

**The Adelaide Health Forum:
Reforming Financial Management and Control Systems in the Irish Health Service**

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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.

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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 difference 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.

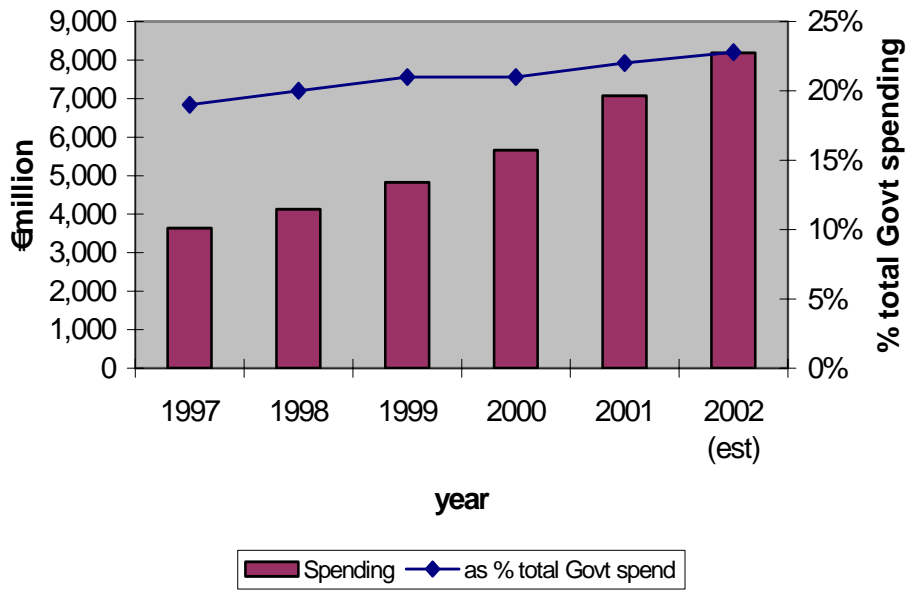
Why is accountability important - Amounts of monies involved

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 (see Figure 1)
- 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 (see Figure 1 and Table 1).

Figure 1: Evolution of Exchequer Allocations to Health 1997 - 2002



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

Table 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	707	17%	33%
2000	5,656	825	17%	56%
2001	7,077	1,421	25%	95%
2002 (est)	8,189	1,111	16%	125%

Source: Revised Estimates for Public Services 1998 to 2002

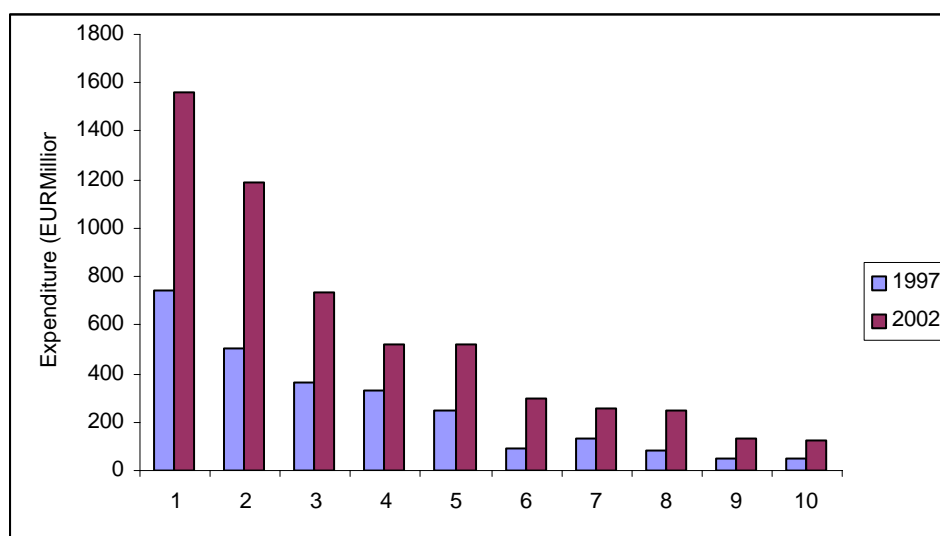
Table 2 and Figure 2 illustrate the scale of increase in funding in a range of areas of the health service for the period 1997 to 2002. This shows that in areas such as hospitals and the GMS, funding has more than doubled, with other areas recording even larger increases.

Table 2: Growth of Non-Capital Expenditure in Selected Areas 1997 – 2002

	1997 (€million)	2002 (€million)	% Increase
1 Services in Public Voluntary Hospitals	744	1558	109.4
2 Services in Regional Hospitals	502	1191	137.3
3 GP Service (including prescribed drugs)	366	738	101.6
4 Psychiatric programme	327	520	59.0
5 Mentally Handicapped Special Home Care	246	518	110.6
6 DPS: Subsidy for drugs not covered by GMS	93	295	217.2
7 Services in Long-stay Hospitals	131	255	94.7
8 Child care services, including residential care	84	245	191.7
9 Superannuation	48	129	168.8
10 Family planning & pregnancy counselling	48	123	156.3

Source: Department of Health and Children

Figure 2: 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 – 3 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 oncologists 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 & Intellectually Disabled - 465 dedicated respite places and around 1,300 additional residential places have been provided (*Source: Department of Health and Children*)

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.

Ethical principles and value for money

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. This is an issue not just for management – value for money cannot work in our health services unless medical decision makers, in addition to managers, embrace this as part of their responsibilities.

Doctors are required under the Hippocratic Oath to treat the sick to the best of their ability, to preserve patient privacy, to teach the secrets of medicine to the next generation, etc – sometimes summarised as “to help or at least do no harm”. A growing number of physicians have come to feel that the Hippocratic Oath is inadequate to address the realities of a medical world that has witnessed huge scientific, economic, political, and social changes. The classical Hippocratic Oath makes no mention of such contemporary issues as doctors’ societal or legal responsibilities. One such issue is the individual’s ethical responsibility for a just allocation of medical resources among

citizens. What role does beneficence (to help), non-malificance (do no harm) and equality play where resource allocation is concerned? Are resource allocation decisions to be left to managers or does it fall within medical ethics and within the professional concerns of doctors? It could be argued² that professionals have a responsibility to patients waiting for treatment as well as existing patients. Given that resources are constrained and limited, resources committed unnecessarily, wastefully or inefficiently to the treatment of one patient mean the denial of treatment or care to other patients.

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”

² See, for example, Hayes, M. (1988) *The Ethics of Resource Allocation*, Paper presented at the Academy of Medical Laboratory Science Conference, Kilkenny, 11 November 1988.

- 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.

Table 3 provides examples of some of the problems we found.

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.

Table 3: Examples of poor financial management in the Health Services

Poor planning

- Extension of medical card to over 70s: Initial estimate: 39,000 over 70s, Cost projected at €19 million. Actual number 77,000 over 70s, cost estimated at €51 million.
- Childcare Workers 2001 Pay Deal: original estimate cost of this pay deal was €4.7 million per annum. actual cost for childcare workers alone turned out to be €11.4 million per annum. knock-on effects to linked grades is expected to come to an additional €34 million to €38 million per annum. Total eventual cost is therefore in the range €45 to €50 million. Arrears of €30 to €34 million are also due to be paid on this deal.
- Estimated spending overshoot in 2002 for the General Medical Services (GMS) is €183 million on a budget of €739 million – 25 per cent. Systematic nature of underestimation of costs a surprise. Analysis of the period 1997 to 2002 shows estimated annual average increase of around 6.8% in the Book of Estimates. The actual annual average increases in costs were in excess of 21% for the same period.

Unauthorised expenditure

- Contractual commitments of health boards included approximately €15 million in 2000/2001 not approved by the Department of Health and Children.

Non-imposition of charges

- Hospital charges not properly imposed or collected: 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.

Accounting deficiencies

- Unsatisfactory audit reports: 11 (46%) out of 24 audit reports of the eight health boards for 1998, 1999 and 2000 were found to be unsatisfactory by the C&AG.
- Eastern Health Board: Audit backing documentation was not available to substantiate a debtor of £356,541 and its related bad debt provision of £273,730.
- Eastern Health Board: At 31 Dec 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.
- Western Health Board: There were serious inaccuracies in the financial statements as presented" in the financial statements of the Western Health Board.
- Midland Health Board: Included in debtors is a salaries and wages overpayment of £115,429
- Southern Health Board: Salary overpayment: the largest of these was an overpayment of £23,000 to an individual over a 10 month period
- 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.
- 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.
- 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.

Inadequate records / vouching

- 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 pharmacy claims in the period 2000/2001.

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 Commission presented its report to the Minister for Finance on 24 March 2003. Publication of the report was further delayed by three months (to 18 June 2003) to await completion of the Prospectus “*Audit of Structures*” Report. By September 2003 two key appointments necessary to progress our recommendations had not been made.

There is anecdotal evidence of Government reports in the past gathering dust. Concerned about this, we included a separate chapter on implementation, with an addendum listing all 136 recommendations together with the IT implications and timeframe for each recommendation (see Chapter 11: <http://www.finance.gov.ie/publications/otherpubs/brennan.PDF>).

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 October 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.

Chairman of Implementation Committee

Given these concerns, pending establishment of the Executive, the Brennan Report recommended the creation of a high level and well-resourced implementation committee. Critical to implementation of substantial change in any organisation is an individual to drive the change. For this reason, we recommended that an **independent** person be nominated by Government to chair a high-level, well-resourced national implementation committee. Someone from outside, 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. We had in mind someone with experience of change management in other large organisations; someone of substantial character who would pro-actively drive change and stand up to the natural resistance to change that is an

inherent element of any change programme. It is essential that the person be independent – those working in the sector may have (or may appear to have) conflicts of interest that would make them unsuitable for the task. In any event, the scale of change requires a full time commitment from some outside person – those working in the system are too busy with their normal duties to take on a task of this magnitude.

We recommended that the Implementation Committee would hand over to the board of the new Health Services Executive within two years. In our opinion, the two-year timeframe set out for implementation is reasonable. Those who say it will take ten years do not have the can-do, make-it-happen attitude that is required for successful implementation.

Chairman of the Interim Health Service Executive

The Government indicated on 18 June last that: “*An interim board of the health Service executive will be appointed shortly*” It is now (mid-October 2003) four months since that statement was made and there is no evidence that the interim board has been put in place. The Addendum to our implementation chapter shows that many of the 136 recommendations cannot commence until the Health Service Executive is established. It is critical that the interim board be appointed immediately – until that happens the process of appointing the management (especially the CEO) of the Health Service Executive cannot commence. In the meantime, there is a risk that existing managements in the health boards may put in place entrenchment mechanisms that may make change more difficult.

Current status of implementation

The Department of Health and Children has established 14 projects to move the reform agenda forward. These project groups are co-chaired by Department officials and Health Board CEOs (quite an unusual arrangement to have co-chairmen). Steering groups, project managers and project teams drawn from existing health service staff are being put in place. These are in a two/three month planning phase. Just as our health services are highly fragmented (65 different agencies) (and are inefficient as a result), this seems to be a very fragmented approach to implementation.

Of our 136 recommendations we identified 52 as being capable of being implemented (or implementation started) immediately. This begs the question: How many of these

immediate recommendations have actually been actioned since our report was presented to the Minster seven months ago?

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.