Research Repository UCD

Provided by the author(s) and University College Dublin Library in accordance with publisher policies., Please cite the published version when available.

Title	Value for money and the Irish Health Services
Authors(s)	Brennan, Niamh
Publication date	2003-10
Publication information	Public Affairs Ireland, (7): 10-12
Publisher	PAI Publishers
Item record/more information	http://hdl.handle.net/10197/5370

Downloaded 2019-03-22T23:12:07Z

The UCD community has made this article openly available. Please share how this access benefits you. Your story matters! (@ucd_oa)

Some rights reserved. For more information, please see the item record link above.

Brennan, Niamh [2003] Value for Money and the Irish Health Services, *Public Affairs Ireland*, 7(October): 10-12

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. Due to its long title, it has become known as the Brennan Commission after the chairman of the group. In that Budget statement the Minister indicated that the Commission would examine, evaluate and make recommendations on relevant financial systems, practices and procedures throughout the health services. 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 asked to report by the end of 2002.

The Commission comprised 12 people. As it had a strong managerial remit, members tended to have a managerial or financial background. Notwithstanding media comment, only five of the 12 were accountants, of which two were from the Department of Health and Children and a Health Board respectively. Two Commission members were former chief executives of hospitals. One member of the Commission was a patient of the system.

The Commission met formally 18 times until its final meeting on 31 January 2003. In addition, there were many informal meetings to progress issues.

Submissions from a range of 46 interested parties that might reasonably be expected to have a substantive contribution to make to the Commission's deliberations were

invited. In all, written submissions were received on behalf of 20 groups. In addition, the Commission 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.

Terms of reference

The Commission was given eight terms of reference which could be described as narrow and focused on financial management issues only. In interpreting these narrow terms of reference, a broader perspective was taken than might have been anticipated. Structural and organisational issues were addressed that were considered essential to improving the management of public expenditure mentioned in the Minister for Finance's Budget 2001 speech referred to above. These structural and organisational issues are central to value for money in the health services. The Irish taxpayer was to the fore in the Commission's deliberations (without compromising service to patients and other service users).

Standard of accountability in the public sector

It can be argued that the level of accountability Irish taxpayers are entitled to expect is to the same standard as a publicly quoted company (plc) such as a top London Stock Exchange FTSE-100 company. Both the Irish public service and a plc do the same thing – they take other people's money (either shareholders or taxpayers) and spend it. However, there is one significant different between a shareholder in a plc and the Irish taxpayer. If plc shareholders do not like the standards of accountability, they can sell their shares and buy into another plc. Irish taxpayers have no such option. One can therefore argue that the standards of accountability owed by the State to its taxpayers are of an even higher standard than a plcs. The money is taxpayers' money, and does not belong to the State or to the public servants who spend the money. Therefore the State and its public servants owe taxpayers the highest standards of accountability and value for money. Unfortunately in every single aspect of the health services the Commission examined, low standards of accountability, and a complacent and casual attitude in this respect from the public servants in charge of taxpayers' monies, were found.

Why is accountability important - Amounts of monies involved

It is, and always will be, a fact of life in the health services (no matter the country) there will never be sufficient financial resources to treat all the patients in the most ideal way possible. Given that financial resources are, and always will be, a limiting factor, surely it is obvious that if these resources are managed to best effect, that more patients can be treated for the same amount of money (to use a colloquism, "more bang for our buck").

The amounts of monies being spent on our health services are huge as the following brief statistics reveal:

- The health services cost €2,000 for every person in the country
- Each taxpayer pays on average €6,800 for our health services
- Total national public expenditure on health has increase has increased from 19.2% in 1997 to 22.8% in 2002
- 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 billion. Gross expenditure by 2003 is over €9 billion.

Taxpayers do not necessarily resent spending €6,800 per annum of their money on treating public patients. They do resent their money being wasted. Therefore, before taxpayers are asked to spend even more money on the health services (and the public sector generally), they are entitled to better assurances than are currently possible that their hard-earned money is well spent.

The Brennan Report

Although it completed its deliberations on 31 January 2003, the Brennan Report was not published until 18 June 2003. Consistent with its value for money remit, the report generated a small profit for the State in that all 2,200 copies were sold out by the end of July 2003 (a fairly unique experience for government reports!). Thus, it is no longer available in hard copy but can be accessed at http://www.finance.gov.ie/publications/otherpubs/brennan.pdf.

Problems with the existing health services

As already stated, the Commission found problems in the financial management of almost every aspect of the health services. In the past, commentators have referred to a black hole in the health services. The problems found were not so much a black hole – there are so many holes in our health services that it is more akin to a colander than a black hole.

Some of the problems found were:

- Management and control of services and resources is too fragmented: The most fundamental problem was structural. Recognising that its job was not to manage the health services on a day-to-day basis, the Department of Health and Children over the years established agencies for this purpose when the need arose. As a result, there are 65 different agencies managing the health services. There was no "head office" in charge (in day-to-day management terms) of these 65 agencies. This proliferation of agencies leads to inefficiencies in that they do not all "sing from the same hymn sheet"
- There is no one person or agency with managerial accountability for how the executive system performs: A chief executive with overall responsibility for day-to-day management of the health services should be appointed. Currently, the Minister for Health and Children has to deal with day-to-day issues that are outside his control. This is unreasonable.
- Systems are not designed to develop cost consciousness among those who make decisions to commit resources and provide no incentives to manage cost effectively.
- Those who make decisions to commit resources (mainly consultants and other medical practitioners) are not accountable for deciding the outputs to be delivered.
- The usefulness of data for resource management and for strategic planning purposes is limited because doctors treating the patients are not interpreting the data and 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.

- 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.
- Inadequate investment in information systems and management development.

Four core principles

The Commission adopted four core principles in addressing the problems identified above:

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

Principle 3 is worth elaborating on further. It is fundamental to the clinical autonomy of doctors that they treat patients following best clinical practice. All taxpayers want their loved ones to be treated regardless of cost. This principle should never be compromised, even if it costs the taxpayer (say) over €1 million to treat a single patient. However, where consultants are performing routine operations (e.g. hip replacements) they should know what the treatment costs. If the same routine operation costs Consultant A twice as much as Consultant B, then this should be known. The more cost effective Consultant B is entitled to demand more resources, as s/he is so cost effective. Consultant A may change his/her medical practices if s/he knows they are less cost effective than other consultants.

Recommendations

The Commission made 136 recommendations, the main ones being:

- 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.
- Reform of the medical card (GMS) scheme to include a Practice Budget for each GP, monitoring of activity and referral patterns etc.
- Introduction of a process of evaluating clinical and cost effectiveness for publicly-funded drug schemes

The chief executive of the new Executive will carry considerable responsibilities. Irish taxpayers and Irish patients are entitled to expect a first class health service. A first class chief executive is required for this purpose. Accordingly, the Commission recommended that recruitment of the CEO of the Executive should be by means of an international search and select process. To attract the best managers you have to be prepared to pay the market rate, following private sector norms. Pay and conditions need to be different to that traditionally applying in the civil service. The Commission recommended that remuneration of the CEO could be determined in a similar manner to the salaries of CEOs in the non-commercial State sector.

Implementation

The Brennan Report includes as an Addendum to the final chapter, a list of the 136 recommendations together with the IT implications for each recommendation (a crude proxy for cost of implementation), and with a timeframe for implementation. Of the 136 recommendations, the timeframe for implementation as:

- Immediate, in the case of 51 recommendations.
- Medium-term (i.e. within one year or less) in the case of 13 recommendations.
- Longer-term (or as soon as practical) in the case of 72 recommendations.

Of the 136 recommendations, only 17 have IT implications. Of these 17 recommendations, 13 can be begun without any additional IT expenditure, although

additional IT facilities are required to implement the recommendations fully. Finally, four recommendations will have significant IT implications.

With commitment and determination all 136 recommendations can be implemented within a two-year timeframe.

Government response

Consistent with the principal recommendation, the Government has indicated that it will establish a Health Services Executive. Allied with this will be major rationalisation of a very fragmented health services such that 27 agencies will be subsumed into the Health Services Executive and seven agencies will be merged/abolished.

The Prospectus Report on the audit of structures recommended that the health boards be abolished. The Brennan Report recommended that health boards be retained (but significantly reduced in number) as they currently deliver worthwhile advantages in terms of corporate governance and accountability functions and in terms of local democratic accountability. The Government opted for the Prospectus recommendations and four regional health offices are to be established in place of the existing health boards.

Concerns

The Brennan Report made 136 recommendations. As outlined above, the Government has indicated that some of these recommendations will be implemented. However it is (by August 2003) completely silent on some recommendations, and makes commitments in relation to others in such general terms that it is unclear exactly what is being planned in relation to specific recommendations. This is of concern.

Key to the success of the Brennan Report is implementation of **all** its recommendations. There may be a temptation to implement the easier recommendations and sideline the tougher decisions. Given these concerns, pending establishment of the Executive, the Brennan Report recommended the creation of a high level and well-resourced implementation committee. A highly independent,

strong-minded person, with considerable experience of change management, should chair this committee.

On page 19 of a PowerPoint presentation by the Secretary General of the Department of Health and Children (see http://www.doh.ie/pdfdocs/hssecgen.pdf) the implementation process is shown headed up by a Project Office. It is not clear who will be in charge of the Project Office. The Commission strongly believes that someone outside of, and independent of, the health services should be in charge of implementation. Anyone working directly within the health services could have a conflict of interest in relation to implementing many of the Brennan Report recommendations.

Concluding comment

There is no magic wand to solve all the complex problems facing our health services. However, if the 136 recommendations of the Brennan Report are implemented this will bring about significant improvements that will lead to better value for hard-earned taxpayers' monies spent on our health services. This would be good for patients - more of whom could be treated for the same amount of taxpayers' money which is and will always be in limited supply.