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Standard of accountability in the public sector

I believe 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 our money as taxpayers, and does not belong to the State or to the public servants who spend the money. Therefore the State and its public servants owe us taxpayers the highest standards of accountability and value for money. Unfortunately in every single aspect of the health services the Commission examined, we found low standards of accountability, and a complacent and casual attitude in this respect from the public servants in charge of taxpayers’ monies.

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 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 possible currently that their hard-earned money is well spent.

Problems with the existing health services

The Commission on Financial Management and Control Systems in the Health Services (the “Brennan Commission”) which I chaired did not find a black hole. We found so many holes that our health services are more akin to a colander than a black hole.

Some of the problems we 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, we found 65 different agencies managing the health services. There was no “head office” in charge (in day-to-day management terms) of these 65 agencies. Is it any surprise then that we found they did 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.
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. We taxpayers and 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. We recommended that remuneration of the CEO could be determined in a similar manner to the salaries of CEOs in the non-commercial State sector.

Government response

Consistent with our 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 we were of the opinion that they delivered 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 July 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 gives us concern.

Key to the success of the Brennan Report is implementation of all its recommendations. We are worried that the easier recommendations will be implemented but the tougher decisions will be sidelined. Given these concerns, pending establishment of the Executive, we recommended the creation of a high level and well-resourced implementation committee.

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