RESTRUCTURING THE DEPARTMENT OF HEALTH

The Separation of Policy and Execution

Department of the Public Service,
Department of Health,
July, 1973

DUBLIN :
PUBLISHED BY THE STATIONERY OFFICE.

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PREFACE

In May, 1972, the Government decided to restructure the Department of Health and its public bodies on the lines of the "Aireacht/Executive Unit" and related concepts as proposed in the report of the Public Services Organisation Review Group. The Government wished this restructuring to be part of an experiment, involving a number of Government Departments, which would test the practical feasibility of restructuring all Departments on "Aireacht/Executive Unit" lines.

A Task Force, representative of the proposed Department of the Public Service and the Department of Health, was established in September, 1972, to examine the problems involved in setting up the experiment; to recommend to the Government the appropriate structural and organisational arrangements; and to supervise the implementation of the scheme if and when it is accepted by the Government. Its members were:—

Dr. Noel Whelan (Chairman)	—	Deputy Secretary, proposed Department of the Public Service.
Dr. B. Hensey	—	Assistant Secretary, Department of Health.
Mr. P. Gaffey	—	Principal, proposed Department of the Public Service.
Mr. D. Condon	—	Principal, Department of Health.

It was assisted in its job by a small working group:—

Mr. J. O'Dwyer, Department of Health; and
Mr. J. McMahon, proposed Department of the Public Service.

What follows is a report of the analysis and recommendations of the Task Force.

July, 1973.

BACKGROUND AND SUMMARY

Background

This report was produced by a Task Force representative of senior officials from the proposed Department of the Public Service and the Department of Health.

Terms of reference

The Task Force's terms of reference were :—

> " To investigate and report on the steps necessary to apply, on an experimental basis, in the Department of Health the Aireacht/Executive Unit and related concepts recommended in the report of the Public Services Organisation Review Group ".

The Welfare Dimension

The terms of reference did not include an examination of the steps necessary to amalgamate the Departments of Health and Social Welfare as recommended by the Public Services Organisation Review Group. Such an examination would have required fundamental appraisal and evaluation of many matters, both political and administrative, which do not relate to the Aireacht/Executive Unit concept *per se*. In addition, it would have required an examination of the distribution of almost all the functions of Government since many Departments are concerned with welfare to some degree; the series of experiments was authorised, however, only in respect of four viz. Health, Transport and Power, Industry and Commerce, and Local Government. The implementation of the recommendations which have been made in the report will not, however, prejudice the amalgamation of the Department of Health with the Department of Social Welfare, but the working out of the detailed steps necessary to do so would have to be the subject of a separate examination, involving officers of the Department of Social Welfare and other Departments, particularly Finance and Labour, together with the Revenue Commissioners (paragraphs 1.1.2; 1.1.3; and 2.2.1 to 2.2.7 inclusive). The report does discuss the welfare aspects of a Department of Health and recommends that, when the services divisions of the Department of Health are being reorganised, the welfare function of the Department should be more exactly defined and any anomalies in the distribution of functions between it and other Departments concerned with welfare should be removed. This would need to be studied in the context of what institutions of Government ought to be responsible for different aspects of " welfare " as a function of Government.

Outline of the Report

The report of the Task Force:—

(i) sets out the background to the report, including the relevant recommendations of the Public Services Organisation Review Group in relation to the Aireacht and the executive unit concepts (Chapter 1);

(ii) outlines the key features of the health services with particular regard to finance, organisation, and the functions of the major executive bodies (Chapter 2);

(iii) gives details of the recommendations made by the Public Services Organisation Review Group in relation to the future organisation of a Department of Health and Welfare, and explains the organisational changes which have taken place in the health services since then (Chapter 3);

(iv) gives details of the organisation of the Department of Health proposed by McKinsey and Company Inc., Management Consultants (Chapter 4);

(v) sets out the principles on which the Task Force based its examination and the particular issues which it had to consider (Chapter 5);

(vi) recommends a new organisation for the Department of Health (based on a range of policy functions considered appropriate for "health" as a function of Government), and suggests the future pattern of relationships between the Aireacht and its executive area (Chapter 6);

(vii) suggests a programme of decisions and action which are required for the implementation of the recommendations in the report (Chapter 7);

Summary of Main Recommendations

(i) the recommended Aireacht organisation for the Department of Health is outlined in *Exhibit 11* opposite page 42;

(ii) the functions which at present are discharged by the Department of Health in respect of:—

—the Registrar-General's Office;
—the Voluntary Hospitals Superannuation Scheme;
—certain inspection functions;
—the Hospitals Construction Unit;

should be devolved to the executive area of the Department. The emphasis for the functions remaining

within the Aireacht would be on policy formulation and overall control and direction (Sections 5.3 and 5.11);

(iii) the Registrar-General's Office and the Hospitals Construction Unit should, for the duration of the experiment, operate as executive offices, while operation of the Voluntary Hospitals Superannuation Scheme and of certain inspection functions would be delegated to voluntary hospitals and health boards respectively. The total staff involved would number 83 (Section 5.11);

(iv) there should be two Assistant Secretaries in line management in the Aireacht, one responsible for hospital services, and one for community services. (Section 5.7);

(v) the Chief Medical Officer would retain his separate status as the officer principally responsible to the Secretary and Minister for the medical and related aspects of policy making in the health service (Section 5.6);

(vi) there should be six staff functions in the Aireacht; one each for Planning, Finance, Personnel, and Organisation, (as recommended by the Public Services Organisation Review Group), one for International and Public Relations, and one for Legal Advice* (Sections 5.4 and 5.9);

(vii) the Finance and Personnel functions should each be headed by an Assistant Secretary (Section 5.8); the other staff functions should each be headed by a Principal;

(viii) there should be a Management Advisory Committee within the Aireacht consisting of the Secretary, Chief Medical Officer, line Assistant Secretaries and such other heads of Staff Units as the Secretary may decide from time to time (Section 5.10);

(ix) the head of each Unit or Division should, when nominated, determine, as a matter of urgency, the specific expertise and skills needed in his area. The required emphasis within the Aireacht on policy formulation will generate a demand for expertise of high analytical capacity in many fields but particularly in those of economics, sociology, and finance. The formal organisational restructuring of the Department of Health will not achieve the desirable end results unless the

*Shared with the Departments of Local Government and Social Welfare.

appropriate personnel and expertise are also present to make the system function properly (Section 6.1);

(x) the proposed Organisation Unit in the Aireacht should initiate, in conjunction with line management, a systematic review of the organisation of the executive bodies under the aegis of the Department (Section 6.6);

(xi) for the Aireacht to obtain the co-operation of the health boards and their staffs in implementing agreed policy, they and their Chief Executive Officers must be allowed to make a considerable input in relation to policy making. The reorganisation of the Department of Health which is recommended has been designed to facilitate the development of these arrangements (Section 6.4);

(xii) the report has been concerned, mainly, with administrative structures and procedures for a new Aireacht and with the relationships between it and the rest of the health administration. The best possible structures will produce a poor organisation if the parallel development of personnel to fill the posts adequately does not receive sufficient attention. Any action which might be taken to implement the decisions recommended in the report will be only partially successful if the considerable job of developing those involved and reorienting them to the new style of working is not developed with a vigour equal to that of the structural reorganisation. Urgent steps should be taken to equip the officers within the Aireacht to fulfil their tasks to the full and to meet the challenges presented by the new structures and processes (Section 7.2);

(xiii) it is not necessary to introduce legislation to enable the experiment to commence. In the case of the Department of Health, the legal implications of the implementation of all of the proposals, including the devolution of certain executive activities from the existing Department to the executive area, are not significant. Most of the executive activities of the Department have already been assigned statutorily to the health boards which were set up under the Health Act, 1970. The new executive offices which are recommended in this report are not large enough to warrant separate legislation and, in any event, can operate for the period of the experiment on the basis of delegated powers (Section 7.1).

CHAPTER 1

BACKGROUND TO REPORT

1.1 *Terms of reference*

1.1.1. Our terms of reference were:—

> "To investigate and report on the steps necessary to apply, on an experimental basis, in the Department of Health, the Aireacht/Executive Unit and related concepts recommended in the report of the Public Services Organisation Review Group*".

A brief outline of the nature and scope of the PSORG recommendations is given in Sections 1.4 to 1.7 below.

1.1.2. The PSORG Report recommended the amalgamation of the Departments of Health and Social Welfare into a Department of Health and Welfare. The examination and evaluation of this recommendation was not included in our remit; it would have required fundamental appraisal and evaluation of many matters, both political and administrative, which do not relate to the Aireacht/Executive Unit concept *per se*. In addition, it would have required an examination of the distribution of almost all the functions of Government since many Departments are concerned with welfare to some degree; the series of experiments was authorised, however, only in respect of four viz. Health, Transport and Power, Industry and Commerce, and Local Government.

1.1.3. We believe, however, that implementation of the recommendations in this report and the consequent creation of an Aireacht within the existing Department of Health would be a highly desirable first step towards any amalgamation of the existing Departments of Health and Social Welfare. The Aireacht which will be created if the recommendations of this report are accepted will be such that it could be given, without undue difficulty, extra functions. We have dealt with considerations affecting this matter in greater detail in paragraphs 2.2.5., 2.2.6. and 2.2.7. below.

1.1.4. In pursuing our terms of reference we were primarily concerned with the establishment of the Aireacht and with the relationships between it and the main executive agencies. We did not consider the structure of the health boards and the regional hospital boards since they had been established pursuant to recent legislation and were, at the time of our examination, only becoming fully operational.

*Subsequently referred to as "PSORG".

1.2 *Procedure*

1.2.1. In September, 1972, a Task Force representative of both the proposed Department of the Public Service and the Department of Health was established with the terms of reference quoted. A small working group conducted the field studies. These involved:—

—Interviews with senior officers of the Department down to and including Assistant Principal and other equivalent grades;
—Consultations with Chief Executive Officers of health boards and with the Chairman of Comhairle na nOspidéal;
—An analysis of the current work, functions and operations of the Department of Health and its executive area;
—Identification of the functions of the Department of Health which are appropriate to

(i) the Aireacht;

(ii) the executive area;

—Clarification of responsibilities within the Aireacht;
—Proposing a structure and organisation for the Aireacht;
—Suggesting how executive functions might be devolved from the present Department to the executive area;
—Considerations of legal and other implications;
—Explanation of the nature and duration of the proposed experiment to Departmental staff; and
—Outlining necessary action and suggested next steps for implementation.

1.3 *The Role of the Government and the Public Service*

1.3.1. The PSORG Report saw the Government as having two main tasks:—

"First, it has to run the country, under the Constitution and in accordance with the rules laid down by the Oireachtas and with the resources granted by and accounted for to the Oireachtas each year. Secondly, it deals in the Oireachtas with changes in legislation affecting the community. For its first task, the Government acts mainly in a managerial capacity over the public service; for its second task, it uses the public service in a staff or advisory capacity".

1.3.2. For the public service, PSORG also saw two main tasks. The first was described in paragraph 12.1.6. where it states:—

"The Government must have the best possible advice in appraising and ranking possible courses of action both at Ministerial and cabinet levels. This requires that some members of Ministers' staffs can give undivided attention to the examination of plans and policies, appraising existing policies, identifying problems and proposing remedies for any deficiencies which may exist".

The second task of the public service was described in paragraph 12.2.2. It was the executive task of assisting the Government to run the country under the rules laid down by the Oireachtas and to implement its policies. When, therefore, the business of Government is allocated between Departments, the Minister responsible for each Department should have available to him an organisation which consciously distinguishes these two tasks and is structured accordingly.

1.4 *The concept of a Department as seen by PSORG*

1.4.1. In the restructured public service, PSORG envisaged that Departments of State should comprise those units of Government service headed by Ministers, amongst which the administration and business of the public service is distributed by law.

A Department would embrace:—

(i) The Aireacht, viz., the top-level policy formulation, direction and control area of the Department, and

(ii) the executive units where settled policy is carried out.

The report envisaged the executive units as comprising *executive offices* (each headed by a Director) to discharge those functions now mainly allocated to executive branches of the civil service and *executive agencies* (each with a board) to discharge those functions now mainly allocated to "non-commercial" state-sponsored bodies. The problem of the "commercial" state-sponsored bodies does not arise in the case of the Department of Health. All the staffs of Departments, following the PSORG Report, would become members of the new civil service (paragraphs 13.6.1. and 13.6.2.).

1.4.2. In paragraph 13.6.3., the report stated that:—

> "The local bodies should have the same reporting relationships to the appropriate Departments as have the Executive Agencies, and their staffs, as members of a single local government service, considered also as members of the public service".

1.4.3. Two matters arise from these definitions—the relationship of the health boards to the Aireacht and the status of the staff of these boards. In relation to the first of these, although the administration of the health services at regional and local levels is no longer part of the local government system, the health boards with their element of local representation have still strong affinities with that system. Whether or not they should be regarded as part of the Department in the sense used by PSORG is a question which does not need resolution at this stage. All that is necessary is that, as recommended by PSORG, they should have the same reporting relationships to the Aireacht as have the executive agencies.

1.4.4. As regards the status of the staff of the health boards, these staff are not at present civil servants—the Civil Service Regulation Act does not apply to them. They are "public servants", in so far

as the term has any real meaning, in the sense that they are paid from public funds and that the Minister for Health has very definite statutory powers in relation to them. In this report, we do not propose any changes in the status of health board staff since this is a matter for personnel development policy in the medium to long term. We do recognise, however, that the Aireacht will have very definite responsibilities in regard to their organisation, their recruitment and development. Furthermore, we recognise that the Department of the Public Service and the other Departments concerned will need to undertake at an early date the development of the new public service and that the staff of the health boards will be involved in this development.

1.4.5. In the meantime it is necessary to deal in some detail with the Aireacht, and its main administrative relationships with the health boards, hospital co-ordinating bodies, bodies established under the Health (Corporate Bodies) Act, 1961, statutory bodies established under various health enactments, and the various advisory and co-ordinating committees.

1.5 *The Aireacht and its functions*

1.5.1. It was envisaged that the Aireacht would concern itself only with issues of direct concern to the Minister. This business was seen to fall generally into the following broad categories:—

(i) the formulation of overall strategy, the general policy of the Department and the preparation of legislation;

(ii) the co-ordination, continuous appraisal and review of existing policies in regard to the executive responsibilities of the Department;

(iii) the general direction and control of the executive activities of the Department; and

(iv) international activities of the Department.

1.6 *The Executive area and its functions*

1.6.1. All the executive functions under the aegis of a Department should, it was recommended, be performed by units with specific and identifiable links with the Aireacht. As already mentioned, these units would not be part of the Aireacht itself. It was hoped that, by clearly separating the Aireacht and the executive units, a more precise recognition of their respective roles would emerge. While the unity of the total public service would need to be maintained, there would be the greatest practical delegation of power and responsibility for executive action. Executive activities would be grouped on the basis of cognate functions and assigned to executive units of Departments which would be responsible for the

execution of agreed policy, for internal management, the achievement of agreed goals, and contributions to the review of policy.

1.7 *Staff and line functions in the Aireacht*

1.7.1. To enable the Secretary to carry out his business under the Minister, PSORG suggested that he should have four staff units—to cater for the functions of finance, planning, organisation, and personnel. These units would, in the formal structure, report to him directly, advising and assisting him on specific aspects of administration. They would derive their authority from both their professional competence and this relationship to the Secretary. They would serve, in practice, mainly the Assistant Secretaries and the other line officers to whom the Secretary's authority was delegated. The line activities of the Department—the business that the Department was in existence to discharge—would be the responsibility of Assistant Secretaries who would be in direct managerial control of areas of the Department's functions. The devolution of responsibility for executive action from the Secretary, through the line Assistant Secretaries, to the executive units was designed to curtail the inordinate amount of day-to-day problems which was reaching a high level in the Department, and displacing the effort which senior officers should have been spending on the broader issues of policy formulation and review.

CHAPTER 2

KEY FEATURES OF THE HEALTH SERVICES

2.1 *The Nature of the Health Services*

2.1.1. In order to appreciate the role and functions of the Aireacht for the Department of Health it will be necessary to outline certain key features of the health services in Ireland.

2.1.2. Health services, whether concerned with prevention, diagnosis, care or rehabilitation, are concerned with the whole person. The mix of services available must at all times be balanced so as to provide an integrated efficient service for the individual. Notwithstanding this, it is essential for effective management that services be divided into manageable units with clear-cut objectives established for discrete groups of services. It is necessary, therefore, to achieve an optimal balance between the benefits flowing from good management practice on the one hand and the need to recognise the essentially unified and personal nature of the total health service on the other. This task is complicated by the extent to which welfare and health services are now increasingly accepted as being essentially part of a total service to the individual.

2.2 *The Welfare Dimension*

2.2.1. Responsibility for services for the mental and physical welfare of the people, or of specific categories of people, spans the work of several Departments other than the Department of Health. These Departments include Local Government, Social Welfare, Education, and even Agriculture. Welfare may be more narrowly defined but, whatever definition is adopted, it is clear that health care, as represented by the activities of the Department of Health and its executive agencies, is one of the predominant parts of welfare activity.

2.2.2. For most groups of the population, the need for medical care comes in the form of self-contained episodes which are not related, essentially, to "welfare" in any broader context. As examples, other welfare services are not usually involved in such episodes as the calling in of a general practitioner for a patient with the "flu", a visit to a hospital for the removal of an appendix, or a visit to a dentist for a filling or extraction. Much of the health services can, therefore, be planned without reference to any broader concept of welfare. However, for certain groups, such as deprived children and old people in need of care, health care must be combined with other forms of welfare and must be intertwined with them.

2.2.3. The Department of Health and its executive agencies have become involved, increasingly, in welfare services for such groups. A "lead role" was taken, for example, by the Department in studies on the care of the aged. Health boards have been involved in running the county homes and have been active in recent years in a programme to provide modern welfare homes for the aged on a considerable scale. The boards are also responsible for the boarding-out of "deprived" children and for the supervision of children boarded out privately. The Reformatory and Industrial Schools Systems Report (the report of the "Kennedy" Committee) recommended the extension of the role of the Department of Health in this field. Central functions relating to services for the welfare of the blind were taken over, recently, by the Department of Health from the Department of Social Welfare. The health boards were given, under the Health Act, 1970, a broad power to make arrangements for assisting in the maintenance at home of sick or infirm persons and certain other categories, with specific reference to cases which would otherwise need to be maintained in an institution. The boards may give grants also to voluntary agencies providing services "similar or ancillary" to the services provided by the boards. The need for the development of co-ordinated welfare services was stressed by the Minister for Health by setting up the National Social Service Council in October, 1971.

2.2.4. This broader welfare concern of the Department of Health is likely to increase in the future. We allow for this in our recommendation concerning the re-organisation of what are now known as the services divisions of the Department. We recommend that, with this re-organisation, the welfare function of the Department should be more exactly defined and any anomalies in the distribution of functions between it and other Departments concerned with welfare should be removed.

2.2.5. We considered, also, the broader recommendation in the PSORG Report for a straightforward amalgamation of the Departments of Health and Social Welfare. As explained in Section 1.1 the application of the Aireacht/Executive Agency structure to a combined Department of Health and Welfare was outside our remit. To explore such a proposal in depth would require, first, a major study of the total package of welfare functions discharged by the Government. It would require, also, a study of the existing organisation and restructuring which would be needed in the present Department of Social Welfare. This study might have to be much more fundamental than that we have undertaken in relation to the Department of Health where the division between "Aireacht" and "executive unit" functions was reflected, already, in the existing organisation. This is a task for another body which should, of course, include representatives of the Department of Social Welfare. It would require, also, a political decision to examine the functions of the Minister for Social Welfare. Consideration would need to be given to such broad questions as how the pension and

other income maintenance services organised under that Department relate to the activities of the Departments of Labour and Finance and, perhaps, to the necessity of amalgamating some of the activities of the Department of Social Welfare with those of the Revenue Commissioners, as is currently proposed in Britain.

2.2.6. These are matters which would require careful examination by the Department of the Public Service, the other Departments concerned and, eventually, by the Government. Our mandate was to produce a workable model for the Department of Health, as a test case. We concluded that, in making recommendations on the Department of Health, we should not await detailed consideration and ultimate decisions in relation to the Department of Social Welfare. Our recommendations relate, therefore, to a Department of Health with its present range of functions but having regard to the views mentioned in paragraphs 2.2.3. and 2.2.4. above in relation to its welfare functions.

2.2.7. The structure which we recommend for this Department, we believe, would not need too much adaptation if broader functions were to become the responsibility, later, of a combined Department of Health and Welfare. This is borne out by a comparison of our recommended structure with that of PSORG for the combined Department.

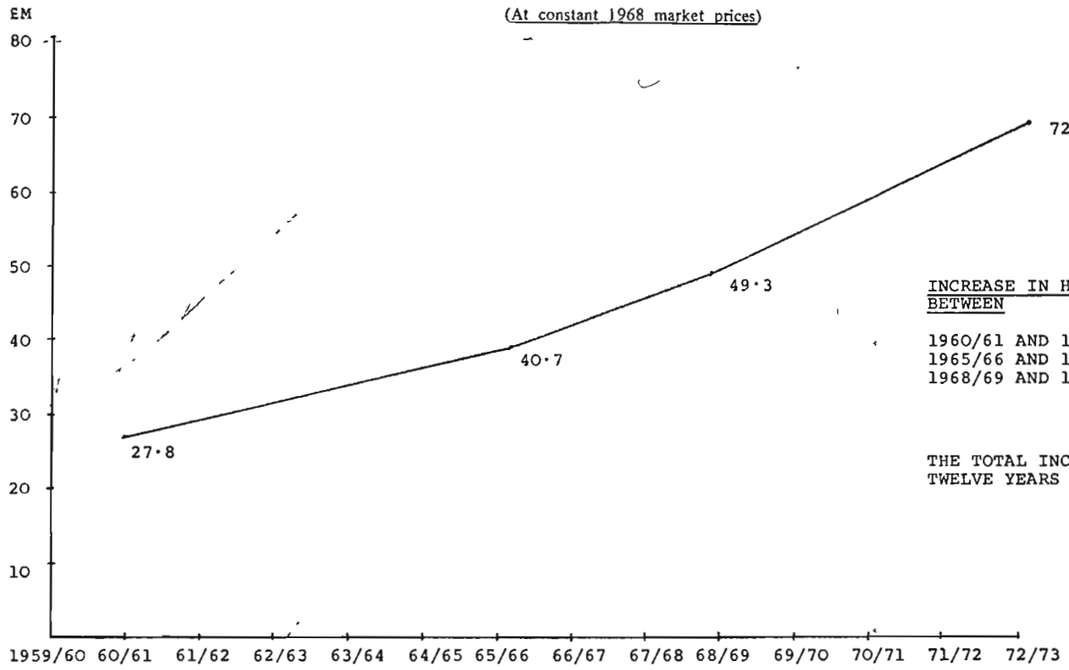
2.3 *Links with Local Government*

2.3.1. The health services were, until April, 1971, administered as an integral part of the local government services through the local authorities which acted as health authorities. (Indeed, most of the present staffs of the health boards are former officers of local authorities and the conditions of service for officers in both local authorities and health boards are, even now, similar). The Chief Executive Officers of health boards and the County and City Managers at present operate as a single employers' body on the Local Government Staff Negotiations Board; under the proposed revised conciliation and arbitration scheme for local authorities, practically all matters of remuneration and conditions of service would be processed through the scheme under the Board.

2.3.2. Health boards and local authorities co-operate in the provision of a number of services. At present, medical advice in relation to environmental and related matters is provided by the medical officers of health boards on an agency basis for local authorities and the inspection functions of the local authorities as sanitary authorities are discharged through health inspectors who are employed by health boards. In the administration of home assistance, health boards administer the scheme for 22 of the responsible local authorities.

EXHIBIT 2

CURRENT PUBLIC EXPENDITURE ON HEALTH
(At constant 1968 market prices)



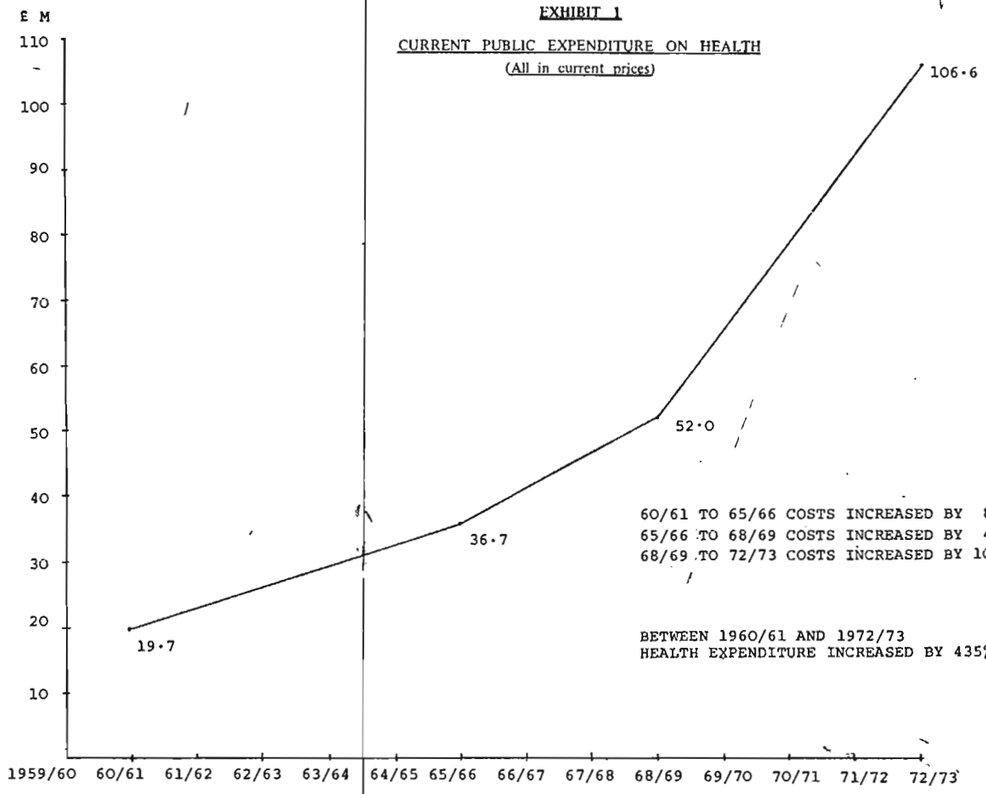
INCREASE IN HEALTH EXPENDITURE BETWEEN

1960/61 AND 1965/66 46%
1965/66 AND 1968/69 21%
1968/69 AND 1972/73 47%

THE TOTAL INCREASE OVER THE TWELVE YEARS WAS ABOUT 160%

EXHIBIT 1

CURRENT PUBLIC EXPENDITURE ON HEALTH
(All in current prices)



60/61 TO 65/66 COSTS INCREASED BY 86% (FOR 5 YRS)
65/66 TO 68/69 COSTS INCREASED BY 41% (FOR 3 YRS)
68/69 TO 72/73 COSTS INCREASED BY 105% (FOR 4 YRS)

BETWEEN 1960/61 AND 1972/73
HEALTH EXPENDITURE INCREASED BY 435%

2.4 *General Features of the Health Services*

2.4.1. The following general indicators show the scope of the health services: —

—Public expenditure on health services in 1972/73 was about £113 millions (including £6½ millions capital expenditure). Section 2.5 below explains the current system of financing the health services.

—The growth of current expenditure on health services in recent years, both in absolute and real terms, has been steep—see *Exhibits 1 and 2* opposite. For example, in 1968/69 the total current expenditure on health was £52 millions and over the next four years it rose by 105% to the current figure of £106.6 millions. At constant 1968 market prices, the increase was from £49.3 millions to £72.5 millions, an increase of 47%. In the same period, gross national product at constant prices is estimated to have increased by 13.9%.

—Over two thirds of the total public expenditure on health services is on hospital services.

—*Exhibit 3* opposite page 10 shows the current distribution of resources between various health programmes.

—About half the general hospital beds in the country are in voluntary hospitals. Most of these hospitals are in Dublin. They also play an important role in some other parts of the country see *Exhibit 4* opposite page 10.

—Long-stay mental hospital accommodation is generally old and in poor condition.

—The average size of hospital in Ireland is about 90 beds and is small by international standards.

—It is estimated that, at present, some 42,500 people are involved in the provision of health services.

2.4.2. The Department of Health is already close, in many ways, to the Aireacht/Executive Unit concept. The Department concentrates on policy formulation to a very large degree and almost all executive activity has been delegated to executive bodies of one kind or another. It employs less than 1% of the total health establishment.

2.5 *Financing of Health Services*

2.5.1. Current expenditure on the health services is paid from the Exchequer, the rates, the Hospitals Trust Fund and by way of health

contributions from eligible persons. In 1972/73 the amount from each of these sources was:—

	£m	£m	
(i) *The Exchequer*			
(a) Grants to health boards	57·6		
(b) Other expenditure from Health Vote ..	1·5		
(c) Agricultural Grant	10·6		
(d) Grant-in-Aid of revenue expenditure of Hospitals Trust Fund	9·4		
	79·1		
Less Health contributions (appropriation-in-aid)	5·0		
	74·1	74·1	(70%)
(ii) *Health Contributions*		5·0	(4·5%)
(iii) *Rates*			
(a) Payments to health boards	36·4		
(b) *Less* Agricultural Grant	10·6		
	25·8	25·8	(24%)
(iv) *Hospitals Trust Fund*			
(a) Payments from Fund to Voluntary Hospitals	11·1		
(b) *Less* Grant-in-Aid	9·4		
	1·7	1·7	(1·5%)
Total Expenditure		106·6	

2.5.2. The inter-relationships between these sources of finance are complex. Most of the Exchequer expenditure takes the form of grants to the health boards. The income from the local rates is also channelled to the health boards and, indirectly, this source benefits from the Agricultural Grant paid from the Exchequer in relief of rates. On 29 March, 1973, it was announced that the rate in the pound to be levied in 1973/74 for the health services should be the equivalent of 75% of the rate for 1972/73. Further reductions in the rates contribution to health expenditure are expected in the next three years, so as to eliminate this contribution entirely. Some 90% of the total expenditure on health services is channelled through the health boards.

2.5.3. Health contributions, which are at present £7 a year per person, are payable by all persons with "limited eligibility" for services. The amount accruing to the Vote for Health from these contributions in 1972/73 was £5 millions.

2.5.4. The direct expenditure of the Department of Health itself accounts for less than 1½% of public expenditure on health. In 1972/73 the amount was £1.5 millions.

2.5.5. Capital expenditure on health services in 1972/73 was over £6½ millions. The sources of funds for this expenditure are the Hospitals Trust Fund and borrowings by health boards from the Local Loans Fund and other sources, normally the banks who act as treasurers for the health boards.

EXHIBIT 3

CURRENT DISTRIBUTION OF HEALTH EXPENDITURE

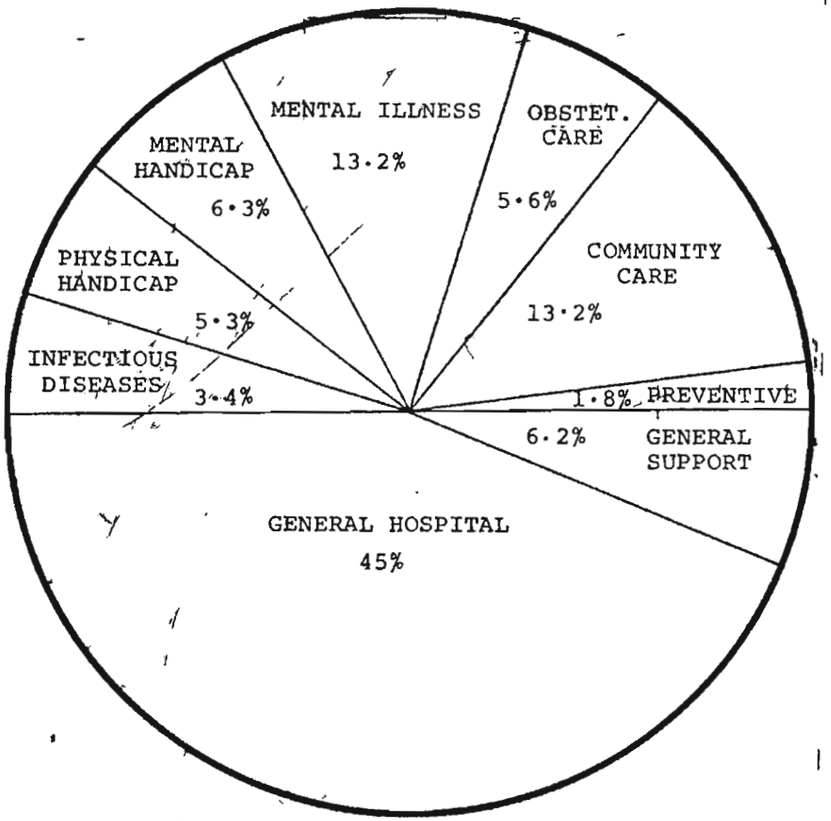


EXHIBIT 4

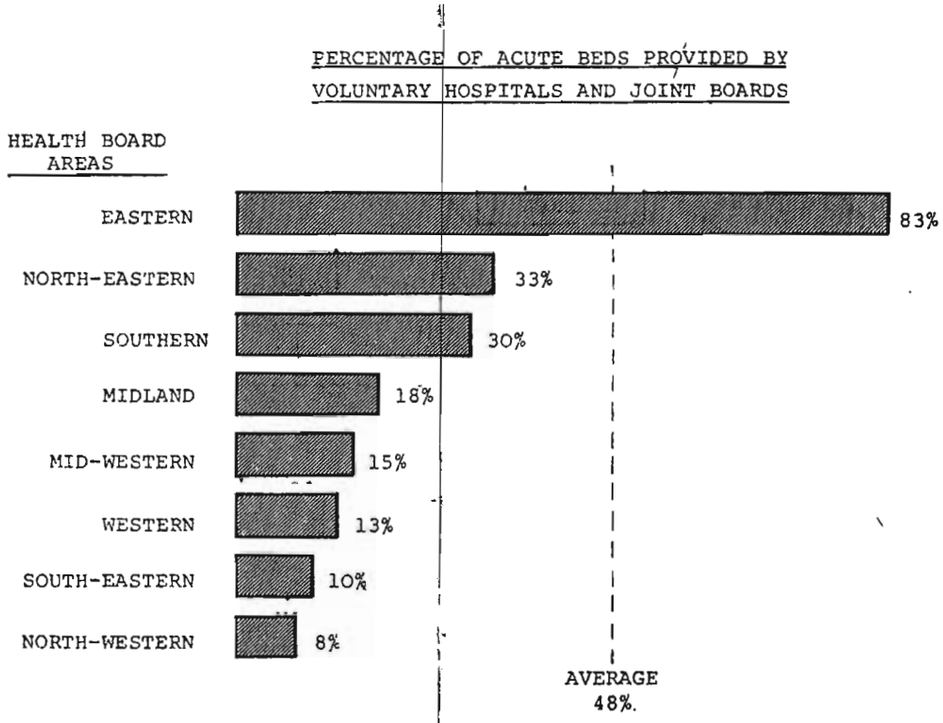
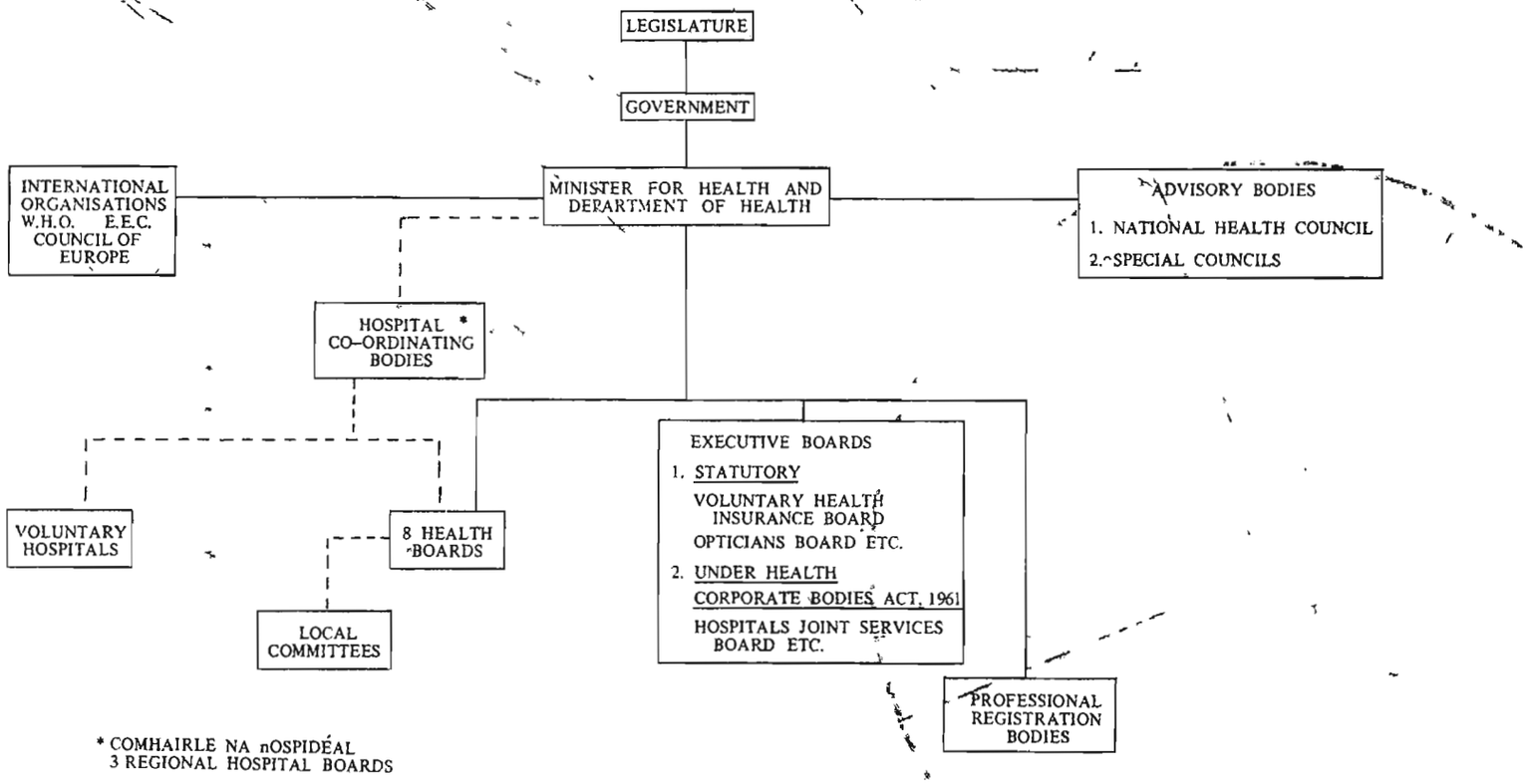


EXHIBIT 5

ADMINISTRATIVE STRUCTURE OF THE HEALTH SERVICES



* COMHAIRLE NA nOSPIDÉAL
3 REGIONAL HOSPITAL BOARDS

2.6 *Overall Administrative Structure*

2.6.1. The Chart at *Exhibit 5* opposite gives a picture of the overall administrative structure of the health services. It does not, for reasons of space, incorporate all of the health bodies in the executive area. A list of these is contained in *Appendix I*. Apart from the 58 voluntary hospitals, there are a further 47 bodies of one kind or another involved in the administration of the services. Many of these are small and specialised.

2.6.2. The overall organisational picture differs substantially from that which existed at the time of the PSORG Report. The major reorganisation of the administration of the health services under the Health Act, 1970, has since taken place enabling the health boards, Comhairle na nOspidéal and the three regional hospital boards to be established.

2.7 *Functions and Organisation of the Department of Health*

2.7.1. The Department of Health was established under the Ministers and Secretaries (Amendment) Act, 1946, and became a separate Department on 22 January, 1947. Its functions were defined in a White Paper in 1947. These have existed to the present. They were:—

> "the administration and business relating to the preparation, effective carrying out and co-ordination of measures conducive to the health of the people including, in particular, measures for
> —the prevention and cure of disease;
> —the treatment and cure of persons suffering from physical defects or mental illness;
> —the regulation and control of the training and registration of persons for health services;
> —Control over the appointment and conditions of service of appropriate local officers;
> —the initiation and direction of research;
> —ensuring that impure or contaminated food is not marketed and that adequate nutritive standards obtain in essential foodstuffs;
> —the control of proprietary medical and toilet preparations;
> —the registration of births, deaths and marriages; and
> —the collection, preparation, publication and dissemination of information and statistics relating to health".

While the functions of the Department have not been materially changed in the meantime, the emphases on particular aspects of services have varied from time to time to reflect the needs of the community and the increased resources which were made available for improving facilities. An example of this change of emphasis is the increasing involvement of the Department of Health in the provision of welfare services.

2.7.2. While the health services generally have been the subject of continuous review and appraisal in the period since 1947, it was not

until the Health Act, 1970, that a major re-organisation of administration of the services was undertaken. In the intervening period, particularly in the 1960's, the major organisational occurrence was the introduction and use of the Health (Corporate Bodies) Act, 1961. This Act, which still exists, enables the Minister without recourse to individual legislation to establish corporate bodies to operate particular health services usually unsuitable for localised operation. This was in accordance with the policy which had already been established to devolve detailed executive work from the Department thus anticipating, to a degree, one of the major recommendations of PSORG. In addition to giving the Minister power to establish a corporate body to administer a health service by an Order, the 1961 Act also enabled the limited liability companies established earlier as executive bodies for the health services to be transformed into bodies under the new Act by the passing of a simple resolution. This provision has been used by a number of these companies e.g. the Blood Transfusion Service Board and the National Rehabilitation Board. The executive bodies established under the 1961 Act are identified in the list in *Appendix I.*

2.7.3. At present, therefore, almost all the executive work has been delegated to executive bodies of one form or another. The legislation governing the provision of services by these various bodies, notably the Health Act, 1970, embodies controls on all the key aspects of services and their management and at the same time permits changes to be made through regulations and Ministerial directions without amendment of the legislation. While the overall structure is similar to that recommended by PSORG, the underdevelopment of the staff functions of finance, planning, organisation, and personnel, and a certain lack of functional clarity impairs the lines of communication between the executive area and the Department. The process of delegation to the executive area can be improved through clarification of roles and functions, and by the exercise of more sophisticated financial management, while at the same time allowing the executive bodies the flexibility necessary to attain established objectives.

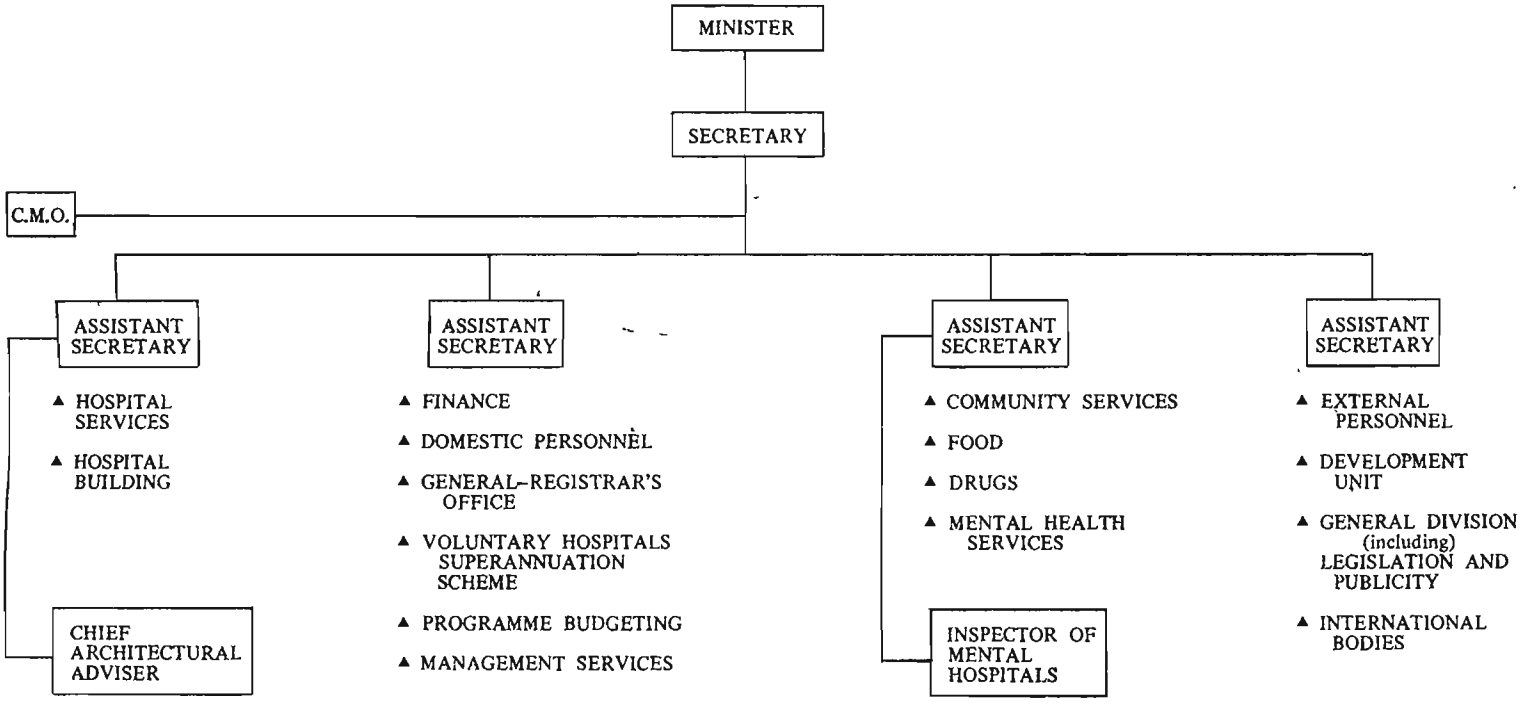
2.7.4. The current organisation of the Department is shown at *Exhibit 6* opposite. The chief officers of the Department reporting directly to the Secretary are the Chief Medical Officer and the four Assistant Secretaries. Each Assistant Secretary has three or four Principals working to him and, in turn, each Principal has a number of Assistant Principals and other staff. All of the Assistant Secretaries have, in one way or another, direct contact with the health boards, the main executive agencies of the Department.

2.7.5. While the finance, planning, organisation, and personnel functions are all discharged to some extent, staff units for finance, planning, organisation, and personnel as envisaged in the PSORG Report have not been established.

2.7.6. The Chief Medical Officer is the principal medical adviser. Working to him are three Deputy Chief Medical Officers, who have

EXHIBIT 6

PRESENT ORGANISATION OF DEPARTMENT OF HEALTH



in turn three Senior Medical Officers and four Medical Officers assisting them. The Dental Adviser, the Pharmacist, the Nursing Adviser and the Superintendent Health Inspectors all work under the Chief Medical Officer.

2.7.7. The Inspector of Mental Hospitals is responsible for the discharge of the statutory inspection and other functions laid down in the Mental Treatment Acts and is the principal adviser on medical aspects of psychiatry and mental handicap. He reports to the Assistant Secretary, Mental Hospital Services, and is assisted in his work by two Assistant Inspectors of Mental Hospitals.

2.7.8. On social work, the Department has a permanent Children's Officer and has had the temporary services of three social workers, primarily for the development of social service councils.

2.7.9. In relation to building, the Department has a Chief Architectural Adviser, a Deputy Chief Architect and five architectural inspectors; a Principal Engineering Adviser, two civil engineers and two mechanical and electrical engineers. The Chief Architect works mainly with the Principals on building and reports to the Assistant Secretary on that side of the Department.

2.7.10. The total *administrative staff* from Assistant Principal upward in the Department is as follows:—

Secretary	1	
Assistant Secretaries	4	
Principals	15*	
Assistant Principals	29*	*Total* 49

The total number of *medical and related staff* is as follows:—

Chief Medical Officer	1	
Inspector of Mental Hospitals ...	1	
Deputy Chief Medical Officers ...	3	
Assistant Inspectors of Mental Hospitals	2	
Senior Medical Officers	3	
Medical Officers	4	
Dental Adviser	1	
Pharmacist	1	
Superintendent Health Inspectors	2	
Nursing Officer	1	
Children's Officer	1	*Total* 20

The total number of *other professional staff* is as follows:—

Chief Architect	1	
Deputy Chief Architect	1	
Architects	5	
Engineers	5	*Total* 12
		Grand Total 81

*(1 Principal seconded to the Institute for Public Administration.
1 Principal seconded to the Hospitals Commission.
1 Assistant Principal seconded to the General Medical Services (Payments) Board.)

2.8 *Functions and Organisation of Health Boards*

2.8.1. In this report we were concerned, primarily, with the establishment of the Aireacht and the relationships between it and the main executive agencies. As mentioned in paragraph 1.1.4. we did not consider the structure of the health boards and the regional hospital boards since they had been established pursuant to recent legislation and were, at the time of our examination, only becoming fully operational.

2.8.2. The main burden of the work of administering the health services is laid on the health boards. Section 4 (1) of the Health Act, 1970, provided:—

> "For the administration of the health services in the State, the Minister shall, after consultation with the Minister for Local Government, by regulations establish such numbers of boards (to be known and in this Act referred to as health boards) as may appear to him to be appropriate and by such regulations shall specify the title and define the functional area of each health board so established and, subject to sub-section (2), shall specify the membership of each health board".

2.8.3. Each of the eight health boards set up under the 1970 Act is a body corporate. The boards are responsible for the administration of all the health services, which include hospital services, general medical services, services for mothers and children and preventive services. Certain welfare services are also provided by the boards. The boards have responsibility, also, for the payment of disablement allowances, for the home help service, for the boarding-out of children and for welfare homes for the aged. While local authorities retain statutory responsibility for the provision of home assistance, the boards administer the service on an agency basis for twenty-two of the local authorities, thus facilitating co-ordination of health and welfare services.

2.8.4. The membership of health boards is composed of local authority members (who must be in the majority), representatives of the medical and ancillary professions elected by their colleagues in the area served by the health board and, on each board, three persons appointed by the Minister. The title, the areas and population served and membership of each of the health boards is set out in the following table:—

Title of Board	Area Served	Population (1971)	Membership							
			Local Authority Members	Medical Practitioners	Dentists	Pharmacists	General Nurses	Psychiatric Nurses	Ministerial Nominees	Totals
Eastern Health Board	Dublin City and County, Counties Kildare and Wicklow (1,800 sq. miles)	990,491	19	9	1	1	1	1	3	35
Midland Health Board	Counties Laoighis, Longford, Offaly and Westmeath (2,250 sq. miles)	178,908	16	7	1	1	1	1	3	30
Mid-Western Health Board	Counties Clare, Limerick City and County, Co. Tipperary (N.R.) (3,040 sq. miles)	269,804	15	6	1	1	1	1	3	28
North-Eastern Health Board	Counties Cavan, Louth, Meath, and Monaghan (1,950 sq. miles)	245,540	16	7	1	1	1	1	3	30
North-Western Health Board	Counties Donegal, Leitrim and Sligo (2,600 sq. miles)	186,979	14	6	1	1	1	1	3	27
South-Eastern Health Board	Counties Carlow, Kilkenny, Tipperary (S.R.), County and City of Waterford and County Wexford (3,630 sq. miles)	328,604	16	8	1	1	1	1	3	31
Southern Health Board	County and City of Cork and County Kerry (4,700 sq. miles)	465,655	18	8	1	1	1	1	3	33
Western Health Board	Counties Galway, Mayo and Roscommon (5,020 sq. miles)	312,267	15	7	1	1	1	1	3	29

The health boards delegate the day-to-day management of the services, on a considerable scale, to their Chief Executive Officers while retaining the tasks of deciding priorities and plans, allocating resources, reviewing performance against plans, and making changes in plans.

2.8.5. *Exhibit 7* opposite shows the management organisation adopted under the health boards. The services are divided into three programme areas viz. community care, special hospital care, and general hospital care. In the four larger boards, a Programme Manager is assigned to each of these programmes. A Programme Manager is responsible to the Chief Executive Officer for the implementation of his agreed programme within budget. The Chief Executive Officer has, in addition to his Programme Managers, three staff units for the functions of finance, personnel, and planning and evaluation reporting directly to him.

2.9 *Functions and Organisation of Comhairle na nOspidéal* and the three Regional Hospital Boards*

2.9.1. The functions of Comhairle na nOspidéal, as set out in section 41 (1) (*b*) of the 1970 Act are:—

"(i) to regulate the number and type of appointments of consultant medical staffs and such other officers or staffs as may be prescribed, in hospitals engaged in the provision of services under this Act;

(ii) to specify qualifications for appointments referred to in subparagraph (i), subject to any general requirements determined by the Minister;

(iii) to advise the Minister or any body established under this Act on matters relating to the organisation and operation of hospital services;

(iv) to prepare and publish reports relating to hospital services;

(v) to perform any functions which may be prescribed, after consultation with the Council and with such bodies engaged in medical education as appear to the Minister to be appropriate, in relation to the selection of persons for appointments referred to in subparagraph (i); and

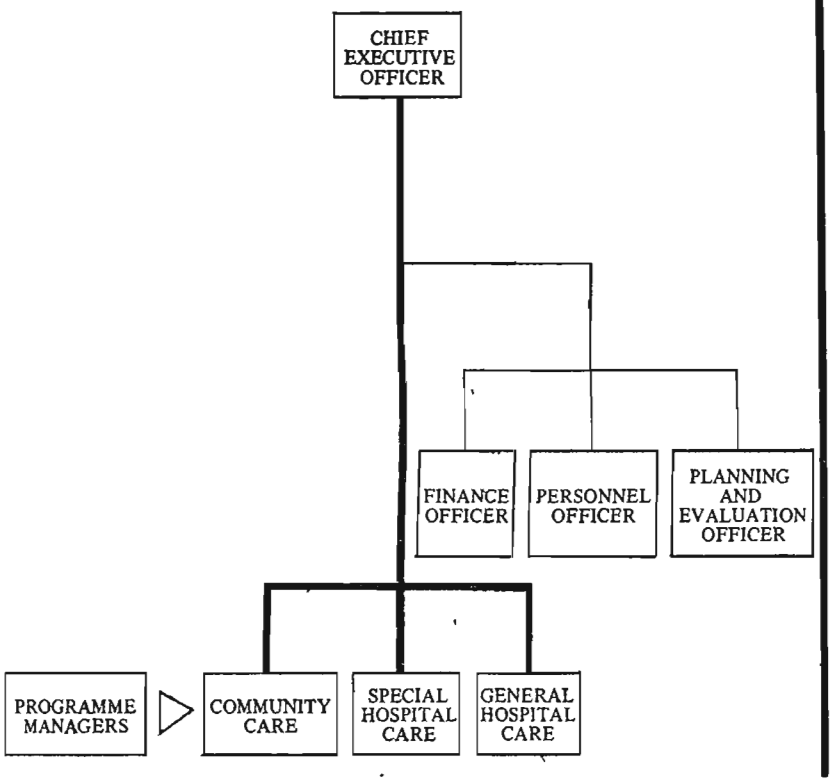
(vi) to perform such other cognate functions in relation to hospital services as may be prescribed".

The Comhairle is also involved in gaining agreement to a common selection procedure for the appointments of consultants and other senior medical staff.

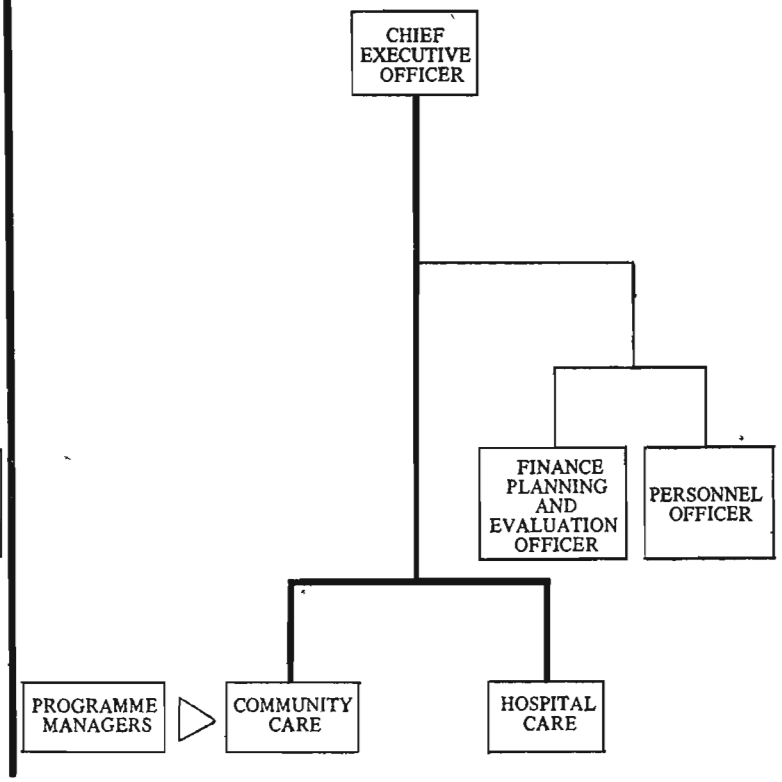
*This body had its origins in the Report of the Consultative Council on the General Hospital Services (the "FitzGerald" Report).

EXHIBIT 7

ORGANISATION OF A LARGER HEALTH BOARD



ORGANISATION OF A SMALLER HEALTH BOARD



2.9.2. Each regional hospital board is charged with:—

> "the general organisation and development of hospital services in an efficient and satisfactory manner in the hospitals administered by health boards and other bodies in its functional area which are engaged in the provision of services under the Act".

It has co-ordinating functions for all hospitals providing services for Health Act patients, including psychiatric hospitals. It is not concerned with the day-to-day running of the hospitals. The ownership and management of the hospitals remain with the health boards and with the proprietors of the voluntary hospitals.

2.9.3. A regional hospital board exercises its co-ordinating function mainly through a continuing review of general organisation and development of hospital services in its region, through examination of proposals by hospital authorities for developments in their hospitals, through examination of hospital budgets and by generally promoting efficiency in hospitals. The main functions of each board are:—

(i) to consider and keep under review the general organisation and the development of in-patient and out-patient services of both health board and voluntary hospitals;

(ii) to consider any proposal of a health board or other body on changes, extensions or discontinuance of hospitals;

(iii) to advise the Minister on hospital policy generally;

(iv) to govern the numbers and types of officers and employments in certain hospitals;

(v) to examine estimates of receipts and expenditure of health boards and other bodies and make recommendations to the Minister;

(vi) to allocate to hospital projects certain public capital funds made available by the Minister;

(vii) to sponsor inter-hospital comparisons and to organise advisory services for hospitals;

(viii) to control the expenditure of capital funds allocated by it under (vi) above; and

(ix) to discharge certain functions in relation to capital allocations to hospital projects.

2.9.4. A management consultant's report on these bodies recommended that, in the interests of effectiveness and efficiency, there

should be a common secretariat for the four bodies. This recommendation has been accepted by the Minister for Health and arrangements for the recruitment of a Chief Officer and staff are now being made. The officers in the secretariat will be employed by the Hospital Bodies Administrative Bureau, which is purely a service organisation. The secretariat will have access to the information available through the computerised management information system currently being developed for the health services and will avail itself, also, of the information and analysis produced by the Planning Unit of the Aireacht.

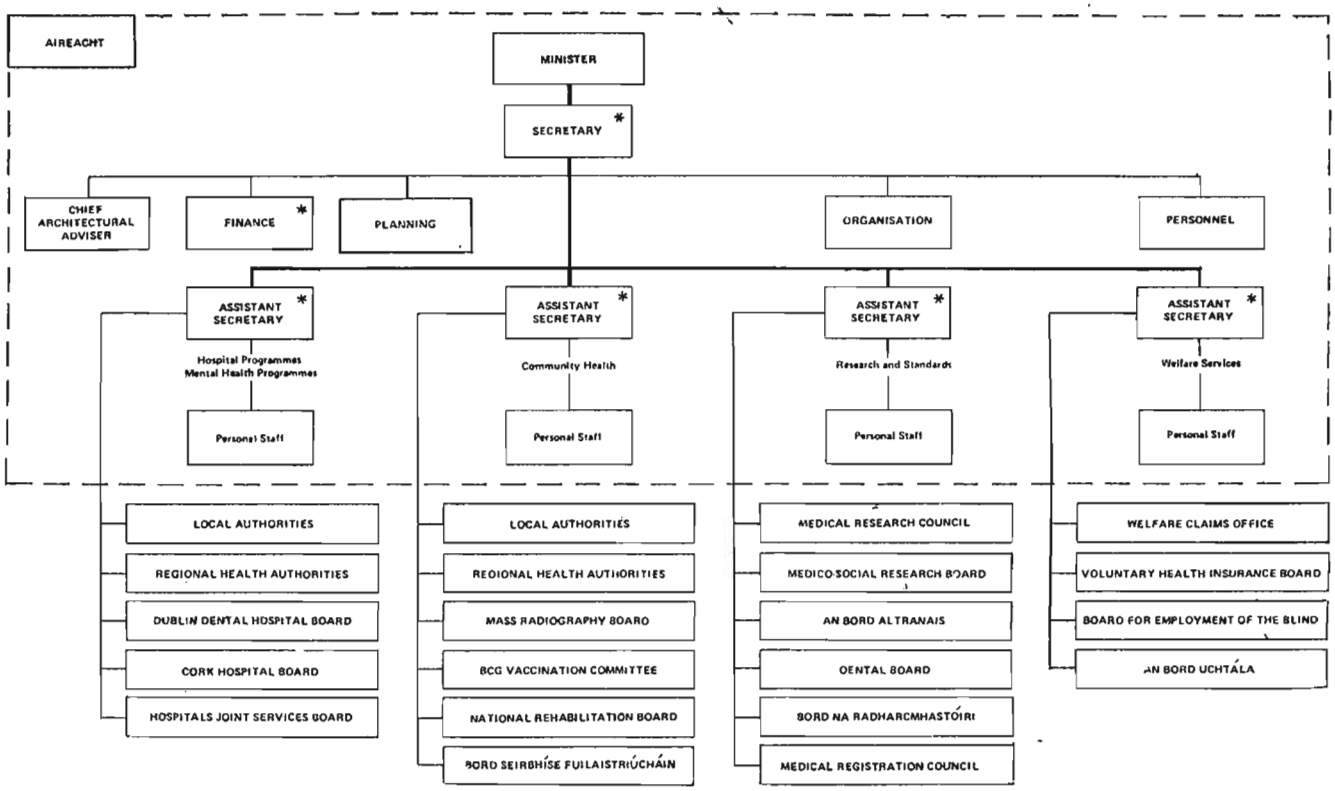
2.10 *The Role of the Voluntary Hospitals*

2.10.1. The nature and role of the voluntary hospitals have been summarised as follows in the Report of the Consultative Council on General Hospital Services (the " FitzGerald " Report):—

> " The voluntary hospitals are now, as in the past, mainly located in Dublin, Cork and Limerick cities. Most of them are public hospitals but a few of them are private in character. In the former category the majority of the patients pay little or none of their expenses. The management authorities of the hospitals are varied. Some are owned and operated by religious orders, notably the Irish Sisters of Charity, the Sisters of Mercy, the Sisters of Bon Secours and the Medical Missionaries of Mary. Others are incorporated by charter or statute and are operated by lay Boards of Governors who, generally speaking, are elected from amongst the voluntary subscribers to the hospital. A few hospitals, such as the North Infirmary and South Infirmary, Cork, were formerly County Infirmaries and the composition of their Boards, which includes local authority representation, is regulated by early statutes. The constitution of the management authorities of the Meath Hospital (Dublin), and St. Laurence's Hospital (Dublin), is governed by more recent legislation.
>
> Most of these hospitals now depend on public funds for all but a relatively small proportion of their income. With the exception of the private hospitals, they participate in the provision of services for those entitled to them under the Health Acts and are paid certain fixed capitation rates by the health authorities. Many of them also have deficits in their annual operational costs met by a grant paid by the Minister for Health from the Hospitals Trust Fund. Where capital expenditure is concerned most of the public voluntary hospitals are also largely dependent on grants from the Hospitals Trust Fund. The private voluntary hospitals do not participate fully in the provision of services for Health Act patients and do not obtain grants from the Hospitals Trust Fund. Nevertheless, they provide a service for a significant number of patients and must be taken into consideration in reviewing our hospital needs ".

Exhibit 8

DEPARTMENT OF HEALTH AND WELFARE
PROPOSED ORGANISATION



* *Management Advisory Committee*
The National Health Council should be in an advisory position to the Minister
The Department shares a Legal Adviser with the Department of Regional Development

CHAPTER 3

THE ORGANISATION MODEL FOR THE DEPARTMENT OF HEALTH AS RECOMMENDED BY PSORG

3.1 *Changes which have occurred since the PSORG Report*

3.1.1. As we have mentioned already at paragraph 2.6.2., a number of fundamental organisational changes in the health services has taken place since PSORG reported in 1969. Under the Health Act, 1970, the health boards, the regional hospital boards, and Comhairle na nOspidéal have been established and the overall administrative structure is now as indicated at *Exhibit 5* opposite page 11.

3.1.2. Under the Health (Corporate) Bodies Act, 1961, two further bodies viz. the St. James's Hospital Board and the James Connolly Memorial Hospital Board have been established to administer two hospitals. The health boards have availed themselves of the facility under Section 11 of the Health Act, 1970, to establish the General Medical Services (Payments) Board for paying doctors and pharmacists under the "choice-of-doctor" scheme. The Minister for Health has been given responsibility for the welfare of the blind under the Blind Persons Act, 1920. Ministerial functions relating to the officers administering home assistance have been transferred to the Minister for Social Welfare.

3.1.3. On the services side, the major developments have been the introduction of the "choice-of-doctor" scheme and the abolition of the dispensary system, the introduction of a free treatment scheme for persons suffering from long-term illnesses and diseases, a scheme to assist persons in the middle income group and the introduction of a home help scheme.

3.2 *The PSORG Organisation Model for the proposed Department of Health and Welfare*

3.2.1. *Exhibit 8* opposite outlines the proposed Department of Health and Welfare recommended in the PSORG Report. This recommendation envisaged the merging of the Departments of Social Welfare and Health to form a new Department of Health and Welfare. The major reasons for this recommendation were:—

(i) comprehensive care involving medical and social welfare effort was now the accepted basis for most modern health and welfare administrations;

(ii) because an increasing percentage of national expenditure was being allocated to health and social welfare every

year, decisions as to long, medium and short-term priorities should be made after a comprehensive review of all the needs in the area; and

(iii) policy development and planning for health and welfare services will be heavily dependent on statistical, sociological and other scarce skills in the future. A single Department would therefore ensure more economic and effective use of these skills.

While recognising the importance of these considerations, we consider that a decision on the PSORG recommendations in this matter would best be taken as part of a total view on the number and functions of all Government Departments. As we mentioned earlier, in such a general decision wider questions concerning the division of Ministerial responsibilities, the optimum number of Departments and the balance between them would have to be answered. Notwithstanding this, we have, in our recommendations, borne in mind the need for our proposed structure for the Department of Health to be of such a nature that additional functions, particularly in the welfare field, may be added on. In other words, the Aireacht we are recommending for the Department of Health can be expanded readily to include relevant functions from the Department of Social Welfare.

3.2.2. The following are the main features of the PSORG recommendations relating to the Department of Health and Welfare:—

(i) four Assistant Secretaries for the "line" functions, one dealing with hospital programmes and mental health programmes, another dealing with community health, a third dealing with research and standards and the fourth dealing with welfare services;

(ii) five staff units i.e. one each for finance, planning, organisation and personnel, and a staff role for the Chief Architectural Adviser;

(iii) executive units, grouped by function, under each Assistant Secretary in the line.

3.2.3. These proposals should be viewed against the philosophy of the PSORG Report generally and its comments on the total public sector and, in particular, against:—

(i) the new concept of a Department of State, embracing two distinct areas viz. the policy making and the executive areas;

(ii) the primacy of line management in relation to the staff units;

(iii) the integration of professional and administrative staff;

(iv) the counselling role of the Assistant Secretary in relation to executive bodies;

(v) the unifying role of the staff units in linking the central staff area of the Departments of Finance and of the Public Service to the individual Departments and, through them, to the staff units in the executive area.

3.2.4. The Chart at *Exhibit 8* opposite page 19 does not, of course, give any indication of the very complex working relationships which would exist under such a model both within the Aireacht and between the Aireacht and the executive area. We have tried to develop the more significant of these in Chapter 6 but we recognise that processes cannot be fully developed until the Aireacht organisation is physically operational and the practical working problems emerge more clearly.

CHAPTER 4

THE ORGANISATION MODEL FOR THE DEPARTMENT OF HEALTH PROPOSED BY McKINSEY & CO. INC.

4.1 *The Background to the McKinsey Organisation Study*

4.1.1. In February, 1972, the then Minister for Health asked Messrs. McKinsey & Co. Inc., Management Consultants, to:—

> "undertake an assignment to determine the role, organisation and detailed management arrangements of Comhairle na nOspidéal and the regional hospital boards and to consider the implications for the Department of Health itself of the Health Act, 1970, and the relevant changes in the health services, and to make recommendations on the Department's role, organisation and working methods".

4.1.2. The consultants concentrated on the appropriate organisation of that part of the Department which, by and large, was likely to become the Aireacht in a Department divided on the lines envisaged in the PSORG Report. They suggested that the re-organisation should take place in two phases, the first an interim organisation to take account, for a brief transitional period, of the evolving nature of the developments in Comhairle na nOspidéal, the regional hospital boards and the health boards. When these developments had taken place, they envisaged a re-organisation of the Department based on functional lines. *Exhibits 9 and 10* opposite show the interim and final forms of organisation suggested by the consultants.

4.2 *The Final Organisation proposed by McKinsey & Co. Inc.*

4.2.1. The main recommendations were that:—

(i) there should be a strong functional emphasis, with the three staff functions of *finance, personnel,* and *planning and organisation* each headed by an Assistant Secretary (the Assistant Secretary for Planning and Organisation would also be responsible for food and drugs standards);

(ii) the services or line activities of the Department should be consolidated under one Assistant Secretary;

(iii) all services, except food and drugs standards, should be under this Assistant Secretary;

EXHIBIT 9

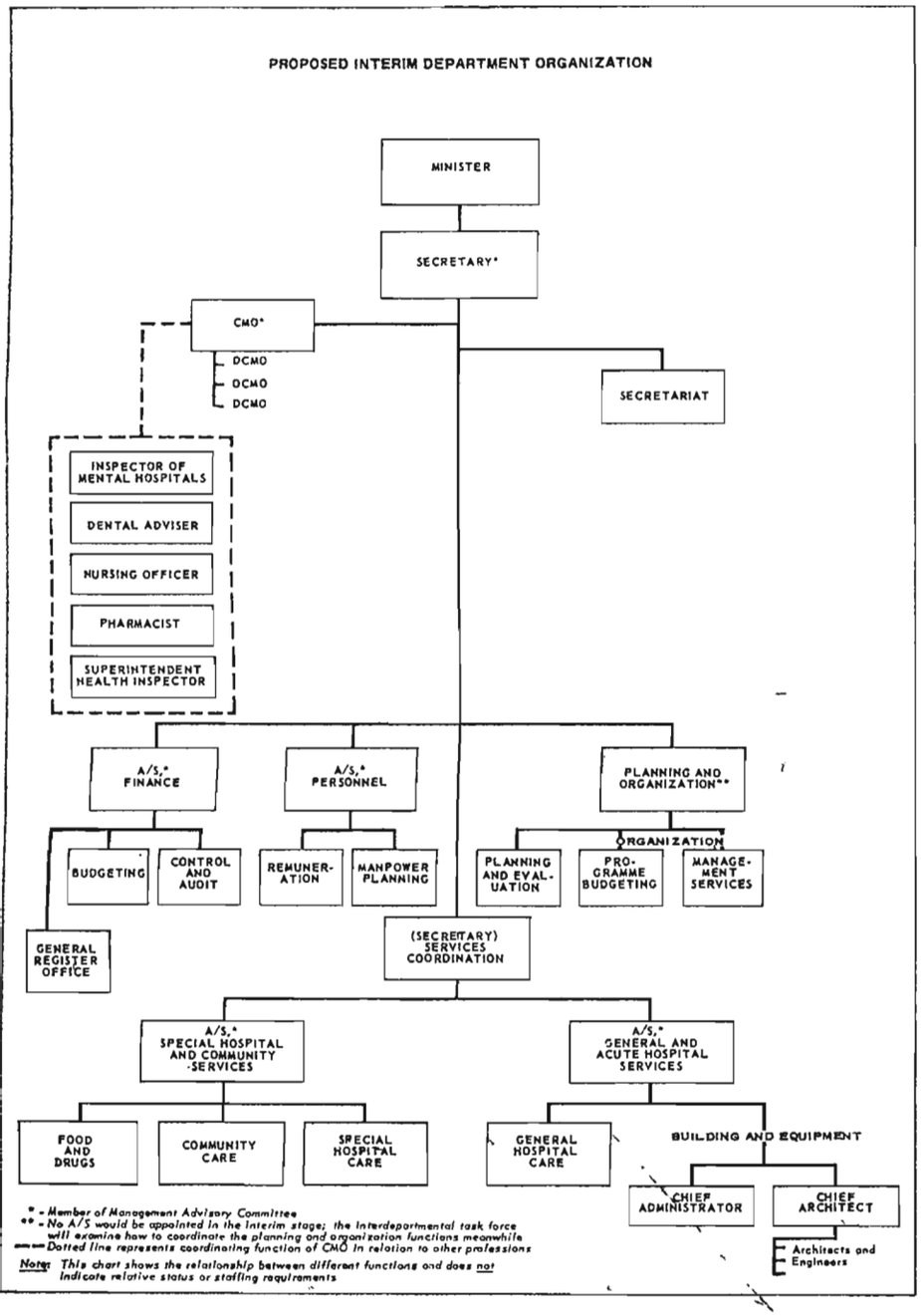
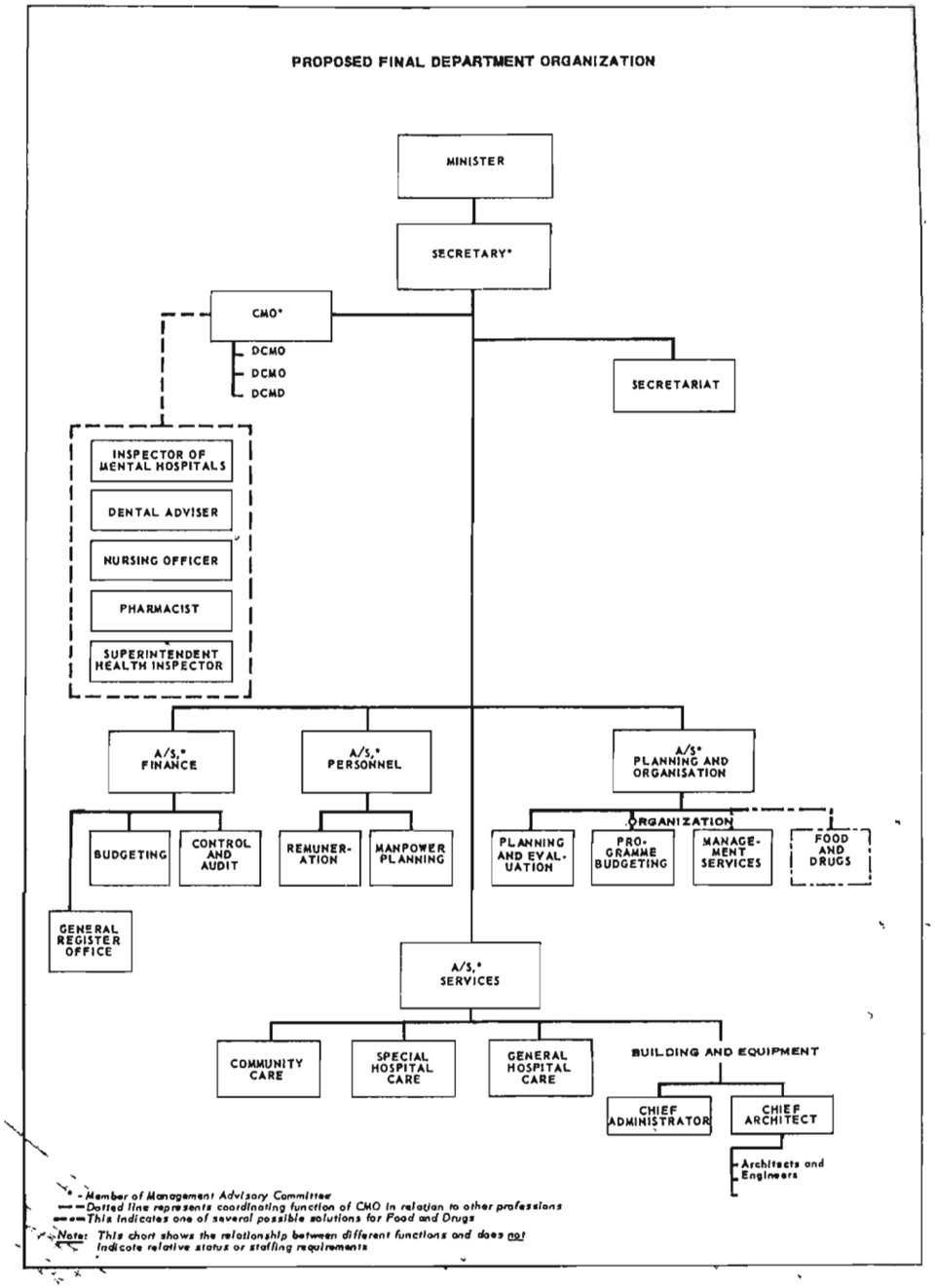


EXHIBIT 10



(iv) a Management Advisory Committee should be established to aid the Secretary in organising and managing the work of the Department, the members of the Committee to be the Secretary, the Chief Medical Officer and all four Assistant Secretaries;

(v) the separate position of the professional staff members should be retained but they should be involved to a greater extent in working parties, task forces etc.;

(vi) a Secretariat reporting direct to the Secretary with responsibility for (a) international affairs, (b) the servicing of the Management Advisory Committee, (c) highlighting major policy issues overlapping areas of responsibility inside or outside the Department, (d) drafting general directives and guidelines ensuring broadly based analysis for the Secretary and (e) providing a point of contact for all bodies outside the Department, should be established;

(vii) programme budgeting should be located in the Planning and Organisation Unit;

(viii) the Registrar-General's Office should be attached to the Assistant Secretary responsible for finance.

4.2.2. The consultants saw major benefits in grouping all services or line management responsibilities under one Assistant Secretary. They argued that it would :—

(i) foster a co-ordinated, integrated approach to services questions within the Department;

(ii) facilitate the strategic control of activities in the field;

(iii) allow him to co-ordinate the work of the individual divisions and sections and to help strike a balance among the services;

(iv) relieve the Secretary of much of the burden he would otherwise carry as the only officer able to consider overall service questions.

4.3 *The Interim Organisation proposed by McKinsey & Co. Inc.*

4.3.1. The proposed interim organisation which was suggested for the reasons set out in paragraph 4.1.2. differed from the final organisation in the following manner :—

(i) the services or line activities of the Department would be divided between two Assistant Secretaries, one responsible for special hospitals and community services, the other for general and acute hospital services and building;