Gerardine Doyle, Department of Accountancy, University College Dublin
Dr. Miriam Wylie, The Economic and Social Research Institute
Dublin Academic Teaching Hospitals
East Coast Area Health Board*
Eastern Regional Health Authority*
Financial Controller, Beaumont Hospital
Health Boards Executive*
IBEC
IMPACT
Institute of Certified Public Accountants in Ireland
Institute of Chartered Accountants in Ireland
Institute of Public Administration
Irish College of General Practitioners
Irish College of Psychiatrists in Ireland*
Irish Health Services Management Institute*
Irish Hospitals Consultants Association*
Irish Medical Organisation
Irish Nurses Organisation
Irish Pharmaceutical Healthcare Association*
Irish Pharmaceutical Union
Joint Standing Committee of the Dublin Maternity Hospitals*
Mental Health Ireland
Midland Health Board*
Mid-Western Health Board*
National Federation of Voluntary Bodies*
North Eastern Health Board*
North Western Health Board*
Northern Area Health Board*
Office for Health Management
Our Lady's Hospital for Sick Children
Professor Muiris Fitzgerald, Dean, Faculty of Medicine, University College Dublin
Psychiatric Nurses Association
Royal College of Physicians in Ireland
Royal College of Surgeons in Ireland

SIPTU*
South Eastern Health Board*
South Western Area Health Board*
Southern Health Board*
VHI
Western Health Board*

Appendix 3

STATUTORY HEALTH SERVICE PROVIDERS

I. HEALTH BOARDS (INCLUDING EASTERN REGIONAL HEALTH AUTHORITY AND AREA HEALTH BOARDS)

Health Board	Area Health Boards
Midland Health Board	
Mid-Western Health Board	
North Eastern Health Board	
North Western Health Board	
South Eastern Health Board	
Southern Health Board	
Western Health Board	
Eastern Regional Health Authority →	East Coast Area Health Board
	Northern Area Health Board
	South Western Area Health Board

II. STATUTE BASED HOSPITALS

Beaumont Hospital Board	Board of the Adelaide & Meath Hospital	Dublin Dental Hospital Board
Leopardstown Park Hospital Board	St. James' Hospital Board	St. Luke & St. Anne's Hospital Board

III. SPECIALIST AND OTHER BODIES ESTABLISHED WITH ADVISORY AND SERVICE FUNCTIONS

Name of Agency	Functions
An Bord Altranais (Nursing Board)	The regulatory body for the nursing profession. Its main functions are to maintain a register of nurses and to provide for the education and training of nurses and student nurses.
An Bord Uchtála (Adoption Board)	Makes Adoption Orders and registers voluntary adoption societies.
Board for the Employment of the Blind	The Board provides for the employment of approximately 30 registered blind and seven sighted personnel in its workshops on Davitt Road.

Name of Agency	Functions
Bord na Radharcmhastóirí (Opticians Board)	The regulatory body for opticians. The Board's main functions include the training and registration of ophthalmic and dispensing opticians and regulating the practice of optics.
An Bord Cioch Scrúdaithe Naisiúnta (National Breast Screening Board)	Responsible for the National Breast Screening Programme which aims to reduce breast cancer related deaths in women.
Comhairle na Nimheanna (Poisons Council)	Advises the Minister for Health and Children on the control of poisons.
Comhairle na nOspidéal	The statutory body responsible for regulating the number of and type of consultant and senior registrar appointments and for specifying the necessary qualifications for these posts.
An Comhairle Fíaclóireachta (Dental Council)	The regulatory body for the dental profession. Its functions include maintaining a register of dentists and dental specialists, ensuring that the standards of dental training are maintained and inquiring into the fitness of a dentist to practice on specific grounds.
Consultative Council on Hepatitis C	To advise and make recommendations on all aspects of Hepatitis C and in particular on the organisation, delivery and confidentiality of services, developments arising from research into Hepatitis C under the aegis of the Health Research Board, and the publication of information on Hepatitis C.
Crisis Pregnancy Agency	To prepare a crisis pregnancy strategy and implement its objectives thereafter. This strategy is to provide for: - A reduction in the number of crisis pregnancies. - A reduction of the number of women with crisis pregnancies who opt for abortion. - The provision of counselling and medical services after crisis pregnancy.
Drug Treatment Centre Board	Provides a range of programmes for the treatment of drug addiction.
Food Safety Authority of Ireland	Provides advice on issues relating to safety, nutrition, food law and other matters regarding the processing and sale of food.
Food Safety Consultative Council	To enable the Food Safety Authority of Ireland to consult representatives of consumers, producers, retailers, distributors, caterers and manufacturers and, where appropriate, official agencies about the activities or other measures to be undertaken for the purpose of establishing and maintaining the highest level of standards of food hygiene and safety reasonably available in the interests of public health and consumer protection.

Name of Agency	Functions
Scientific Committee of the Food Safety Authority of Ireland	To assist and advise the in relation to matters of a scientific nature.
Food Safety Promotion Board	A North/South institution which promotes food safety awareness. It also supports North/South scientific co-operation, promotes links between institutions working in the field of food safety and promotes specialised laboratory services.
General Medical Services (Payments) Board	Administers payments to doctors and pharmacists under the General Medical Scheme.
Health Board Executive (HeBE)	Established to improve the efficiency and effectiveness of health and personal social services. Its role is to enable the health boards and the ERHA to work jointly on a national development agenda that will support the modernising of health services and to undertake other executive functions including operational functions to be devolved from the Department of Health and Children.
Health Insurance Authority	To manage and administer schemes prescribed under the Health Insurance Act and to maintain a register of businesses engaged in the health insurance business.
Health Research Board	Provides advice on health research and related matters.
Health Service Employers Agency (HSEA)	A statutory agency representing health service employers. Its functions include the promotion and support of value for money, efficiency and effectiveness in employment practice and the negotiation of industrial relations issues with health unions.
Hepatitis C Compensation Tribunal	To award compensation to certain persons who have contracted Hepatitis C within the State from Anti-D immunoglobulin, other blood products or blood transfusion and to provide for connected matters.
Hospital Bodies Administrative Bureau	Provision of administrative, analytical, clerical and ancillary services and other facilities for Comhairle na nOspidéal.
Hospitals Trust Board	Administers the Hospitals Trust Fund.
The Institute of Public Health	Concerned with tackling health inequalities, strengthening partnerships and networking nationally and internationally, contributing to public health information and surveillance and strengthening public health capacity.

Name of Agency	Functions
Irish Blood Transfusion Service	Organises and administers the national blood transfusion service including the processing and supply of blood and blood products to Irish hospitals. It also operates the National Haemovigilance Office, the Irish Unrelated Bone Marrow Registry and the National Tissue Bank.
Irish Health Services Accreditation Board	To grant accreditation to hospitals and operate hospital accreditation programmes and other schemes aimed at ensuring quality in the provision of healthcare.
Irish Medicines Board	The authority responsible for the licensing of human and veterinary medicines and the approval of clinical trials. It also acts as an advisory body to the Minister for Health and Children in relation to safety, control and regulation of medicines.
Advisory Committee for Human Medicines	To advise and assist the Irish Medicines Board in relation to matters of safety, quality or efficacy of medicinal products for human use.
Advisory Committee for Veterinary Medicines	To advise and assist the Irish Medicines Board in relation to matters of safety, quality or efficacy of medicinal products for animal use.
Medical Council	The statutory body for the medical profession. Its functions include administering the General Register of Medical Practitioners, ensuring that the standards of medical training are maintained and inquiring into the fitness of a doctor to practice on specific grounds.
Mental Health Commission	To promote and foster high standards and good practices in the delivery of mental health services and to ensure that the interests of detained persons are protected.
National Cancer Registry Board	A statutory body established to collect and analyse data and to report on cancer incidence and mortality in Ireland.
National Children's Advisory Council	Advises the Minister for Health and Children on all aspects of children's lives, on better delivery and co-ordination of services to children, contributes to monitoring and evaluation of implementation of the National Children's Strategy, undertakes and advises on research and advises on the development of mechanisms to consult with children.
National Children's Office	Responsible for overseeing the implementation of the National Children's Strategy. It provides advice to the Minister for Health and Children, develops measures to further the goals of the strategy and is responsible for reporting on Ireland's obligations under the United Nations Convention on the Rights of the Child.

Name of Agency	Functions
The National Council for the Professional Development of Nursing and Midwifery	The body responsible for the continuing education and professional development of nurses and midwives.
National Council on Ageing and Older People	Advises the Minister for Health and Children on all aspects of ageing and older people.
The National Disease Surveillance Centre	Ireland's specialist centre for the surveillance of communicable diseases. The aim of NDSC is to improve the health of the Irish population by the collation, interpretation and provision of the best possible information on infectious diseases. This is achieved through surveillance and independent advice, epidemiological investigation, research and training.
National Social Work Qualifications Board	A statutory body which assesses the suitability of social work education and training and advises the Minister for Health and Children on standards which should apply.
Office for Health Management	A body established to implement the national strategy for management and organisational development for the health services in Ireland. Its main function is to facilitate management development for the health services by acting as a central resource and commissioning body .
Office of Tobacco Control	The Public Health (Tobacco) Act, 2002 provides for the establishment of an Office of Tobacco Control to advise the Minister for Health and Children on tobacco control measures, to monitor and co-ordinate the implementation of such measures and to advise the Minister on the control and regulation of the manufacture, sale, marketing and smoking of tobacco products.
The Pharmaceutical Society of Ireland	The professional body for the pharmaceutical profession. Its chief functions relate to the education, examination and registration of pharmaceutical chemists.
Postgraduate Medical and Dental Board	Promotes and co-ordinates postgraduate medical and dental education and advises the Minister for Health and Children on all matters relating to such education.
Pre-hospital Emergency Care Council	Responsible for the recognition of institutions for the education and training of emergency medical technicians.
Social Services Inspectorate	Established in 1999 by the Department of Health and Children as an independent body to inspect social services provided by health boards. To date the SSI has focused on child care services.
Voluntary Health Insurance Board	Provision of private voluntary health insurance.

Name of Agency	Functions
Women's Health Council	Advises the Minister for Health and Children on all aspects of women's health.

Appendix 4

DESCRIPTION OF THE ESTIMATES AND ALLOCATIONS PROCESS

INTRODUCTION

This appendix describes the process whereby annual budgets are allocated and reported on within the health service. The description covers all the major stakeholders and, as such, deals with all the main institutional players, viz. the Department of Finance, the Department of Health and Children and the 10 health boards plus the Eastern Regional Health Authority. As far as possible, the various stages are described chronologically in order to convey the step-by-step process involved. This appendix simply describes the system; it provides neither a critique of the systems as described nor an assessment of the extent to which these arrangements are actually followed in practice. A full critique and recommendations for change are set out in the body of the Report.

The appendix is divided into seven sections, describing:

I. The roles and responsibilities of relevant institutions;
II. The national estimates process;
III. The determination process (i.e. allocation of health board budgets);
IV. Supplementary estimates;
V. Health board reporting;
VI. External reporting "up the line"; and
VII. Capital expenditure.

I. ROLES AND RESPONSIBILITIES

Before describing the existing process, it is important to be aware of the role and function of the main institutions involved, i.e. the Department of Finance, the Department of Health and Children and the health boards.

Department of Finance: The principal functions of the Department of Finance[1], in terms of its aggregate responsibilities for expenditure policy, are the allocation, co-ordination and overall management of public expenditure within the context of the overall budgetary and economic parameters set by Government. The key functions of the Department of Finance as they relate to the Department of Health and Children and the health services are to ensure that public expenditure policy is managed in an effective and prudent manner by –

- Negotiating the annual estimates;
- Monitoring the evolution of spending against budget;
- Sanctioning, where appropriate, alterations to schemes and programmes; and
- Providing a second opinion to the Minister for Finance on policy proposals and priorities put forward by the Department of Health and Children in the light of factors such as the Government's programme and commitments arising from national programmes such as the Programme for Prosperity and Fairness (PPF).

[1]Statement of Strategy 2001-2003

Department of Health and Children: The Secretary General of the Department of Health and Children is accountable for the overall spend and for the evaluation and review of policy implementation. The Health (Amendment) (No.3) Act, 1996 devolves accountability for expenditure to the health boards. While the Department of Health and Children is not directly involved in day-to-day spending at health board level, it can monitor expenditure and can influence the level of spending by setting operational criteria (e.g. the terms and conditions of schemes and programmes).

Health boards: Under the Health (Amendment) (No.3) Act, 1996, health board members are responsible for adopting a service plan which must be consistent with the financial limits determined by the Minister for Health and Children. The chief executive officer is responsible for the day-to-day management and control of expenditure within his/her region - under the 1996 Act, s/he must implement the Service Plan on behalf of the health board so that it stays within approved budget. Any excess arising in any year is treated as a "first charge" on the following year's budget. The chief executive officer of each health board is accountable to the Public Accounts Committee for his/her financial performance.

II. THE NATIONAL ESTIMATES PROCESS

The Estimates for Public Services (Abridged Version), published in November of each year, sets out the primary allocations for each Department for the following year. The focus is generally on the cost of maintaining existing services, but the allocations may include the cost of service improvements for the next fiscal year. There may also be some announcements in that regard held over until Budget day. In 1996 a partial system of multi-annual budgets was introduced to accompany the estimates at national level. This involves a projection of spending for a three-year period - i.e. the next fiscal year for which the estimate is being negotiated and the projected cost for the following two years, completed on an "Existing Level of Service" basis (i.e. the cost in years two and three of maintaining services at the same level as pertains in year one). This provides a more rounded, if limited, picture of the medium term costs of policy initiatives proposed in the context of the estimates campaign as well as being a key mechanism in identifying trends as they are likely to affect the overall Government finances.

The amount of tax revenue raised on the one hand, and the level of public expenditure on the other, essentially determines Government's overall fiscal position. As such, the estimates process is a central element in Government fiscal policy. It is a prolonged process that necessitates detailed costings and, sometimes, difficult negotiations.

Existing Level of Service

In April/May of each year, the Public Expenditure Division of the Department of Finance prepares an assessment of the costs of maintaining all public services, including health services, at their existing level. This is done in the context of the preparation, development and agreement of the Government's budgetary and economic strategy for the next three years. The Government decides, based on this assessment and all other relevant considerations (economic, taxation, debt service, etc.), on the aggregate and departmental levels of spend for the forthcoming budget year that is consistent with sustainable economic and budgetary development. This is the basis for the "Estimates Circular" that is then issued by the Department of Finance to all other Departments, including the Department of Health and Children, asking them to submit estimates for the coming years consistent with the Government decision.

In response to the circular, the Department of Health and Children submits a "bid" for the following year and forecasts of the costs of continuing the services proposed in the two years thereafter.

A priority for the Department of Health and Children in this process is to obtain sufficient funding to continue developments started in previous years.

Health Board Input

Health boards do not generally make formal submissions to the Department of Health and Children regarding the following years funding. However, they usually discuss needs with the appropriate line division in the Department of Health and Children.

These discussions are, in the first instance, based around each health board's estimate of the costs of continuing to provide its existing level of services. However, the discussions also deal with proposals for new service developments within their area, taking account of national and local strategies and analyses of needs.

This process typically includes costings on those areas giving rise to additional spending pressures such as:

- Full year costs of developments begun part way through the current year;
- Cost pressures impacting on core funding requirements (e.g. inflation, increasing demand/activity);
- Potential costs - both pay and non pay - of proposed new service developments; and
- Future revenue impacts of capital developments about to come on stream.

The financial aspects of these discussions are usually prepared by the health board's central finance department in conjunction with care group managers (e.g. community care, mental health, etc.). In some health boards, dedicated finance staff have been recruited to support managers in the financial analysis and costing aspects of planning.

These submissions are sent to the appropriate "line division" in the Department of Health and Children. From that point up until each health board receives formal notification of its final allocation in its Letter of Determination (see Section III below), communication between the Department of Health and Children and health boards tends to be informal. Only limited discussion takes place on the core funding issues and there is no advance indication of the final allocation. However, within the current system of incremental budgeting, health boards would be aware that the previous year's level of funding forms the baseline for the coming year's allocation. It is not possible for the Department of Health and Children to be specific on the amount available for the following year until the Estimates for Public Services (Abridged Version) is published in mid-November.

Department of Health and Children Input

Following consultation and review with health boards and other service providers, each line division within the Department of Health and Children prepares a "bid" for funding setting out the associated service implications, the costs involved and any additional posts which may result. The costing process takes account of information provided by agencies, including health boards, and details prior experience of similar proposals. The bids from the various line divisions are

collated and assessed by the Department's Finance Unit who then formulate an aggregate departmental demand.

The aggregate departmental demand contains detailed estimates of proposed service developments (i.e. new policy initiatives) for the following year and projections of the follow-on costs in the subsequent two years of these new measures. These measures are ranked in order of priority by line divisions and, as a general rule, focus on initiatives identified within the National Health Strategy.

The aggregate departmental demand is presented to the Department's Management Advisory Committee, comprising the Secretary General and other senior management. Following approval by the Management Advisory Committee and the Minister, the bid is submitted to Department of Finance.

Negotiation of Abridged Estimates provision

The Department of Finance reviews the aggregate departmental demand as submitted by the Department of Health and Children and compares its bid against the Department of Finance's own prior assessment of the funding requirements. Typically, there is a preliminary meeting in early September between officials from the two departments to identify the major areas of variation between the two sets of figures. This is followed by a series of meetings during September/October focusing on the detailed material provided by the Department of Health and Children's line divisions in their estimates bid. The objective from the Department of Finance side is to match the aggregate level of funding demanded with the level previously agreed by the Government.

Matters that cannot be resolved at official level are taken up during bilateral meetings between the two Ministers. Ministers often become heavily involved in negotiations at this stage. Original bids may be scaled down/prioritised in response to the outcome of these discussions. High-level agreement is then reached between Ministers. An agreed "envelope" (i.e. overall allocation) is identified as available to the Minister for Health and Children for the coming year. This figure is then apportioned across the various subheads, in agreement with the Department of Finance, to produce the Estimates for Public Services (Abridged Version), which is presented to the Dáil and published in November.

Budget Day Adjustments

The Budget announcement in the first week of December may include funding for additional measures over and above those contained in the Estimates for Public Services (Abridged Version). The Minister for Finance normally determines the overall provision for Budget Day developments, if any, in consultation with the various individual Ministers, including the Minister for Health and Children, in light of available resources. Prioritisation of any measures to be funded from the Budget day package is primarily a matter for the Minister for Health and Children.

The Revised Estimates for Public Services

The Revised Estimates for Public Services is published in March and contains all funding provided for public services, including health services, from:

- the Estimates for Public Services (Abridged Version)

plus
any Budget day package
plus
any other technical or policy changes which have emerged between Budget day and publication of the Revised Estimates for Public Services.

III. THE DETERMINATION PROCESS

Letters of Determination

The Letters of Determination, signed by the Secretary General of the Department of Health and Children, set out for each health board and the Eastern Regional Health Authority the amount of funding available and the terms for the expenditure of any new funding. The letter also includes details of each health board's overdraft limit, the limit on each health board's overall level of indebtedness and the areas of funding that are eligible for supplementary funding (see Section IV below). It therefore sets out the overall policy and control context underpinning the funding approved.

Under the terms of the Health (Amendment) (No.3) Act, 1996, the Letter of Determination must issue from the Department of Health and Children to the health board/authority within 21 days of the publication of the Estimates for Public Services (Abridged Version). In practice, the Letters of Determination issue on, or just after, Budget Day in December.

Each line division in the Department of Health and Children is responsible for dividing funding within their policy remit between the various health boards for inclusion in each health board's Letter of Determination. Aggregating this information, the Finance Unit of the Department builds up the approved level of expenditure for each health board. Senior management and the Minister for Health and Children must finally review and approve the health board allocations.

The determination or allocation for each health board/agency is calculated as:
The previous year's final revised determination;
less any once-off increases allowed in the previous year;
plus full year cost of any service developments started part way through last year;
plus the full year cost of any pay awards implemented part way through last year;
plus any inflation factor;
plus any new development funding – i.e. new money made available for new or enhanced services;
plus or **minus** the relevant casemix adjustment (see Box 1 below).

Box 1: Casemix

Casemix is the comparison of activity and costs between hospitals. In this way, hospitals' efficiency can be measured relative to each other. A "budget neutral" adjustment is made to each hospital's allocation annually. Those hospitals whose efficiency relative to the others is above the norm are rewarded, and those below the norm are penalised. The net effect on the Exchequer is neutral.

A more detailed description of the Casemix programme is contained at Appendix 5.

The most detailed element of the Letter of Determination relates to new development funding. The new development funding is additional funding available to health boards for service improvements. All other funding is committed to fund existing services together with the full year costs of services begun part way through the previous year. The funding is allocated on an incremental basis, with the detailed analysis and commentary in the Letter of Determination focused strongly on funding for new initiatives. As such, health boards' Service Plans tend to concentrate on new services rather than on the core or existing services, which invariably account for over 97% of the total cost of services delivered by health boards.

There are a number of agencies, other than the health boards, that receive funding directly from the Department of Health and Children. These agencies are funded from a separate Vote Subhead (Subhead B.4 for 3 agencies, and Subhead F for the majority of the remainder). The determination process for these agencies mirrors that of the health boards, although responsibility for issue of the letters of determination rests with the relevant line division within the Department of Health and Children (i.e. Food Unit has responsibility for the determinations for the Food Safety Advisory Board and the Food Safety Authority of Ireland; Personnel Unit has responsibility for Comhairle na nOspidéal etc.).

Service Plans

Under the Health (Amendment) (No.3) Act, 1996, health boards are required, within 42 days of receipt of their Letter of Determination, to adopt and submit to the Minister for Health and Children an annual Service Plan, outlining the planned activity which they will deliver for the funding they have received. As the Letters of Determination are issued in the first week of December, the deadline for submission of Service Plans falls in mid-January.

In order to be in a position to meet their statutory obligations, health boards engage in a process of advance preparation. In advance of receipt of their determination, health boards themselves will have assessed their own minimum funding requirements to deliver the same level of service in the following year as in the year about to end. For example, a health board may, at a detailed level, calculate each cost centre's pay costs and non-pay costs (updated for inflation) with adjustments for once-off expenditure which will not be repeated, costs of known contracts and the full year costs of staff recruited part way through a year.

By comparing the outcome of this with the allocation in their Letter of Determination, each health board's finance department can advise senior management of difficulties, if any, which require corrective action to ensure a balanced budget. This highlights areas of funding difficulties before the year begins so that immediate corrective action can be taken by the chief executive officer and the relevant care group manager and allowed for in the Service Plan.

At the end of the process, all funding is allocated between pay and non-pay cost elements across the health board's cost centres. Health board cost centres include all hospitals, child residential units, etc. Allocations to individual cost centres are then consolidated to derive programme budgets and care group budgets (see Box 2 below).

Box 2: Programmes and Care Groups

Programmes and Care Groups are essentially different ways of analysing health board activities.

Traditionally, each health board is divided into three programmes:

- Hospital Care (all Acute Hospitals),
- Special Hospitals (Elderly and Mental Health cost centres), and
- Community Care (Care Unit cost centres).

The Care Group approach, which has become more common in recent years, looks at services from a client perspective. For example, in the Midland Health Board, the following Care Groups are in place:

- Episodic (Acute Hospitals and Primary Care),
- Older People (Services for Older People),
- Mental Health (Community & Residential),
- Disabilities (Intellectual & Physical), and
- Children and Families (Child Protection & Family Health).

At all stages of the process there are extensive consultations on how service delivery can be maximised given the available resources. However, the extent to which this process is devolved down as far as care or clinical service units varies significantly. Within the acute hospital programme, the lowest cost centre for budgetary purposes is generally the hospital itself (in some cases it could be support functions, such as laboratory or radiography, or specialty). Clinicians will agree their activity levels with hospital management, which informs the hospital/health board Service Plan, but there is no link between that activity and a budget at the level of the Clinician. Within the other two programmes (special hospitals and community care), the budgets as they stand are in many cases already sufficiently devolved, as managers of care units, who have budgets, make the resource consuming decisions.

Performance indicators: The health board Service Plans include key performance indicators across a number of headings as well as targets for delivery of service developments. Costs associated with delivery of these targets are also set out in the plan. These indicators were agreed between the Health Boards Executive (HeBE) and the Department of Health and Children and relate primarily to health boards' operational performance across a number of headings within all Care Groups. They are output-based indicators, moving towards an outcome-based scenario. This is consistent with international experience, where outcome-based indicators are difficult to achieve.

Operational Plans: Within each health board, in addition to the formal health board-wide Service Plan, each care group (e.g. community care, mental health, etc.), prepares its own Operational Plan. This underpins the Service Plan, but at a greater level of detail, typically setting out (i) detailed targets, (ii) departments/individuals responsible for delivery, (iii) performance indicators to assess achievement, and (iv) potential bottlenecks. Full year budgets and the associated staffing complement, analysed by cost centre and cost element, are also part of these Operational Plans.

Ratifying and Submitting the Service Plan: The health board's senior management team agrees the overall Service Plan and presents it to the board's Finance Sub-Committee. It is then put before a health board meeting for adoption by the board. When adopted, it is forwarded to the Department of Health and Children for Ministerial approval. The Service Plan is generally submitted by early/mid January.

Once received by the Department of Health and Children, Service Plans are immediately put on the Department's intranet and all line divisions *(Secondary Care, Childcare, Services for Older People, Community Health, Mental Health Division, Services for the Physically and Intellectually Disabled, Personnel, I.T., Hospital Planning Office etc.)* are advised of their availability. The financial element of the each health board's Service Plan is examined by the finance unit to ensure that it is within determination.

The Minister may, within 21 days of receipt, direct the health board to make modifications to the Service Plan.

Health boards are required to submit a cash profile of their expected cash drawdown during the coming year. This profile, the requirement for which is set out in the Letter of Determination, must be submitted by the beginning of January. The individual health board figures are aggregated by the Department of Health and Children, supplemented by direct spending by the Department, and submitted to the Department of Finance.

IV. SUPPLEMENTARY ESTIMATES

Under government accounting rules, a Department which finds itself faced, during the course of a year, with a prospective overrun on its aggregate spending or a shortfall in its income, may - subject to the prior approval of the Minister for Finance - apply to the Dáil for a Supplementary Estimate. The norm is that Departments must live within their allocated budget and the Minister for Finance will only sanction a Supplementary Estimate in exceptional circumstances.

A specific variant to this regime applies in the case of the Department of Health and Children. The Health (Amendment) (No.3) Act, 1996 placed a legal obligation on the chief executive officers of the health boards to live within the annual expenditure budgets determined for each board by the Minister for Health and Children; if they fail to do so, the excess is carried forward to the following financial year as a first charge on that year's expenditure. While the legislation allows for the Minister for Health and Children to vary a determination, it was agreed with the Minister for Finance in 1997 that increases in voted expenditure supported by Supplementary Estimates would only be allowed in respect of specified areas deemed not to be amenable to management/control by the Department of Health and Children or the health boards.

In the context of the 2002 Estimates and Budgets, the Government approved a proposal from the Minister of Finance that, for the future and commencing in 2002, resources provided to the Department of Health and Children would be based on the annual cash allocation as determined in the Abridged Estimates Volume augmented by any subsequent Budget Day provision. In this context, it was further agreed that no requests for Supplementary Estimates would be considered, save in the following specific areas that were considered not to be amenable to management by the Department of Health and Children.

Appropriation-in-Aid Receipts: where these fall short of the originally estimated level, the Exchequer will meet the deficiency. On the other hand, where such receipts exceed the originally estimated level, the level of Exchequer funding will be correspondingly reduced.

Pay: costs arising under the National Programmes, Benchmarking and major unanticipated awards specifically agreed by Government. Health service employers will be required to meet the costs of all other awards.

Drug Payment Scheme/GMS Scheme (Drug Component) and Recombinant Blood Costs: which are effectively demand led.

Professional Indemnity Insurance (including clinical negligence claims against maternity hospitals): which are subject, inter alia, to wider developments in the insurance markets and legal settlements.

Tribunal Enquiries: costs arising from such proceedings are not amenable to management/control by the Department of Health and Children.

In relation to all of the above elements, it was confirmed that, in any event, realistic estimates of the prospective costs must be prepared and agreed for the inclusion in the Abridged Estimates Volume.

These arrangements have been modified by the Minister for Finance in his Budget speech for 2003. He stated that "*Ministers and their Management Committees will be required to manage strictly within the allocations given to them*". The 2003 Letter of Determination to the health boards specifically stated "*there will be no consideration given to a Supplementary Estimate for Health and Children in 2003, without exception*".

V. HEALTH BOARD REPORTING

Internal Management Reports

Internal Monthly Management Accounts: Each health board's finance department prepares management accounts on a monthly basis for review by the senior management team. These reports set out the overall financial performance of the health board, detailed analysis of variances by cost centre and non-financial information on hospital activity versus plan analysed by in-patient, day case and casualty attendances. Information on employee numbers is available from both the payroll system and the HR system. Following month end, the finance department meets with budget holders to review the position and agree corrective actions where necessary.

Internal Quarterly Reports: A quarterly report is prepared by the finance department for review by the each health board's finance sub-committee. The report details the financial performance and highlights any potential difficulties which may prevent the health board meeting its budgetary obligation. Following consideration by the finance sub-committee, the quarterly report is presented for consideration to the next full board meeting along with the minutes of the finance sub-committee meeting. Where corrective actions are required which might necessitate changing the Service Plan, the finance sub-committee makes necessary recommendations for discussion at the next full board meeting. The full board must adopt any

changes to the Service Plan arising from the health board's financial performance.

Cash Drawdown

In order to fund its activities on a regular basis, each health board needs to draw down cash from the Department of Health and Children on an ongoing basis. The Department of Health and Children, in turn, draws down cash from the Department of Finance.

Weekly Cash Turnaround Statements: These statements detail cash flow requirements. They are prepared by the health boards and submitted to the Department of Health and Children. The management of cash is vital to avoid breaching overdraft and working capital limits (which are set out in the Letter of Determination). In managing the cash requirements, the Department of Health and Children has regard to each health board's monthly expenditure profile. However, the Department of Health and Children may need to apply some flexibility against profile for a number of reasons such as; timing of capital payments, unexpected service pressures, etc. From time to time during the year health boards may make special requests for an advance in cash for specific agreed purposes. Each request is examined on its merits and having regard to the overall position of the health board and the cash available to the Department of Health and Children.

Annual Financial Statements and Annual Reports

Under legislation, Annual Financial Statements for the year ending 31st December must be adopted by each health board and submitted "ready for audit" to the Comptroller and Auditor General by end-March following the previous year-end. The Annual Financial Statements are the statutory accounts of the health board and must be prepared in accordance with the accounting standards produced by the Department of Health and Children.

Under Section 6 of the Comptroller and Auditor General (Amendment) Act, 1993, the Comptroller and Auditor General is required to audit each health board's Annual Financial Statements by end-September. Under this Act, the audited accounts are placed before the Oireachtas annually and are reviewed by the Public Accounts Committee.

Under Section 15 of the Health (Amendment)(No.3) Act, 1996, health boards must, no later than the 30th June in each year, prepare and adopt an Annual Report in relation to the performance of its functions during the preceding year. This report must include a statement on the services provided by the health board in the preceding year, and any other particulars (including financial statements) that the health board considers appropriate, or that the Minister for Health and Children specifies. The Annual Report should be comparable with the Service Plan, allowing the comparison of a health board's resultant performance against plan.

VI. EXTERNAL REPORTING "UP THE LINE"

Monthly Integrated Management Reports: This is the main means by which health boards report on their financial performance to the Department of Health and Children. Integrated Management Reports are prepared monthly by all health boards for submission to the Department of Health and Children by the 25th of the following month. They include financial and non-financial (i.e. hospital activity) information, as well as employee number data (expressed in terms of Whole Time Equivalents). The financial data includes income, actual and budgeted pay costs and non-pay costs, variances and the full year budget. Before submission, it

[2]This deadline was extended by Government Decision to end-April in 2001 as a special measure in response to the foot-and-mouth outbreak

is reviewed by the health board's senior management team and is signed off by the chief executive officer.

Each Integrated Management Report must be accompanied by a commentary from the chief executive officer, detailing the causes of any variances and how the health board intends to deal with such variances prior to the end of the year. The commentary is a central element of the return. Although the figures may appear satisfactory, the commentary may provide the Department of Health and Children with an early warning of emerging problems. Where the figures are indicating a problem the commentary must set out both the cause of the problem and the steps the chief executive officer is taking to bring expenditure back within determination. Where the commentary shows excess in particular service areas, the Integrated Management Report is copied to the relevant line division in the Department of Health and Children for observations. All line divisions have desktop access to the Integrated Management Reports.

Consolidated Monthly Integrated Management Reports: These are due from the Department of Health and Children to the Department of Finance (except in January). This is essentially an analysis of the various Integrated Management Reports as submitted to the Department of Health and Children, detailing the variances against budget to date being experienced in the system, and containing summary financial, activity and employment control information at a national level. It also sets out problems and pressure points in the system.

The Department of Finance requires that a separate report on the performance of the voluntary hospitals should be appended to the monthly health board returns. Specific returns are also presented for the General Medical Services (Payments) Board.

Quarterly Performance Indicator Reports: In 2001, a set of performance indicators was agreed between the health boards and the Department of Health and Children and these are built into the Service Plan. Their purpose is to enable both the Department of Health and Children and the health boards to reach a better shared understanding of the position in monitoring and evaluating the attainment of Service Plan objectives by the health boards. The Quarterly Performance Indicator Reports are used as an indicative picture of each health board's position in relation to the delivery of the Service Plan goals. This process is still in its very early stages with joint Department and health board teams working to further enhance these performance indicators.

Working Capital: Under Section 8 of the Health (Amendment)(No.3) Act, 1996, each health board is required to manage within the level of indebtedness specified by the Minister for Health and Children in the Letter of Determination. Health boards must submit details of their working capital levels to the Department of Health and Children on a quarterly basis. This is designed to ensure that excess debts, which would allow financing of current expenditure beyond approved levels, cannot accumulate.

Service Plan Reviews: Formal review meetings take place between senior staff at the Department of Health and Children and each health board on a regular basis over the course of the year to assess progress on delivery of service plan objectives. Prior to the reviews, the health boards are required to report to the Department with regard to their performance to date against plan. These reports are placed on the Department's Intranet and line divisions are

advised of their existence. Service Plan Review Reports are more comprehensive than the highly aggregated monthly Integrated Management Reports, and relate more closely to individual service developments as set out in the Service Plan.

Monthly Returns to the Department of Finance: Separate monthly returns for current and capital cash issued, showing actual amounts issued from each subhead per month to date and projected amounts to the year end, are submitted by the Department of Health and Children to the Department of Finance by the 10th working day of the following month (from January 2003, this "lag" period is to be reduced to 5 working days). The cumulative variance against budget is explained. These reports contain information about the cash drawn down by the Department of Health and Children from the Exchequer and paid to the health boards and other providers in order to finance their activities. They provide no more than a broad indication of the volume of spending being undertaken by the health boards and other providers. Details of expenditure actually incurred, analysed by health board, are provided in separate expenditure reports submitted by the Department of Health and Children to the Department of Finance.

These monthly cash drawdown figures are assessed by the Department of Finance against the monthly profile prepared by the Department of Health and Children at the beginning of the year and against the previous year's expenditure for the same period. Any necessary explanations are sought from the line divisions in the Department of Health and Children. This process is typically the key element in the monitoring of voted expenditure trends and the resulting analysis, taken in conjunction with trends in the main revenue aggregates, are used to inform the Government of the emerging budgetary outturn and to highlight, where necessary, the need for corrective action. Consolidated Integrated Management Reports, when received, are also checked for consistency with these monthly returns.

VII. CAPITAL EXPENDITURE

Of the total ¤8.2[3] billion allocated to the Department of Health and Children in 2002, just under ¤500 million related to capital expenditure. This was allocated almost entirely to health boards.

Hospital Planning Office: The Hospital Planning Office has the lead role within the Department of Health and Children in assessing, planning and monitoring capital projects throughout the health service, including non-hospital projects. Its functions include:

- Assisting in the preparation of the Department of Health and Children's annual and long term capital programmes;
- Providing investment, planning, programming and cost advice to line divisions within the Department of Health and Children and to health boards as contracting authorities;
- Advising and supporting health boards in the management of their programmes;
- Preparing design briefs, cost estimates, budgets and cashflow forecasts in relation to specific projects;
- High level management and control of the approved capital expenditure allocation; and
- Ensuring compliance with EU directives, building regulations and national standards.

National Development Plan: Published in 1999, the National Development Plan provided

[3]Estimates for Public Services (Abridged Version) 2002.

for a multi-annual programme of infrastructure development in the health service covering the period 2000 to 2006. The Health Capital Programme falls within the Economic and Social Infrastructure Operational Programme. Funding on a global rather than project-specific basis for each year of the Plan was indicated at the outset and this indicative funding forms the basis for discussion with the Department of Finance for the annual Estimates, together with issues such as inflation, essential projects, and other estimates adjustments.

At the outset, in 1999, each health board was, for planning purposes only, provided by the Department of Health and Children with details of indicative allocations analysed by care group (i.e. acute hospitals, disability services, services for older people, mental health, community health and childcare). The indicative allocations for individual health boards were determined in line with the regional criteria set for the overall National Development Plan and by reference to the overall indicative funding level.

For multi-annual planning purposes, health boards were requested to draw up capital expenditure plans for the period 2000 to 2006, for submission to the Department of Health and Children, in line with their indicative allocations and taking account of all contractual commitments being carried forward from projects commenced prior to the National Development Plan. The purpose of these capital expenditure plans was to identify, in broad terms, how each health board foresaw the development of health infrastructure within its area and within each care group over the life of the National Development Plan, working within the annual funding limits available. Each health board's capital expenditure plan is subject to continuous review by the health board's chief executive officer and National Development Plan manager to reflect inflation, changes in funding, service delivery, etc. The Hospital Planning Office is responsible for managing the Health Capital Programme under the National Development Plan in association with the appropriate line division within the Department of Health and Children.

Project Approval Process: Notwithstanding the indicative allocations flowing from the National Development Plan, each capital project requires specific approval from the Department of Health and Children. All capital projects costing in excess of ¤6.3 million require approval from the Department of Health and Children at up to 17 separate stages as well as approval from the Department of Finance at both design and tender stages. Minor capital works (i.e. those costing less than ¤6.3 million) and equipment procurement also require the specific approval of the Department of Health and Children (see below).

Approvals Required in line with Procurement Procedures for Capital Projects.

Major/Medium projects

- DoHC agreement to develop project
- Approval to establish Project Team to develop design brief

DOF approval at this point.

- Approval of design brief (including setting construction cost limit) and advertising for design team selection
- Approval to appoint selected design team
- Approval of Development Control Plan (Stage 2)
- Approval of Sketch Design Stage (Stage 3)
- Approval to advertise for contractors

DOF approval at this point.

- Approval to seek tenders
- Approval to tender acceptance
- Approval to significant nominated sub-contracts (e.g. mechanical/electrical etc.)
- Approval to appoint site staff
- Approval to appoint project manager (where appropriate)
- Approval of variations over an agreed cost threshold (where appropriate)
- Approval of construction contract final account
- Approval of equipment lists
- Approval of equipment tenders
- Approval of project final cost

Minor Capital

- Approval of Project Brief and project cost

Equipment (stand alone)

- Approval of proposed requisition

Health boards must also adhere to normal public sector procurement processes such as those relating to National Procurement Procedures and EU Directives.

Each project is managed by the relevant health board with provision for professional and line division input from the Department of Health and Children for all major projects as required.

The various stages involved are set out in detailed procedural manuals, based, inter alia, on the Department of Finance's *"Guidelines for the Appraisal and Management of Capital Expenditure Proposals in the Public Sector"*, which have been further developed by the Department of Health and Children.

Public Capital Programme: The National Development Plan contains indicative capital allocations only. Actual capital expenditure allocations are determined in each year as part of the annual estimates negotiations described above. The capital allocation is published, initially, in the Estimates for Public Services (Abridged Version) and, subsequently, in the Revised Estimates for Public Services. The Public Capital Programme published simultaneously with the Revised Estimates for Public Services contains greater detail on the range of public capital expenditure, including that for the health services.

Funding Capital Projects: The Department of Health and Children provides, on an ongoing basis, cash to fund projects, through the contracting authority (usually a health board) on a

reimbursement basis. Reimbursement is based on a system of certification of expenditure incurred for approved projects by the chief executive officer of the relevant health board.

In practice, the health boards incur the expenditure and submit a claim form which is approved by the chief executive officer, to the Department of Health and Children. The Department then recoups cash to the health boards. Only approved projects are funded by the Department of Health and Children.

In the short term, pending completion of the certification and re-imbursement procedures described in the preceding paragraph, health boards make due payments to contractors from their revenue funding stream (which is designed to meet the cost of the day-to-day activities of the health board).

Managing Capital Projects within Health Boards: All health boards have employed National Development Plan managers to co-ordinate all capital projects within each health board. They have a liaison role with the Department of Health and Children and regularly provide reports on expenditure, budget, contractual commitments, etc.

[2]The Health Board Executive (HeBE) is a statutory body to promote and develop conjoint working between health boards. Its functions include rationalising, in one organisation, the administrative work that is common to all health boards. This will also include developing an IT strategy for the health boards, and co-ordinating a common approach on materials management and procurement, in particular.

Appendix 5

DIAGNOSIS RELATED GROUPS/CASEMIX

Traditionally, the output of hospital services was measured in terms of patients treated, sessions provided, bed days used or average length of stay. While useful in themselves, these indicators of activity revealed little about the complexity of cases treated, the likely costs involved or the relative efficiency of hospitals in managing their caseload. It was recognised that funding hospitals on an incremental basis, without relating costs directly to complexity of activity, was unsatisfactory since neither equity nor efficiency could be promoted. The first proposals for reforming budgetary allocations to hospitals were made by the *Commission on Health Funding* in 1989. The Commission recommended that hospitals should receive global budgets for the provision of an agreed service level based on:

- an assessment of the activity level implied by the hospital's agreed role and catchment area, and
- the casemix-based cost of meeting that activity level.

In 1991 the Department of Health established a National Casemix Project to select a measure capable of quantifying hospital workload in a way that was meaningful to clinicians and managers. The objectives of this project were to[1]:

- quantify hospital output in a way that would be meaningful to all participants in the health care system, both in terms of activity and cost;
- use casemix analysis to promote equity in resource allocation between hospitals;
- provide hospital management with a means of managing resources more effectively;
- assist in developing mechanisms for monitoring the quality of patient care; and
- put in place a system of output measurement which would support performance audit in health agencies and in the Department of Health.

The casemix measure chosen assigns all in-patient cases exclusively to one category (known as a Diagnosis Related Group).[2] Each Diagnosis Related Group represents a class or category of cases which may be expected to have the same clinical characteristics, receive similar treatment and absorb the same amount of hospital resources, i.e. physician and nursing input, theatre, laboratory, pharmacy, catering and cleaning costs.

Wiley and Fetter (1990)[3] demonstrated that this casemix measure could be applied successfully to Irish hospital discharge data, collected through the Hospital In-patient Enquiry System. The Hospital In-patient Enquiry system is the national database for all acute hospital discharges which records demographic data, hospital stay information, diagnostic data and data on procedures performed for each discharged patient. The information system was and is therefore in place for the collection of the casemix measurement activity data.

Estimates of the casemix budget adjustment draw on two main data sources: hospital activity data (from the Hospital In-patient Enquiry system) and hospital cost data. The hospital cost data are submitted to the Department of Health and Children through a 'Speciality Costing' system. This system has been operating within the Department of Health and Children for a number of

[1]Casemix Manual, 1993, Department of Health.
[2]Diagnosis related groups were developed by a team of researchers at Yale University led by Fetter, Thompson and Brown (1994). The development of diagnosis related groups was motivated by the need for a utilisation review, mandated by the 1965 Medicare law on payment of elderly patients in hospitals (Rodrigues, 1989).
[3]Wiley, M.M., and Fetter, R. Measuring Activity and Costs in Irish Hospitals: A Study of Hospital Casemix, Dublin, 1990.

years. The speciality costing system has as its output a set of costs for each speciality area within a hospital. It distinguishes between the direct costs of treating a patient and the indirect cost associated with patient care.

In 1993 the Department of Health, for the first time incorporated a casemix adjustment within its budgetary allocation to a group of fifteen hospitals. Wiley (1997)[4] summarises the essentials of this casemix adjustment as follows:

> 'hospitals are stratified according to teaching or non-teaching status; activity data from the relevant hospitals are assigned to Diagnosis Related Groups and a case mix adjusted cost is estimated for the individual hospital and hospital group; a budget allocation rate is then determined on the basis of a 'blend' of the hospital's case mix adjusted case cost and that estimated for the relevant hospital group.'

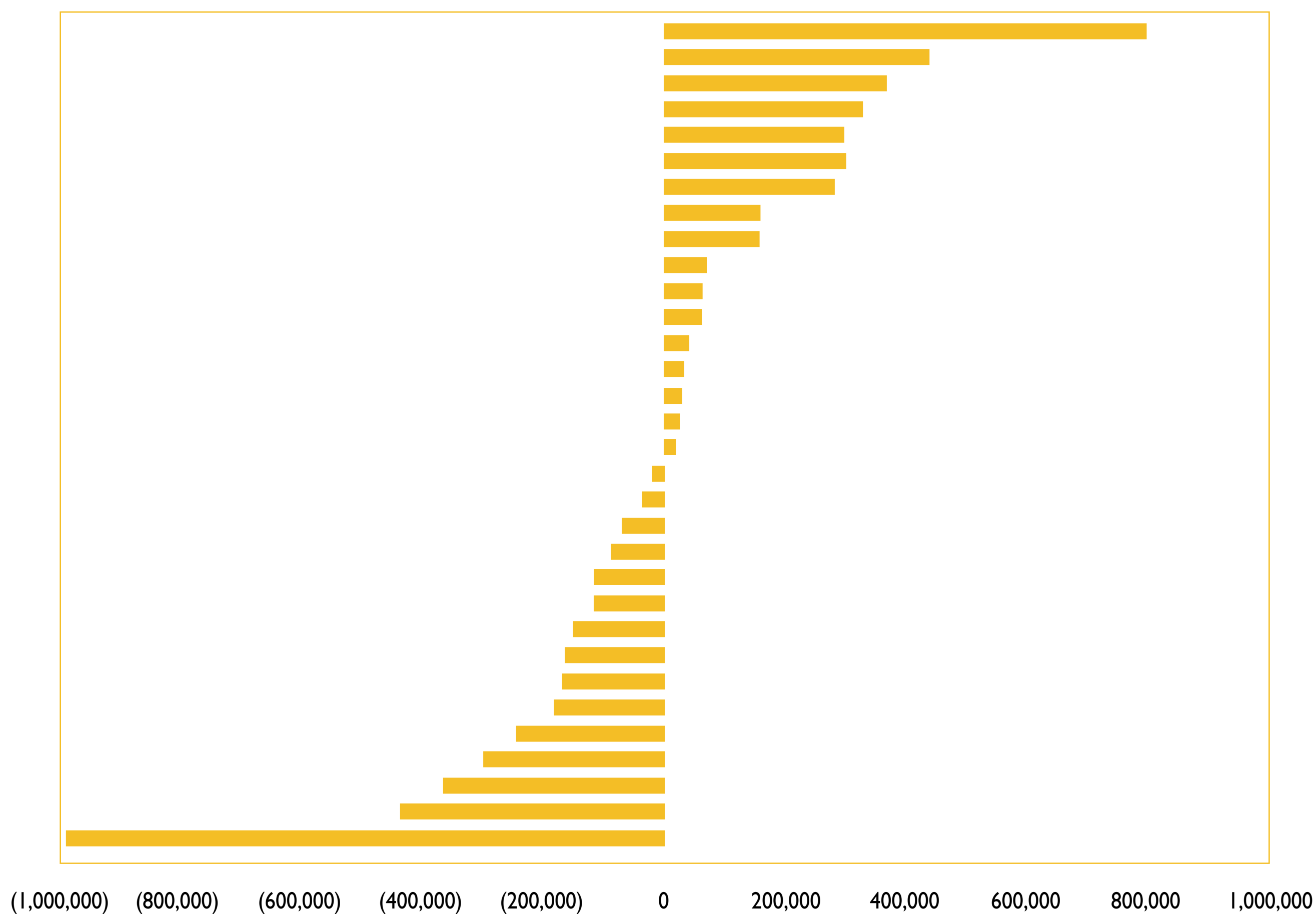
Casemix analysis was used to make small adjustments to 5% of the in-patient budgets; the remaining 95% was based on the hospital's historical allocation. This mechanism was introduced on a budget neutral basis, with the inefficient hospitals losing funding and the efficient hospitals gaining additional funding.

This process was extended to 21 hospitals in 1994, 23 hospitals in 1995 and 26 hospitals in 1996 (Fitzgerald et al, 1998)[5]. It has since been extended to all public acute hospitals discharging more than 5,000 patients per annum, 32 in total. These 32 hospitals account for 74% of all acute hospital activity in Ireland. Casemix has also been extended to day cases.

The casemix adjustment for 2002 for the 32 hospitals are shown in Figure Ax.1. This shows that one hospital lost approximately ¤1million, while one hospital gained approximately ¤800,000.

[4]Wiley, M.M., Financing the Irish Health Services, Chapter 15; Robins, Joseph, (ed), Reflections on Health: Commemorating Fifty Years of the Department of Health, 1947-1997 (Dublin, Department of Health, 1997) pp 210-221.
[5]Fitzgerald, A, and Lynch, F., Casemix Measurement: Assessing the Impact in Irish Acute Hospitals, Administration (Spring 1998) 46 pp 29-54.

Figure: Ax.1 Casemix Adjustment 2002

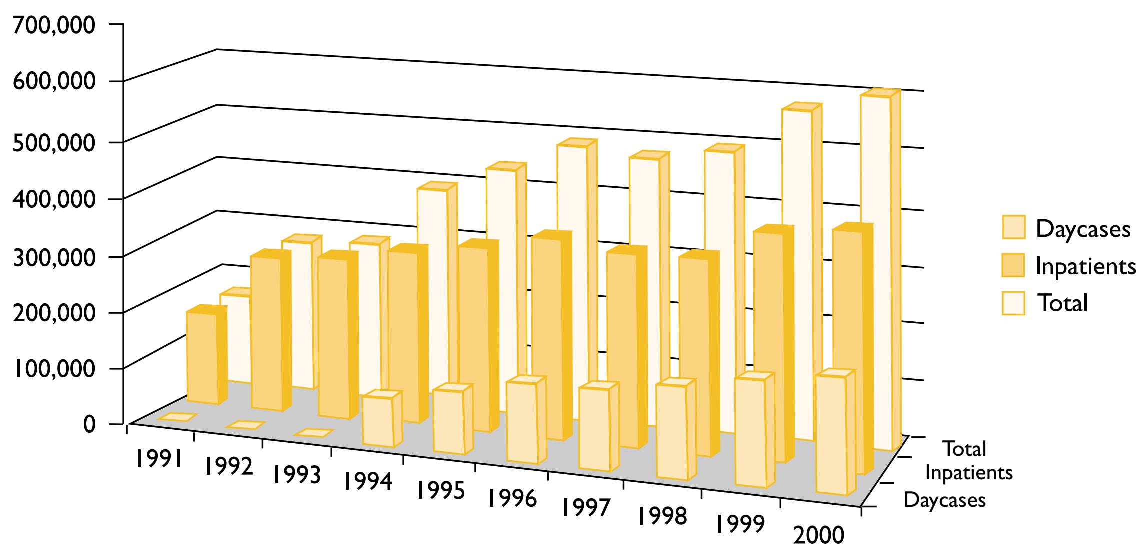


Graph depicts actual Casemix Budget outturns by hospital (names deleted) from a negative outturn of ¤ 1m to a positive outturn of ¤ 800,000

The casemix budgetary mechanism was designed to improve hospital efficiency. Hospitals are informed, by the Department of Health and Children, of their ranking relative to others within their group. Although the adjustments are small in the context of the overall hospital budget, it does provide an incentive for hospitals to improve productivity so as not to lose funding.

The rate of adjustment to hospital budgets (known as the blend rate) has increased over time to 20% of the hospital in-patient budget and to 10% for day cases. The Department of Health and Children has indicated that it plans to extend this blend rate in the future. It has been recognised, however, that some improvements need to be made to the speciality costing system to ensure uniformity of cost data across hospitals. Once this has been achieved, the blend rate may be extended. Figure Ax.2 shows the development of casemix over time.

Figure: Ax.2 Growth in the application of Casemix



Appendix 6

AUDIT OF STRUCTURES

The primary focus of the "Audit of Structures" is to establish the organisational improvements needed to strengthen the health system to meet the challenges of implementing the programme of development and reform set out in the Health Strategy *(Quality and Fairness: A Health System for You)*. The scope of the project involves a critical examination of:

- The number and configuration of existing health organisations;
- Their interactions with one another and with the Department of Health and Children;
- The adequacy of governance arrangements; and
- The scope for rationalisation.

Within the scope of this analysis and proposed changes the Audit should ensure that there are clear lines of accountability and communication between each part of the system; no overlap or duplication between organisations; and a proper alignment of the structures to the objectives outlined in the Health Strategy.

The Audit is examining the role and functions of a wide range of State agencies (excluding voluntary hospitals and agencies funded by the State).

Appendix 7

EXTRACTS FROM THE CONSULTANTS' COMMON CONTRACT[1]

Clinical Independence of Consultants (Contract - Section 5.2)

5.2 Being a consultant involves continuing responsibility for investigation and for the treatment of patients without supervision in professional matters by any other person. This continuing responsibility for investigation and for treatment of patients is a personal matter between each consultant and each patient in his care and it extends for as long as the patient remains in the consultant's care. The consultant may discharge this responsibility directly in a personal relationship with his patient, or, in the exercise of his clinical judgement, he may delegate aspects of the patient's care to other appropriate staff, or he may exercise responsibility concurrently with another doctor or doctors. Notwithstanding this however, the unique position of the consultant in the hospital requires that he carries the continuing responsibility for his patients so long as they remain in his care.

Responsibilities of Consultants (Contract - Section 6.2)

6.2 As a consultant, your responsibilities will include, inter alia, responsibility for:

(i) producing a realistic agreed schedule which specifies how you intend to discharge in person your full contractual commitment, over the period from Monday to Friday, taking into account the exigencies of the service and the most effective utilisation of resources,

(ii) supplying adequate advance notice in writing to hospital management advising them of all planned absences, together with their duration,

(iii) ensuring that fixed sessions, in particular Out Patient and Theatre sessions etc., should start as scheduled in order to minimise delays for patients and possible disruption of services,

(iv) providing management with rosters indicating clearly who will be on call and available to the hospital at any given time where approved on-call/emergency services are to be provided,

(v) agreeing with management the details of the service levels and mix to be provided within the scheduled commitment,

(vi) supplying to (the employing authority) such information on the discharge of your scheduled fixed and flexible sessions as is necessary and reasonable to establish that you are fulfiling your contractual commitment. The obligation to provide a schedule and information on the discharge of the scheduled commitment exists independently of the other provisions of this contract and accompanying Memorandum of Agreement,

[1]The Consultants' Common Contract is in two parts; (i) the Contract; and (ii) a Memorandum of Agreement

(vii) participating, as of right in the selection process for Non-Consultant Hospital Doctors, and in the selection process for such other staff as the employing authorities agree are appropriate, in in-service teaching and training of medical and other staff, in research within the hospital and in administration outside the management of your own particular department or unit of the hospital,

(viii) participating in a process of clinical audit, which will preserve the confidentiality of the doctor/patient relationship,

(ix) providing information to (the employing authority) including data for hospital information systems and service planning and for such other purposes as (the employing authority) and you agree are appropriate.

Consultant Time Commitment (Memorandum of Agreement – Section 2.11)

Scheduled Commitment

2.11.1 The time commitment contracted by a consultant will be expressed in terms of notional three hour sessions.

2.11.2 A consultant's time commitment, which will be personally discharged, will be scheduled in sessions during the hours normally worked within the Monday to Friday working week. The requirement to personally discharge all of the commitment does not preclude the consultant from delegating aspects of his scheduled work while the time commitment to (the employing authority) is being personally discharged elsewhere.

Consultants in Management (Memorandum of Agreement – Section 6.6)

6.6 Consultants in Management

6.6.1 For hospitals to operate in an efficient and effective manner it is necessary that decisions affecting patient care are taken as near as possible to the point of service delivery. Consultants need to be involved in the management process. This involvement commences with the consultant's responsibility to manage his own practice and will involve co-operation with colleagues and other health professionals, at department, unit, hospital or hospital group level, extending to involvement in the management of the hospital/hospital grouping through direct membership or representation on the hospital Executive Management Board.

6.6.2 Each hospital or hospital grouping will have an Executive Management Board, the precise constitution and role of which will depend on the structure and size of the hospital or hospital grouping. It is equally necessary that sub-Board structures are put in place to assist in the management process. The recent experience of the pilot projects in a number of hospitals confirms that the concept of a distinct unit, grouping the clinical functions together under the leadership of a selected consultant (e.g. a Clinical Directorate model), represents an effective model to facilitate the participation of Hospital Consultants in the management process.

6.6.3 It is agreed that (the employing authority) and the Consultants will work together, and will have the support of the Department of Health and Children, in identifying the most suitable management models for implementation in individual hospitals/hospital groupings.

6.6.4 It is acknowledged that the effectiveness of the leader of the unit is dependent not alone upon the calibre of the person appointed but upon the support, co-operation, and commitment of the members of the unit and of the Consultants in general. The leader of the unit will be appointed by management on the recommendation of the Consultants in the unit and should be for a fixed term, (e.g. 3 to 5 years) and involve the allocation of a number of designated sessions to fulfil his role.

Appendix 8 - Integrated Management Reports

IMR'S (FINANCE) 2002 - VARIANCE AGAINST DUE DATES[1]

HEALTH BOARDS	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
DATE DUE	25-Feb	25-Mar	25-Apr	25-May	25-Jun	25-Jul	25-Aug	25-Sep	25-Oct	25-Nov	25-Dec	25-Jan
ERHA	-44	-16	-7	-12	-7	-35	-10	-2		-7		
MIDLANDS	-2	3	3	-3	3	0	2	0	0	0	6	
MID-WESTERN	-4	-1	0	-3	0	-1	-2	-2	-3	-1	-12	
NORTH EASTERN	-39	-11	-1	-10	-1	6	-3	-5	-3	-1		
NORTH WESTERN	-31	-3	-7	-12	-8	-13	-8	1	-3	0		
SOUTH EASTERN	-63	-35	-4	-10	-43	-13	-16	-6	-5	0		
SOUTHERN	-28	-14	-8	-35	-8	0	-4	-5	-4	-4	-12	
WESTERN	-25	-10	1	-2	1	-4	-2	-1	0	0	-12	
VOLUNTARY HOSPITALS												
MERCY	-65	-37	-6	-12	-6	2	-29			-18		
PORTIUNCULA	-25	-10	1	-2	6	-6	-1	-1	0	-1	-12	
SOUTH INF/VIC.	-7	-2	-5	-2	-5	0	2	-1	-1	-1	-12	
ST. JOHN'S	-28	0	-1	3	-1	3	3	-1	0	-1	-4	

(-) Indicates the number of days the report was late.
0 - Indicates the report was on time.
[1]Based on dates IMRS were received in the Department of Health and Children.

Source: Department of Health and Children

Appendix 9

INVESTMENT IN INFORMATION TECHNOLOGY IN THE MIDLAND HEALTH BOARD

SAP is a fully integrated software package with available modules including financials, materials management, human resources, payroll, asset management and asset maintenance. PPARS (Personnel, Pay, Attendance and Recruitment System) is the human resource module of SAP. The investment in IT, particularly SAP, has led to significant improvement and changes even within the current organisational culture and structures.

The following are some examples from a financial perspective:

Financial Performance prior to SAP:	**(1998 AFS)**
- Cumulative deficit:	¤ (1.2m)
- Stock value:	¤ 3.3m
- Stock held as a % of expenditure:	2.1%
- Patient debtors:	¤ 1.3m
- Patient debtors as a % of income:	9.1%

Financial Performance since SAP:	**(2001 Draft AFS)**
- Cumulative surplus:	¤ 0.7m – a turnaround of ¤ 1.9m
- Stock value:	¤ 3.9m
- Stock held as a % of expenditure:	1.3% - improved utilisation of working capital
- Patient debtors:	¤ 0.86m
- Patient debtors as a % of income:	3.5% - improvement in debtor management

As well as the obvious financial improvements, SAP has enabled the Midland Health Board exploit business process improvements. Examples include:

- Electronic Fund Transfer Payments instead of manual cheques
- Consignment stock and reduced investment in working capital
- E–procurement and automated stock replenishment
- Reduction in Store locations
- Automated purchase to pay process
- Commitment reporting
- Control and approval at point of order
- On line bank reconciliation
- Controls embedded in system – facilitates budget management
- Bar coding – reduction in stocks and stocktaking
- Real time integrated financial information for improved budget management

ADDENDUM

Number	Recommendation	IT Requirements	Timeframe
	THE NATIONAL MANAGEMENT OF THE HEALTH SERVICE		
R3.1	We recommend that the national management of the health service should be carried out by an "Executive" outside the Department of Health and Children.	none	asap
R3.2	Establishment of the Executive must involve the consolidation of many of the existing agencies within its functions.	none	asap
R3.3	There should be no net increase in staffing levels within the health service to give effect to recommendation R3.1.	none	n/a
R3.4	Staff of the Executive should be recruited by way of open competition and not restricted to the civil or public service.	none	n/a
R3.5	Recruitment of the CEO of the Executive should be by means of an international search and selection process.	none	n/a
	THE RESTRUCTURED ROLE OF THE DEPARTMENT OF HEALTH AND CHILDREN		
R3.6	The role of the Department of Health and Children should include: (i) Acting as advisor to the Minister and the Government; (ii) Developing and costing policy responses and strategies to achieve the necessary reform to address identified problems arising from existing policy; (iii) Developing and costing policies for future service developments; (iv) The dissemination and active sponsorship of best practice; (v) The Estimates process; (vi) The management of the legislative agenda as it relates to the health service; (vii) Acting as "regulator" in respect of national health care standards; (viii) International representation of the Irish health service (at the OECD, WHO etc.); (ix) Research and identification of ongoing developments in international best practice in the health area and consideration of the extent to which they may be adapted for implementation in an Irish context; (x) Risk assessment/management; and (xi) Issues relating to public sector pay policy.	none	On establishment of the Executive

Number	Recommendation	IT Requirements	Timeframe
	THE ROLE OF THE EXECUTIVE		
R3.7	We recommend that the role of the Executive should include: (i) Strategic planning and management of change in the health system, including location of services, aimed at improved service delivery; (ii) Managing the delivery of health services within budget; (iii) Manpower planning and needs assessment; (iv) Managing staff relations; (v) The resource allocation process; (vi) Analysing annually health spending by: (a) Programme/care group (childcare, hospital services, disability services etc.), (b) Health board region; (vii) Under each of the headings at (vi)(a) and (vi)(b) above, the following actions should be undertaken: (a) A comparison of performance, productivity, quality of care and value for money, (b) Summary results of the comparative analysis undertaken at (vii)(a) above should be published, in a standardised format, within 6 months of the end of the relevant accounting period; (viii) Identify the problems and issues highlighted by the comparative analysis undertaken at (vi) and (vii) above; (ix) Research and identification of ongoing developments in international best practice in the health area and consideration of the extent to which they may be adapted for implementation in an Irish context; and (x) Risk assessment/management.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	On establishment of Executive
R3.8	In regard to recommendation R3.7(vii)(a), we recommend that the existing National Performance Indicators Project Team define appropriate measurable definitions and indicators of "performance", "productivity" and "value for money". This group should submit its recommendations to the Secretary General and Minister for Health and Children.	None	Within 6 months of report publication
	RESTRUCTURING GOVERNANCE OF THE HEALTH SERVICE – THE EXECUTIVE		
R3.9	The Executive board should be statutorily responsible for the execution of national health policy and should be formally accountable for its performance to the Minister for Health and Children.	none	On appointment of Executive Board

Number	Recommendation	IT Requirements	Timeframe
R3.10	The Executive board at R3.9 above should assume the functions associated with the management of the health service. These would be similar to the normal functions exercised by any corporate board and would include: (i) Implementing the overall strategic direction of national health policy for the health service; (ii) Approval of the annual regional Service Plans; (iii) Monitoring performance against objectives and ensuring that corrective action is taken when necessary; (iv) Ensuring that services are delivered within budget/determination; (v) Appointment of the chief executive officer (CEO) of the Executive; (vi) Establishment of an audit committee; and (vii) Approval of the Annual Report and Financial Statements.	none	On appointment of Executive Board
R3.11	The board of the Executive should be accountable to the Minister for Health and Children.	none	On appointment of Executive Board
R3.12	The CEO of the Executive should be accountable to the board of the Executive.	none	On appointment of Executive CEO
R3.13	The CEO of the Executive should be an accounting officer.	none	On appointment of Executive CEO
R3.14	The CEO of the Executive should be responsible for the provision of financial and other information necessary to support the Secretary General of the Department of Health and Children in his/her role as accounting officer and policy advisor to the Government.	none	On appointment of Executive CEO
R3.15	The Executive board should have not more than 12 members made up as follows: (i) An independent Chairman drawn from outside the health sector; (ii) Ex-officio, the CEO of the Executive; (iii) Ex-officio, the Director of Finance of the Executive; (iv) A nominee of the Department of Health and Children; and (v) Not more than 8 non-executive members, reflecting the balance of expertise required, appointed by the Minister for Health and Children.	none	On appointment of Executive Board
R3.16	In appointing the non-executive members at R3.15(v) above, the Minister should have regard to the appropriateness of each candidate's skills and experience.	none	n/a

Number	Recommendation	IT Requirements	Timeframe
	RESTRUCTURING GOVERNANCE OF THE HEALTH SERVICE – HEALTH BOARDS		
R3.17	The functions of the regional health boards should include: (i) Advising on local and regional health service requirements; (ii) Representing local community and professional interests in terms of regional service provision; (iii) Advising and providing input in respect of the regions annual Service Plan; (iv) Monitoring performance within the regional area against national health care objectives; (v) Establishment of an audit committee; and (vi) Approval of the regional Annual Report and Annual Financial Statements.	none	On establishment of Executive
R3.18	The CEOs of the regional health boards should be accountable to the CEO of the Executive for the execution of their functions, including delivery of services within budget/determination, in respect of national service provision.	none	See R3.17
R3.19	CEOs of regional health boards will be accountable to the CEO of the Executive for the performance of all staff, including the managers of health board hospitals, employed by their health board.	none	See R3.17
R3.20	The CEOs of the major teaching hospitals providing national services would be accountable directly to the CEO of the Executive because of their role in the provision of national services and specialties.	none	See R3.17
R3.21	The necessary changes to the Health Acts 1970 and 1996 and the Eastern Regional Health Authority Act 1999 should be brought forward by the Department of Health and Children to give effect to the above changes.	none	asap
	CODE OF GOVERNANCE		
R3.22	The Department of Health and Children should produce a written Code of Governance for all agencies in the public health sector. This code should enshrine the principles contained in the Department of Finance Code of Practice for the Governance of State Bodies.	none	Within 6 months of the report publication
R3.23	All Executive board members should be independent and act solely in the interest of the board.	none	n/a

Number	Recommendation	IT Requirements	Timeframe
	SERVICE PLANNING – SUPPORTING THE MANAGEMENT FUNCTION		
R4.1	A single, comprehensive and standardised template for Service Plans should be adopted. This should cover Service Plans at all levels: clinical Consultants, hospitals and non-hospital General Managers at sub-health board level as well as regional health boards and the national Executive. Higher level Service Plans should be derived from lower level Service Plans (e.g. hospital from the aggregate of individual Consultants).	none	On completion of R4.2
R4.2	Pending establishment of the Executive, a working group, including representation from the the Department of Health and Children, Department of Finance, and the regional health boards, should be established to devise an appropriate standard template and to make recommendations to the Secretary General and Minister for Health and Children.	none	To commence immediately and report within 6 months
R4.3	The terms of reference for the working group recommended at R4.2 above should, having regard to the data improvements afforded by the investment in information technology recommended in Chapter 10, include consideration of how best the Service Plans could be structured to provide: (i) Clear statements of projected service provision analysed by the main care groups (including each specialty in hospitals), linked to funding (both pay and non-pay elements); (ii) Integrated financial and non-financial data. Formal and clear inter-connections are needed between cost (approved determination) and activity (level of service being provided); and (iii) Pay and employment data.	none	See R4.2
R4.4	The working group at R4.2 above should also consider how existing reporting arrangements might be restructured to provide, again in a standardised format, an ongoing report on progress against targets and objectives set out in the Service Plan (see also Chapter 9 recommendations in this regard). In particular: (i) Monthly Integrated Management Reports should be closely linked to the Service Plan. (ii) Quarterly Performance Indicator Reports should continue to be explicit on delivery of targets and should also be linked to the Service Plan. (iii) Annual Reports and Financial Statements should specifically link back to financial and activity performance envisaged in the Service Plan. This would provide the final link between the Letter of Determination, Service Plan, Integrated Management Reports, Annual Financial Statement and Annual Report.	none	See R4.2
R4.5	Service Plans of the Executive and the health boards should ideally be agreed and in place before the commencement of the year to which they relate.	none	asap

Number	Recommendation	IT Requirements	Timeframe
	REBALANCING FINANCIAL ALLOCATIONS		
R4.6	Funding of regional health boards should be evidence based and prioritised across identified needs. In particular, in allocating budgets between health boards, the Executive should take account of a number of nationally agreed key factors, as they apply across health board regions, such as: Demographics / Specialities / Client Profile / Capacity Services / Activity / Infrastructure / Socio-economic profiles	none	Commence on completion of R4.7
R4.7	Pending establishment of the Executive, a working group representative of the Department of Health and Children, Department of Finance, and the regional health boards should be established: (i) To conduct advance development work on defining the appropriate factors under R4.6 above; (ii) To detemine the relative weighting which should be ascribed to each factor in determining each health board's allocation; and (iii) To examine the phasing arrangements that are appropriate to ensure a smooth transition to the new arrangement.	none	To commence immediately and report within 12 months
	MULTI-ANNUAL BUDGETING		
R4.8	Service Plans should be framed on a multi-annual basis.	none	2004 Service Plan Cycle
	SUPPLEMENTARY ESTIMATES		
R4.9	If, notwithstanding the statement of the Minister for Finance in his Budget speech delivered in December 2002 that Ministers and their Management Committees will be required to manage strictly within the allocations given to them, there are to be supplementary estimates in the future, we recommend that the Department of Finance and the Department of Health and Children should: (i) Review the appropriateness and coverage of "allowable supplementaries"; (ii) Make recommendations to the Minister for Finance in this regard; and (iii) Thereafter conduct biennial reviews by reference to the volume and content of supplementary estimates allowed in the intervening period.	none	n/a

Number	Recommendation	IT Requirements	Timeframe
	DEFINING UNIT OF ACCOUNTABILITY IN GENERAL HOSPITALS		
R5.1	We recommend that clinical Consultants and their practices in individual clinical specialties be designated as the primary unit of accountability in the general hospital programme.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	immediate
	CONSULTANTS' COMMON CONTRACT		
R5.2	The Consultants' common contract should be reviewed, for existing Consultants, to ensure that the following principles are explicitly reflected in the contract: • Formal recognition and agreement by Consultants, as the key decision makers, of their responsibility to manage resources to which they are entitled to conduct their practice within agreed budgets at department, specialty and individual Consultant level. • Participation in arrangements for collective representation of Consultants at hospital management committee level. • Agreement of core hours of attendance. • Active management and optimisation by Consultants of resource allocation against agreed practice, specialty and department Service Plans and budgets. • Cooperation with arrangements for measurable and transparent systems of continuously monitoring adherence to public and private practice contractual commitments. • Where there are competing public and private practice demands on Consultants' time and resources, the former should have priority call on such time and resources at all times.	none	asap
R5.3	All new Consultant appointments, covering new posts and the replacement of existing Consultants, should be on the basis of contracting the Consultants to work exclusively in the public sector.	none	asap
R5.25	The provisions of Consultants' existing common contract should be enforced to ensure that the following is undertaken: (i) The setting of core times when a Consultant must be available to patients in the public hospital; and (ii) Formal active monitoring of work commitment in respect of public patients.	none	immediate

Number	Recommendation	IT Requirements	Timeframe
R5.26	The health board/hospital CEO should put mechanisms in place to ensure (i) Consultants' sessional contractual commitments to the public hospital are met; and (ii) The cap on private activity in public hospitals is observed both with respect to inpatients and day-cases (i.e. agree with Consultants on the number of private patients to be treated in public hospitals).	none	immediate
	SERVICE PLANNING IN HOSPITALS		
R5.7	In the case of admitting Consultants who assume clinical care for a patient, the following steps should be taken: (i) Hospital/health board CEO, as appropriate, identify all individual clinical practices within each specialty; (ii) Hospital/health board CEO, as appropriate, identify a lead clinician as Head of Specialty; (iii) Hospital/health board CEO, as appropriate, should agree with the Head of Specialty the assignment of a member of staff as business manager to prepare cost and activity budgets, practice profiles and monthly expenditure reports for the specialty and each individual clinical Consultant's practice within the specialty.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	See R5.1
R5.8	In the case of non-admitting Consultants (e.g. radiology, pathology, etc.), the following steps should be taken: (i) Hospital/health board CEO, as appropriate, identify all non-admitting hospital departments; (ii) Hospital/health board CEO, as appropriate, identify for each department a Head of Department; (iii) Hospital/health board CEO, as appropriate, should agree with the Head of Department the assignment of a member of staff as business manager to prepare cost and activity budgets, practice profiles and monthly expenditure for the department.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental implementation systems development	See R5.1
R5.9	All costs incurred by the non-admitting hospital departments identified at R5.8(i) above should be allocated back to the admitting specialties identified at R5.7(i) above in order to allow the calculation of full costs incurred by specialty and patient.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental implementation systems development	On completion of R5.10

Number	Recommendation	IT Requirements	Timeframe
R5.10	A working group, under the aegis of the Department of Health and Children, should be set up to agree a common national methodology to be applied to the allocation of the indirect costs referred to at R5.9 above.	none	To commence immediately and report within 6 months
R5.11	The business managers recommended at R5.7(iii) and R5.8(iii) above: (i) May cover more than one specialty/department, depending on the particular needs and demands of that specialty/department; and (ii) Should be made available from within existing resources as part of a reorganisation by hospital/health board CEOs of existing duties and responsibilities.	none	See R5.1, R5.7 and R5.8
R5.12	The annual practice/specialty/department Service Plan should include: (i) Clear statements of projected activity, linked to funding (both pay and non-pay elements); (ii) Integrated financial and non-financial data. Formal and clear inter-connections are needed between cost and activity; and (iii) A clear analysis between public and private patients in respect of (i) and (ii) above.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	asap
R5.13	Clear reporting arrangements and responsibilities must be put in place such that: (i) Business managers are responsible for gathering and presenting management data on costs and activities; and (ii) Clinical Consultants/Heads of Department are responsible for providing explanations to the hospital/health board CEO of variances from budget and how such variances will be brought back into line.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	asap
R5.14	Routine reports (monthly, quarterly, annual) should be submitted in the format and within the timescales envisaged in recommendation R9.1.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	See R9.1
	IMPLEMENTATION IN HOSPITAL SECTOR		
R5.15	Business managers should receive continuous relevant training to ensure they have the requisite skills, training and experience in medical and clinical work as well as finance and management to perform their duties. .	none	immediate and ongoing

Number	Recommendation	IT Requirements	Timeframe
R5.16	The health board/hospital CEO should be responsible for determining the appropriate level and quantum of training and for putting in place the mechanisms necessary to ensure that training is delivered.	none	Immediate and ongoing
R5.17	The Executive should liaise with educators to prepare/train clinical Consultants/Heads of Department on an ongoing basis to understand and to work with new financial management information systems.	none	Immediate and ongoing
R5.18	The Department of Health and Children should liaise with the Higher Education Authority to introduce a requirement for medical schools to develop programmes to ensure that every medical student receives at least one module on health economics, technology assessment and financial management and control issues.	none	Immediate and ongoing
R5.19	A working group under the aegis of the Executive, in consultation with the Department of Health and Children, should examine and make recommendations on appropriate incentives for those clinical Consultants/departments that successfully implement recommendations above.	none	On establishment of Executive
	PUBLIC PRIVATE MIX & SERVICE PLANNING		
R5.20	All Service Plans, Practice Plans and monthly, quarterly and annual reports should include a clear breakdown between public and private costs and activities.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	immediate
R5.21	A coding system should be put in place in all cases (e.g. outpatient activity, private patients having tests in a public hospital etc.) and in all hospitals to explicitly identify all activity as relating to public or private patients, as appropriate.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	asap
R5.22	The coding system referred to at R5.21 above should allow for allocating of general overheads incurred by hospitals between public and private patients so that the full cost of treating public and private patients can be calculated. The objective should be to identify the costs of treating individual patients	Systems development required	See R5.21

Number	Recommendation	IT Requirements	Timeframe
R5.23	The Executive should publish in its Annual Report a comprehensive analysis of the amount of public resources consumed by private patients within the public hospital sector.	Systems development required	On establishment of Executive
R5.24	Recognising that implementation of the information systems recommended in Chapter 10 will be necessary to produce accurate information in respect of R5.23 above and the lead in time for the establishment of the Executive, the Department of Health and Children should, on an interim basis, publish such information using the best estimates that are available to it.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	immediate
	EXECUTIVE MANAGEMENT COMMITTEE		
R5.4	Where they do not already exist, chief executive officers in all hospitals should immediately establish an Executive Management Committee.	none	immediate
R5.5.	The role of the Executive Management Committee should include: (i) Agree the hospital Service Plan; (ii) Monitor performance against budget; (iii) Agree corrective measures; and (iv) Advise on policy matters that may arise from time to time.	none	See R5.4
R5.6	The membership of the Executive Management Committee should include, at a minimum: (i) The hospital CEO/manager (as Chairman); (ii) The head of the hospital's finance function; (iii) A clinical Consultant; and (iv) The Director of Nursing.	none	See R5.4
	SERVICE PLANNING IN NON-HOSPITAL PROGRAMMES		
R5.27	In all other areas of the health service (i.e. non-hospital), the individual responsible for the budget (whether clinical or non-clinical personnel) should be held formally accountable for financial performance.	none	Following R5.33
R5.28	The CEO of the Executive and the health board CEOs should analyse the totality of non-hospital related health board activities into clearly defined care groups (e.g. community care, mental health etc) that are consistent throughout the system.	none	On establishment of Executive

Number	Recommendation	IT Requirements	Timeframe
R5.29	The health board CEO should identify a General Manager with responsibility for each care group identified at R5.28 above.	none	immediate and see R5.28
R5.30	Each General Manager should prepare an annual Service Plan and budget for their area of responsibility.	none	See R5.29
R5.31	Each General Manager's Service Plan should include: (i) Clear statements of projected service provision, linked to funding (both pay and non-pay elements); and (ii) Integrated financial and non-financial data. Formal and clear inter-connections are needed between cost and activity.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	See R5.30 and R4.3
R5.32	General Managers should submit routine reports (monthly, quarterly, annual) to the CEO of their regional health board within the format and the timeframe envisaged in recommendation R9.2.	none	immediate and see R9.2
	IMPLEMENTATION		
R5.33	The Health (Amendment) (No. 3) Act, 1996 should be amended, as necessary, to permit the health board CEO to formally assign duties to the General Managers making them accountable to the CEO/line management for their financial decisions. *(The health board CEO should remain the accounting officer for all health board expenditure and nothing in our recommendations is intended to change or undermine this accountability.)*	none	asap
	GENERAL MEDICAL SERVICE		
R6.1	The health board CEO should, in consultation with the General Practitioner (GP), draw up, consistent with national guidelines established by the Executive, a Practice Budget for each GP covering his/her patients registered as medical cardholders.	none	Following R6.6
R6.2	The Practice Budget at R6.1 above should be broken down between: (i) Medical treatments; and (ii) Drug prescriptions.	none	See R6.1

Number	Recommendation	IT Requirements	Timeframe
R6.3	The Practice Budget at R6.1 above should be based on treatment costs having regard to: (i) The demographic profile of each GP's medical card patients; (ii) Attendance, treatment and prescribing patterns; (iii) Attendance of patients at Accident and Emergency clinics; and (iv) Referral patterns to general hospitals.	none	See R6.1
R6.4	In the event that a GP requires funding above the budget agreed at the start of the year, it should be necessary for him/her to submit a request for same to his/her health board CEO citing the clinical factors which have given rise to the overspend.	none	See R6.1
R6.5	Health boards should monitor individual versus normative patterns of referral of patients to hospitals. (This can be facilitated by appropriate identification of patients by source within the hospital coding systems recommended at R5.21.)	none	immediate following R5.21
R6.6	The Secretary General of the Department of Health and Children should take immediate steps to agree with GPs' representatives the necessary changes to GPs' Contract for Service to give effect to recommendations R6.1 to R6.5 above.	none	immediate
R6.7	The Secretary General of the Department of Health and Children should take immediate steps to devise a standard template for annual Practice Plans.	none	Commence immediately and see R6.2 and R6.3
R6.8	GPs should be assigned responsibility for reporting to the health board on the accuracy of their list of registered medical cardholders annually.	none	asap
R6.9	Health boards should introduce new verification and audit procedures to ensure their lists of medical cardholders are accurate.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	immediate
R6.10	Based on an evaluation of the reports at R6.8 by the health board, overpayments made in a previous year (for example, where a patient dies or moves to another GP) should be automatically netted off by the health board against that GP's Practice Budget for the following year.	none	Immediately following R6.8 and R6.9

Number	Recommendation	IT Requirements	Timeframe
	DRUGS PAYMENTS SCHEME		
R6.11	Current arrangements for reimbursing pharmacists under the medical card scheme – i.e. reimbursement on a cost of ingredients basis (without mark-up) plus a flat-rate prescription fee – should be extended to the Drugs Payment Scheme.	none	asap
R6.12	The operation of the Drugs Payment Scheme should be reviewed immediately by the Department of Health and Children, in consultation with the Department of Finance, the GMS (Payments) Board and the health boards. The review should actively examine: (i) Introducing a system whereby health boards would actively monitor and evaluate prescribing patterns by individual GPs, Consultants or Dentists and reimbursement patterns by individual pharmacists, having regard to relevant demographic and epidemiological factors; (ii) Introducing incentive schemes for reducing levels of prescribing and drugs costs; (iii) In recognition of the influence of hospital generated prescribing on community drugs budgets, each health board/hospital CEO should immediately establish Drugs and Therapeutics Committees, comprising Consultants, GPs from the hospital catchment area, supported by pharmacy and financial management expertise, to agree clinically cost-effective common drug formulary; and (iv) Relevant international experience and the lessons from this in containing drugs costs and the rate of growth.	none	Immediate
R6.13	The existing agreement between the Department of Health and Children and the Irish Pharmaceutical Healthcare Association should be evaluated against international experience with similar agreements (particularly in countries of the European Union). The results of this evaluation should be used in the negotiation of any further agreement so as to assure value for money.	none	immediate
R6.14	The Irish Medicines Board should have its remit extended to not just examine new drugs for their efficacy and effectiveness, but also to: (i) Assess their cost effectiveness; and (ii) Approve the drug product for reimbursement under the community drugs scheme (including specifying the conditions on which it may be made available, for example restricted to named patients or in respect of defined clinical treatment regimes).	none	asap
R6.15	The Irish Medicines Board should also be charged with the responsibility to monitor the continuing effectiveness of existing drugs and to delist those which are no longer considered appropriate or clinically cost effective.	none	asap

Number	Recommendation	IT Requirements	Timeframe
R6.16	Where the Irish Medicines Board determines that a cheaper, but equally effective, alternative exists, only the cost of the cheaper drug should be reimbursed by the GMS (Payments) Board. Where a GP prescribes the more expensive branded drug, the cost difference arising should be regarded as entirely private prescribing.	none	Parallel with implementation of R6.14 and R6.15
	COSTING PAY AWARDS		
R7.1	Pending transfer of functions to the proposed Executive, the CEO of the Health Service Employers Agency (HSEA) should report to the Secretary General of the Department of Health and Children and be accountable to him for the financial consequences of pay negotiations and the interim costing of agreements conducted by the HSEA.	none	immediate
R7.2	Prior to any agreement being concluded, the final costing of pay agreements negotiated by the HSEA should be prepared by the Department of Health and Children, drawing on the comprehensive dataset proposed at recommendation R7.6 below.	none	immediate
	EMPLOYMENT INFORMATION AND REPORTS		
R7.3	The CEO of each health board should be responsible for the provision of employment information both for their own direct employees and for employees of all agencies funded by the health board.	none	immediate
R7.4	Health boards should afford appropriate priority and resources to ensure the compilation of timely, accurate and verifiable employment data.	none	immediate
R7.5	Health board CEOs should report employee numbers and pay cost data to the Executive on a monthly basis within the revised Integrated Management Reporting structure recommended at R9.3.	none	immediate on completion of R4.4 and see R9.3
R7.6	The specific details of the pay and employment data to be provided in the health boards' Monthly Integrated Management Reports should be determined by the working group referred to in recommendation R4.4. At a minimum, these should include: (i) Detailed information on gross pay costs, by grade code; (ii) Details on the elements comprising pay (i.e. basic pay, overtime, shift allowances etc), by grade code; (iii) Details on costs of agency working; (iv) Identification of approved vacancies and progress in filling new posts to support service development as set out in the annual Service Plans; (v) Comprehensive listing of voluntary bodies/agencies funded by each health board; and (vi) Similar detail as at (i) to (iv) above in respect of these voluntary bodies/agencies	none	See R4.4

Number	Recommendation	IT Requirements	Timeframe
R7.7	National employment data should be reported by the Executive to the Department of Health and Children within the revised Consolidated Integrated Management Reporting structure referred to at recommendations R9.4 and R9.5.	none	Immediately on completion of R4.4 See R9.4 and R9.5
	STAFFING LIMITS		
R7.8	The Department of Health and Children, in consultation with the Department of Finance, should obtain from the health board CEOs accurate numbers and associated costs of employment (in respect of both their own employees and employees funded by the health boards) to inform the appropriate authorised limit.	none	Within 2 months of report publication
R7.9	The Department of Finance and the Department of Health and Children, with expert assistance as required, should fully review the existing methodology applied by the Department of Finance in calculating the numbers ceiling. The methodology should be based on data from health boards and have regard to the lessons learned from costings produced as part of the "benchmarking" process and to the potential future information flows generated by investment in information technology (see Chapter 10 recommendations on PPARS).	none	Within 6 months of report publication
	COMMON RECRUITMENT POOL		
R7.10	The recruitment of certain key financial, human resource management and information technology personnel, necessary to the successful implementation of the recommendations of this report, should be by means of open competition i.e. from outside the Common Recruitment Pool.	none	Immediate
R7.11	In order to develop and retain suitably qualified personnel in the areas of finance, human resource management and information technology it will be necessary to create appropriate career structures for these personnel.	none	asap
R7.12	The operation of the Common Recruitment Pool should be reviewed having regard to its appropriateness to a modern public service environment, the inflexibilities it engenders and the capacity of the system to attract graduate, professional and other managers to the health service.	none	asap
R7.13	An accelerated management development programme should be put in place for senior managers in the health service.	none	asap

Number	Recommendation	IT Requirements	Timeframe
	AUDIT COMMITTEE		
R8.1	The Secretary General of the Department of Health and Children, the board of the Executive, boards of the regional health boards, boards of agencies and other bodies under the remit of health boards and boards of other statutory agencies should establish an audit committee.	none	Immediate for DoHC & health boards and on appointment of Executive board
R8.2	The audit committee of the Department of Health and Children, of the Executive, of the regional health boards, of boards of agencies and other bodies under the remit of health boards and of other statutory agencies should: (i) Be chaired by: (a) an independent outside person in the case of the Department of Health and Children; (b) a non-executive member of the board in all other cases. (ii) comprise at least 3 members, all of whom should be: (a) independent outside persons in the case of the Department of Health and Children; (b) non-executive members of the board in all other cases. (iii) Report on a regular basis to the Secretary General/board. (iv) Prepare an annual report for the Secretary General/board which, inter alia, should include a copy of its charter.	none	See R8.1
R8.3	The audit committee should be required to follow best practice in ensuring independence and effectiveness in relation to internal audit, risk management and external audit (including managing relations with the external auditor).	none	See R8.1 and R8.2
R8.4	If necessary, legislation should be amended to facilitate these recommendations.	none	asap
	EXTERNAL AUDIT		
R8.5	The draft statutory accounts must be approved by the health board by 1 April following year end and the audited statutory accounts must be completed by the C&AG and laid before the Houses of the Oireachtas within 9 months of year-end in accordance with current statutory requirements. Where this requirement is not met, the CEO should be required to provide a written explanation to the Secretary General, for inclusion in his report referred to at R8.6(v) setting out the reasons why these statutory deadlines have not been met.	none	Immediate

Number	Recommendation	IT Requirements	Timeframe
R8.6	The Department of Health and Children should publish on its website details of the performance of health boards/agencies in terms of meeting their financial accounting responsibilities, including: (i) Year end date; (ii) Date financial accounts/statements are finalised/submitted; (iii) Date audit completed (including Section 6(4) reports, if any, on the accounts); (iv) Details of organisations failing to meet their deadlines should be highlighted in an appropriate manner; and (v) Publish and widely circulate a report with commentary on performance annually by 1 January each year i.e. 12 months after the period to which the report relates.	none	immediate
R8.7	The Comptroller and Auditor General should lay before the Public Accounts Committee a report (with commentary) on performance in meeting accounting and auditing deadlines annually by 1 January each year i.e. 12 months after the period to which the report relates.	none	immediate
	INTERNAL AUDIT		
R8.8	The Secretary General of the Department of Health and Children, the board of the Executive, boards of the regional health boards, boards of agencies and other bodies under the remit of health boards and boards of other statutory agencies should ensure that there is an adequately resourced internal audit function. Where it is considered inefficient, for reasons of scale, for an agency to have a dedicated internal audit unit, the regional health boards should either provide the service centrally or have the function outsourced. .	none	asap
R8.9	The internal audit unit should report directly to the non-executive Chairman of the audit committee	none	immediately following R8.1
R8.10	The audit committee should determine powers and duties of the internal audit unit..	none	immediately following R8.1
R8.11	Internal audit reports should be made available to the external auditor.	none	immediate
	RISK ASSESSMENT AND MANAGEMENT		
R8.12	A systematic assessment of all risks (including financial, operational and clinical risks) must be a central and integral part of all policy development and ongoing operational activity.	none	n/a

Number	Recommendation	IT Requirements	Timeframe
R8.13	A Risk Assessment Unit should be established with immediate effect by the Secretary General of the Department of Health and Children with the task of: (i) Supporting policy makers; and (ii) Driving the implementation of risk management policy and procedures down to local and agency levels.	none	immediate
R8.14	In respect of R8.13(i) the role of the Risk Assessment Unit should be to: (i) Support in an integral and ongoing way national policy developments and negotiations; (ii) Provide technical support and advice to individual officers/sections on the identification and management of risks at policy design stage; (iii) Advise on the design and execution of control measures to minimise risks; and (iv) Review the conduct of risk assessment procedures on new services/schemes within the Department of Health and Children.	none	See R8.13
R8.15	In respect of R8.13(ii) the role of the Risk Assessment Unit should be to: (i) Develop, implement and communicate risk management strategy, policy and procedures across the health service; (ii) Develop and co-ordinate risk management information requirements, reporting thresholds and mechanisms for determining priorities; (iii) Develop, promote and maintain common methodologies for identifying and assessing risk and determining adequacy and cost effectiveness of controls; (iv) Identify and assess accumulations of risk across the health service and interdependencies; and (v) Co-ordinate risk management activity, training and technical support, across the health service.	none	See R8.13
R8.16	A working group should be established to bring forward a report on best practice in terms of risk assessment and risk management in the health sector.	none	To commence immediately and report within 6 months
R8.17	The Risk Assessment Unit should make half-yearly reports to the Management Advisory Committee of the Department of Health and Children on the ongoing effectiveness of, and compliance with, national risk management policy.	none	See R8.13
R8.18	Internal Audit Units in all health service agencies should make half-yearly reports to the Chairman of their local audit committees on the effectiveness of the risk management procedures in place in their organisation. Any legislative amendments to facilitate this should be implemented.	none	See R8.1 and R8.9

Number	Recommendation	IT Requirements	Timeframe
	FRAUD POLICY		
R8.19	The health board CEOs should submit, for approval by the Secretary General of the Department of Health and Children, a written fraud policy statement covering all health boards and all organisations under their aegis.	none	Within 6 months of report publication
	REPORTING – SERVICE PROVIDERS TO HEALTH BOARD		
R9.1	With regard to general hospital expenditure: (i) The Head of Specialty/Head of Department/business manager should prepare standardised reports containing: (a) The plan for the month (financial and activity) as set out in the specialty/department Service Plan; (b) Performance against plan; (c) Details of variance against plan; (d) Clear explanations for variance; and (e) Action to be taken (if any) to bring performance back in line with plan. (ii) All reports should follow the same format as the Service Plan and measure performance against this benchmark. (iii) The Head of Specialty/Head of Department/business manager should provide reports to hospital CEO within 10 days of the end of the period to which they refer. (iv) The hospital CEO should provide the health board CEO with consolidated reports within 15 days of the end of the period to which they refer.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	asap on completion of R4.2
R9.2	With regard to non-hospital expenditure: (i) The General Manager should prepare standardised reports containing: (a) The plan for the month (financial and activity) as set out in his/her Service Plan; (b) Performance against plan; (c) Details of variance against plan; (d) Clear explanations for variance; and (e) Action to be taken (if any) to bring performance back in line with plan. (ii) All reports should follow the same format as the Service Plan and measure performance against this benchmark. (iii) The General Manager should provide the health board CEO with reports within 10 days of the end of the period to which they refer.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	asap in parallel with R4.4 and R5.32

Number	Recommendation	IT Requirements	Timeframe
	REPORTING – HEALTH BOARD TO DoHC/EXECUTIVE		
R9.3	Reports should be: (i) Prepared in a standardised format across health boards/agencies. (ii) Contain information on: (a) The plan for the month (financial and activity) as set out in the health board Service Plan; (b) Performance against plan; (c) Details of variance against plan; (d) Clear explanations for variance; (e) Action to be taken (if any) to bring performance back in line with plan; and (f) The health board balance sheet. (iii) Submitted by the health board CEO to the Department of Health and Children/Executive within 20 days of the end of the period to which they refer.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	asap in parallel with R4.4, R9.1 and R9.2
	REPORTING – EXECUTIVE TO DoHC		
R9.4	Reports from the Executive to the Department of Health and Children should provide information on performance against budget. This analysis should be provided: (i) By health board and care group (e.g. child care, disabilities (intellectual and physical), general hospital services etc.); (ii) Include supporting data detailing activity/output measured against benchmarks set in the Service Plans; and (iii) Include corrective measures to be taken (as necessary) to bring expenditure back on budget.	While existing systems are sufficient to allow commencement, full and effective implementation will require incremental systems development	asap in parallel with R4.4, R9.1, R9.2 and R9.3
R9.5	Reports should be submitted by the CEO of the Executive to the Department of Health and Children within 25 days of the end of the period to which they refer.	none	See R9.4
	POLICY REVIEW PROCESS		
R9.6	The Secretary General of the Department of Health and Children should proactively promote the expenditure review process on a continuous and systematic basis within his Department by: (i) Setting up and chairing a steering group to oversee reviews; and (ii) Through the forum of the steering group, and consistent with Government requirements in this regard, identify and propose on a continuing basis those areas of expenditure that would benefit most from review.	none	Immediate

Number	Recommendation	IT Requirements	Timeframe
	ANNUAL FINANCIAL STATEMENTS & ANNUAL REPORTS		
R9.7	The Annual Financial Statement prepared by the health boards should be tied in more clearly and in a more relevant manner to the services that are being delivered. In this regard,the CEO should prepare a reconciliation document that makes it clear how the figures in the final (i.e. December's) Integrated Management Report of the financial year have appeared in the Annual Financial Statement and Annual Report.	none	immediate
R9.8	The Annual Report prepared by the health boards should be adopted by health boards at the same time as the Annual Financial Statement which is by 31 March following the previous year end.	none	asap
	INFORMATION TECHNOLOGY		
R10.1	The information systems necessary to support financial management and control systems recommended in this report should be built around SAP and PPARS.	Systems development required	n/a
R10.2	This investment should be subject to: (i) Prior arrangements being put in place to ensure that appropriate use can and will be made of new systems as evidenced in a detailed business case as outlined in the text above; (ii) Parallel implementation of the wider organisational changes we recommend throughout this report; and (iii) The recruitment of certain key financial, human resource management and information technology personnel, necessary to the successful implementation of the recommendations of this report, should be by means of open competition i.e. from outside the Common Recruitment Pool (see also recommendation R7.10).	none	immediate
R10.3	There should be an acceleration in investment so as to achieve the early implementation of the following: (i) SAP financials installed in all health boards and the major teaching hospitals; (ii) PPARS (Phase 1) fully implemented in the outstanding sites (South Eastern Health Board, Southern Health Board, Beaumont, Mater, St Vincent's and Tallaght hospitals); and (iii) PPARS (Phase 2) implemented in the health boards and the major teaching hospitals.	Systems development required	asap
R10.4	Roll out of PPARS should continue to be driven by the National PPARS Office, to ensure a consistent and uniform national approach, and that Office should liase on a monthly basis with the Implementation Committee referred to at R11.2.	Systems development required	asap

Number	Recommendation	IT Requirements	Timeframe
R10.5	Hospital information systems which provide information on patients and their procedures (i.e. number of tests, x-ray, lab time, theatre, drugs, etc) be rolled out to all acute hospitals and integrated with the financial and HR systems at R10.3 above.	Systems development required	asap
R10.6	Funding for the IT strategy should be ring-fenced to ensure that: (i) The funding is solely for specified IT investment; (ii) There is increased transparency of where the investment occurs; and (iii) There is clear measurement of the improvements in management information resulting from such investments.	none	immediate
R10.7	Pending establishment of the Executive, the Department of Health and Children should have full control over how this funding will be allocated and should report the results of such investments to the Implementation Committee recommended at R11.2.	none	On establishment of Implementation Committee
	IMPLEMENTATION OF RECOMMENDATIONS		
R11.1	Government should give consideration to assigning non-core health activities, currently undertaken by agencies within the health service, to other bodies.	none	asap
R11.2	A National Implementation Committee should be established with the role of (i) Ensuring the implementation of the recommendations; (ii) Driving the implementation process; (iii) Overseeing the establishment of the Executive and the consequent governance changes in Chapter 3; and (iv) Providing progress reports every 3 months.	none	immediate
R11.3	The Implementation Committee should, within 2 years of the publication of this report, be in a position to hand over responsibility for implementation of any outstanding recommendations to the CEO of the Executive.	none	asap
R11.4	The Government should nominate an independent person to chair the Implementation Committee.	none	immediate
R11.5	Membership should also include the Secretary General of the Department of Health and Children, a Secretary General in the Department of Finance, a health board CEO and three persons from the private sector with appropriate expertise and experience in change management and financial management/audit functions.	none	immediate

Number	Recommendation	IT Requirements	Timeframe
R11.6	In the preparation of the reports referred to at R11.2(iv) above the Implementation Committee, and subsequently the Executive, will: (i) Identify the person(s), by name and/or position, responsible for the delivery of each recommendation (and the elements therein where applicable); (ii) Contact and formally assign responsibility to each person identified at (i) above; (iii) Agree with the person(s) identified at (i) above appropriate deadlines for implementation of each recommendation; (iv) Draw up a schedule of implementation deadlines for all recommendations based on agreements at (iii) above; (v) Audit progress of the responsible person(s) in giving effect to recommendations against the stated objectives; and (vi) Report progress with recommendations for corrective action as appropriate.	none	On establishment of Implementation Committee and ongoing
R11.7	In reporting on progress to the Implementation Committee, and subsequently the Executive, each person identified at R11.6(i) above should: (i) Identify the resources required to deliver the recommendations; (ii) Identify the critical success factors to deliver recommendations on time (and within budget); and (iii) Identify the barriers to success in delivering recommendations on time (and within budget).	none	ongoing
R11.8	*The Implementation Committee and the Executive should have regard to the attached Addendum that summarises the various recommendations throughout the report – cross-referenced to the relevant chapters – showing, where appropriate, a timeframe for their completion.*	*none*	*ongoing*