ENABLING MANAGERS TO MANAGE: HEALTHCARE REFORM IN IRELAND

Laraine Joyce
Executive Director
Institute of Public Administration

and

Christopher Ham
Fellow in Health Policy & Management
King's Fund College, London

Institute of Public Administration August 1990

Enabling Managers to Manage: Healthcare Reform in Ireland

Introduction

In September 1989 the Commission on Health Funding published the results of its analysis of the funding and management of the health services. The Commission's report represents a major contribution to the debate about the future of health services in Ireland. If accepted, the Commission's recommendations will bring about significant changes to the way in which services are delivered.

In this paper, we comment on the Commission's report. In so doing, our aim is to identify those recommendations which should be implemented and those which require amendment or further elaboration. While generally in sympathy with the Commission's analysis and findings, we argue that the Commission's diagnosis is more convincing than its prescriptions, and that there may be more effective ways of bringing about the suggested improvements than the recommendations contained in the report.

Our paper is divided into three parts. Part 1 describes the international context of health reform and explains how health services in Ireland came to be reviewed by the Commission. Part 2 summarises the major recommendations made by the Commission and offers a commentary on these recommendations. Part 3 highlights other issues of importance and suggests action on these issues.

Part I The Context of Health Reform

In many developed countries health services have come under critical scrutiny in recent years. In part this is because of increasing expenditure on health services, much of it funded from public sources, and the pressure this has put on governments seeking to control public spending. Also important has been the perception that the resources allocated to health services are not always deployed in an optimal fashion. At a time when the scope for increasing expenditure is extremely limited, this has prompted a search for ways of using

existing budgets more efficiently. A further concern has been the desire to ensure access to health care of various groups in the population and to provide services to these groups on an equitable basis. In some countries this has been linked to a wish to enhance patient choice and to make service providers more responsive to patients.

Underlying these specific concerns are a number of more fundamental developments which have a significant bearing on the performance of health services. Three are worth highlighting. First, there are demographic changes, including the ageing of the population and the decline in the proportion of the population of working age. These changes will both increase the demand for health care and at the same time limit the ability of health services to respond to this demand. Although there is some evidence to suggest that future generations of people aged over 65 will be healthier than their predecessors, the increase in the number of older people in the population, in particular those aged over 75, can be expected to create pressure for additional spending on services.

Second, advances in medical science will also give rise to new demands within the health services. These advances cover a range of possibilities, including innovations in surgery, drug therapy, screening and diagnosis. The impact of developments in health care technology is already evident in areas such as transplant surgery and medical imaging. The pace of innovation is likely to quicken as the end of the century approaches, with significant implications for the funding and provision of services.

Third, public expectations of health services are rising as those who use services demand higher standards of care. In part, this is stimulated by developments within the health services, including the availability of new technology. More fundamentally, it stems from the emergence of a more educated and informed population, in which people are accustomed to being treated as consumers rather than patients. This has implications both for the quality of the facilities in which services are delivered, and the standards of personal service that are achieved.

Against this background, policy makers in a number of countries have initiated a series of reviews of the performance of health services. In Holland the Dekker Report of 1987 has led to a programme of reforms affecting the funding and provision of services. These reforms involve the introduction of new insurance funding arrangements. In future, there will be a system of basic insurance for all covering essential health services, coupled with optional supplementary insurance covering other services. Insurers will be expected to contract selectively with providers, thereby stimulating competition on the supply side. The introduction of a market-oriented approach to service provision is in part a response to dissatisfaction with government planning and regulation as instruments for increasing efficiency.

In West Germany, a national conference of people drawn from all sectors of

health care recommends growth rates for different types of health expenditure. The conference acts as a major forum in which the main participants in the health service meet in public to debate future developments. The recommendations which emerge serve as guidelines for negotiation between the funders and providers of care. More recently, a health reform law was enacted in 1988, designed to achieve stability in the rate of social insurance contributions paid by employees and employers. This is to be pursued by control over expenditure on drugs, increases in user charges, and changes to the services included in the social insurance scheme.

In the UK, a fundamental review of the NHS conducted during 1988 resulted in a White Paper, *Working for Patients*, published early in 1989. The White Paper recommended no major change in the funding of health services. Its main proposals concerned the delivery of health care where the key recommendation was that hospitals should compete for funds from health authorities and general practitioners. In addition, the White Paper proposed to strengthen the management of the NHS, building on the introduction of general management in the mid 1980s. It also put forward a series of recommendations to make doctors more accountable for their performance.

In Sweden, a committee comprising representatives of local and national government has recently been established to examine options for the future. A wide ranging review is planned over the next 12 months. Having long been viewed as the model welfare state, Sweden is re-appraising many of its public services, although the commitment to provide good health care to all on equal terms is not negotiable. One of the options likely to be studied closely is the transfer of responsibility for primary health care from the county councils to the municipal councils. This may be linked to the development of competition between hospitals for resources.

The last example is New Zealand, a country in which a number of reforms have been introduced in recent years. These include the replacement of hospital boards with a smaller number of area health boards, the introduction of general management, and moves to increase the role of doctors and nurses in management. More recently, the government has articulated a national policy framework, based on the WHO's Health for All by the Year 2000 strategy. Health boards will be required to plan their services in the light of this policy and to negotiate annual management contracts with the health minister.

As these examples illustrate, health care reforms vary in their content from country to country. This reflects the different traditions and circumstances of the countries concerned. Nevertheless, a number of common threads can be discerned. In summary these are:

- a stronger emphasis on reforms to the management and provision of services than on change in methods of funding

- a universal concern to use existing resources more efficiently
- interest in a number of countries in competition between providers as the means of increasing efficiency
- a commitment to strengthen the management of services and to hold service providers more accountable for their performance.

It should be emphasised that there are no quick fix solutions to the problems faced by the health care systems of developed countries. In most countries, there is dissatisfaction with the effectiveness of existing arrangements and a search for new policy instruments. What is most striking from comparative analysis is the widespread interest in reform and the various routes taken by reformers.

Health Reform in Ireland

The impetus for the Irish health reform movement stems from the need that emerged in the course of the 1980s to control public expenditure which had reached an unsustainably high level. The government was becoming increasingly reliant on foreign borrowing to fund its spending. The need to control that spending was generally recognised.

The health services were a particular target for spending cuts as, up to 1985, health expenditure relative to GDP had been increasing, particularly in the 1970s (Table 1). This was in line with trends in other OECD countries. The level of Irish health expenditure was well above the OECD average, however, in the period 1975 to 1980. By 1987 it had been brought back in line with the OECD average. Over the course of the 1980s major reductions in health expenditure took place. No other OECD country achieved such a relatively major reduction in its level of health expenditure over that period. The reductions in the real level of health expenditure from 1980 on are shown in Table 2. The impact of this reduced expenditure is illustrated by the drop in the numbers employed in the health service and the decline in the number of hospitals and hospital beds. (Tables 3 & 4).

Table 1: Total health expenditure as a percentage of Gross Domestic Product

	1960	1970	1975	1980	1985	1986	1987
Australia	4.6	5.0	5.7	6.5	7.0	7.1	7.1
Austria	4.6	5.4	7.3	7.9	8.1	8 .3	8.4
Belgium	3.4	4.0	5.8	6.6	7.2	7.2	7.2
Canada	5.5	7.2	7.3	7.4	8.4	8.7	8.6
Denmark	3.6	6.1	6.5	6.8	6.2	6.0	6.0
Finland	3.9	5.7	6.3	6.5	7.2	7.3	7.4
France	4.2	5.8	6.8	7.6	8.6	8.7	8.6
Germany	4.7	5.5	7.8	7.9	8.2	8.1	8.2.
Greece	3.2	4.0	4.1	4.3	4.9	5.3	5.3
Iceland	1.2	4.3	5.9	6.4	7.3	7.7	7.8
Ireland	4.0	5.6	7.7	8.5	8.0	7.8	7.4
Italy	3.3	4.8	5.8	6.8	6.7	6.6	6.9
Japan	2.9	4.4	5.5	6.4	6.6	6.7	6.8
Luxembourg	-	4.1	5.7	6.8	6.7	6.8	7.5
Netherlands	3.9	6.0	7.7	8.2	8.3	8.3	8.5
New Zealand	4.4	5.1	6.4	7.2	6.6	6.9	6.9
Norway	3.3	5.0	6.7	6.6	6.4	7.1	7.5
Portugal	-	-	6.4	5.9	7.0	6.6.	6.4
Spain	2.3	4.1	5.1	5.9	6.0	6.1	6.0
Sweden	4.7	7.2	8.0	9.5	9.4	9.1	9.0
Switzerland	3.3	5.2	7.0	7.3	7.7	7.6	7.7
Turkey	-	-	-	-	-	3.6	3.5
United Kingdom	3.9	4.5	5.5	5.8	6.0	6.1	6.1
United States	5.2	7.4	8.4	9.2	10.6	10.9	11.2
Mean	3.8	5.3	6.5	7.0	7.4	7.3	7.3

Source: G. Schieber and J. P. Pouillier, (1989) "International Health Care Expenditure Trends: 1987", *Health Affairs 8*:3 169-177

Table 2: Net non-capital expenditure on health services, 1980-1988

	1980	1983	1986	1987	1988
Current Prices (£m)	701.0	1033.0	1219.0	1221.5	1231.5
Constant (1980) Prices (£m)	701.0	698.1	692.1	688.9	648.8

Source: Health Fact Sheet 2.90, Institute of Public Administration, based on Commission on Health Funding figures

Table 3: Number of persons employed by Health Boards and by Voluntary Public Hospitals, various years, 1980-88

	Health Boards	Voluntary & Joint Board Hospitals	Total
1980	38,058	17,589	55,647
1981	39,640	18,390	58,030
1984	39,045	18,538	57,583
1987	38,584	17,678	56,262
1988	35,686	14,985	50,671

Source: Health Statistics, Department of Health, annually.

Table 4: Acute hospitals: numbers, number of beds, average duration of stay, 1980-87

	Number of hospitals	Number of beds	Average Duration of stay (days)
1980	157	19,183	9.7
1981	155	19,203	9.4
1982	154	19,080	9.0
1983	153	19,158	8.6
1984	152	18,857	7.5
1985	131	17,223	7.5
1986	127	16,876	7.4
1987	121	15,225	7.3

Source: Health Statistics, Department of Health, annually

It was in the context of stringent cuts in health expenditure therefore that the Minister for Health established in 1987 the Commission on Health Funding to advise him on how best to provide a comprehensive, equitable and cost-effective health service. It presented its report in the autumn of 1989. Its recommendations were based on an in-depth consideration of international developments in healthcare reform. A process of consultation is now underway and decisions on future administrative arrangements for the health services are expected shortly. Currently, the debate has moved from concern about the level of health expenditure to a focus on the impact of budgetary constraints on the health services.

Part II: Proposals for Reform

The main proposals of the report of the Commission on Health Funding relate to:

- *the funding of the health services,* namely the continuation of tax-based funding and the elimination of subsidies for private health care
- *the structure of the health services,* namely the establishment of a Health Services Executive Authority and the replacement of health boards with health councils
- *management in the health services,* namely the establishment of systems and procedures to promote good management practices in the health service
- *accountability and competition,* namely the increase in accountability at all levels and the introduction of limited competition between providers of services.

1.The Funding of the Health Services

The Commission's View

The terms of reference of the Commission were:

> to examine the financing of the health services and to make recommendations on the extent and source of the future funding required to provide an equitable, comprehensive and cost-effective public health service and on any changes in administration which seem desirable for that purpose.

Following its deliberations, the Commission concluded that the problem facing the Irish health services was not related primarily to the method of funding - it had rather to do with how the services were managed. The Commission, having considered a number of alternative funding systems, opted for a continuation of the existing system which is primarily tax-funded and publicly regulated. It recommended a more streamlined two-tier eligibility system in which all of the population would be entitled, free of charge, to the *core* essential health services. Medical card holders (category 1) would continue to be eligible for all health services free of charge. Non-medical card holders would have to pay fully for non-core services and modest user charges for some core services.

The Commission's recommendations on the public/private mix in the delivery of services were designed to promote equity. Individuals should have a right to opt for private medical treatment if they so wished. However, it would be inequitable if, in doing so, they deprived those less advantaged. They should therefore not be subsidised publicly whilst in receipt of private care. In other words, private patients should no longer be able to skip the queue of hospital waiting lists; instead, there should be a common waiting list in public hospitals. Private patients should pay in full for the services they receive. The tax relief on VHI premia, which in 1987 amounted to £44 million, should be phased out.

Commentary

If equity is the main consideration in analysing funding methods, it is difficult to justify the provision of tax relief on private health insurance. The Commission's recommendation that tax relief and other subsidies to private health care should be removed is therefore to be welcomed.

The Commission makes a compelling case for the continued public funding of the health services. A private insurance funding system is unlikely to meet as effectively its criteria of cost-effectiveness, comprehensiveness and equity. International evidence shows that where private insurance is the main form of health finance it has a number of failings. Adverse selection means that high risk groups find it difficult to obtain cover at affordable premiums. Most policies exclude cover for catastrophic and long term, chronic illness. Insufficient control over treatment levels and prices has sometimes led to serious cost inflation. Low income households can rarely afford adequate cover. To meet these failings, in all advanced countries, governments have invariably assumed major responsibilities for finance. Even in the United States, over 40% of total health expenditure is publicly financed.

Accepting the need for public funding, it is then necessary to choose between social insurance and general taxation as the funding source. The Commission opts for the latter but it is worth re-examining the case for social insurance, particularly as a minority of the Commission favoured this option.

Social insurance funding is, as the Commission notes, operative within most Western European countries. There are two main arguments in favour of this form of funding. First, it can be a more effective way of channelling additional public resources into the health services as health funding can be protected from general fiscal cuts. As a result, health service managers have a predictable funding base which facilitates multi-annual planning and budgeting. Second, the population sees a clearer link between the services provided and the costs of the services. This serves as a brake on unrealistic demands and can lead to more informed electoral choices on healthcare issues.

These are significant benefits, particularly in the current climate. There are

however certain disadvantages in moving to social insurance funding. These include the administrative costs of setting up a new system and the constraints on fiscal policy that would arise from singling out health funding for special treatment. Social insurance is also a more regressive form of funding than general taxation. Finally, there is a strong possiblity that, even under a social insurance system, the government would have to fund some of the health budget from general taxation. In that event, the health services could not be protected from general fiscal cuts.

Given these disadvantages it is difficult to come down heavily either for or against social insurance funding. We believe however that the pros and cons are so finely balanced that this issue warrants further analysis and debate.

2.The Structure of the Health Services

The Commission's View

The Commission was strongly convinced of the need to strengthen the management of the health services. Its report contains an eloquent critique of existing administration and management. The present structure, it alleges, manifests the following weaknesses:

- a confusion of political and executive functions
- an overly centralised system of decision making
- inadequate information and evaluation systems
- inadequate accountability
- insufficient integration of services
- inadequate representation of the consumer viewpoint.

It recommends a new administrative structure, the two central elements of which are the establishment of an executive agency to the Department of Health, a Health Services Executive Authority, and the replacement of health boards by health councils.

Members of health councils would consist only of local elected representatives, nominated by local authorities. Their role would be purely one of "representing local interests by influencing the formation of policy and by monitoring the adequacy and quality of the services available to meet local needs" (p.167). They would have a power to delay decisions with which they did not agree by up to three months, in which time they would be referred to the new authority.

Commentary

The Commission's analysis of the shortcomings in the present management of the health services is insightful. Whilst agreeing with the diagnosis however, we differ with the Commission on some of the proposed structural reforms.

In general, we are not convinced of the need for a radical structural transformation of the Irish health service. Many of the very sensible proposals relating to management in the health service and the promotion of greater accountability can be acted upon and would address the problems identified by the Commission without establishing an executive authority or transforming health boards into health councils. Adaptation and development of existing structures offer a better way forward than major organisational reform.

It is worth considering some of the arguments for and against an executive authority. In support, it can be argued that the health services are a major one billion pound industry that requires dynamic and innovative central management which the civil service, given its constraints, may be unable to provide. The experience of hiving off the Irish postal and telecommunications services to state-sponsored bodies and the results they have achieved can be cited as supporting evidence. Against this, it can be argued that health management is far more complex than the management of postal or telecommunications services. This is for a number of reasons:

- decisions on healthcare have implications for the quality of life and even death of people
- given the finite resources available to meet the demand for health care, difficult rationing and resource allocation choices must be made
- the consumer of health services is both the user and the raw material of services
- a multiplicity of interests are involved in or interested in health service delivery
- health outcomes are difficult to measure and are affected by policies and agencies not in the health business.

As a result, there is a tendency for the centre (i.e., the Minister and the Department) to exercise tight control over health policy and execution militating against effective local management. There is a danger that the establishment of an executive authority could lead to a further centralisation of administrative decision making, removing what freedom there is at present for health boards

to develop services to meet the particular needs of their own area. The Commission recognised and warned against this danger. Given the complexity of the health services, policy cannot be specified in detail by the centre. It does not lend itself to the clear split between policy and execution implicit in the Commission's model. Rather, the implications and relevance of general policy objectives need to be worked out at regional level in the light of local needs and values. This process requires both a political and a professional input as is provided at present by the health board structure.

On balance therefore, we consider that the arguments against an executive authority outweigh those in favour of it. Great devolution and decentralisation of decision making on the health services, coupled with increased accountability, is being used more and more in other countries to encourage greater responsibility in resource use.

What is required is a strengthening of the Department's policy making role, a clearer and greater delegation of functions from the Department to the health boards, and a change in the statutory responsibilities of health boards and their CEOs. The Department and the Minister must be clear as to what it is they want health boards and other health agencies to do. The policy making role of the Department must be strengthened to enable this to happen. The purpose and mission of the health services must be clearly stated. National policy objectives for health must be developed.

Having made clear <u>what</u> it is that boards are to do, the centre must then give them the freedom to do it. Health boards must be given discretion to determine <u>how</u> it is to be done. The centre should only intervene in crisis situations or when it is clear that there has been a breakdown of local management control. Granting this freedom will be a major step forward in transforming the health services from an administered to a more dynamic managed service.

The price of greater freedom will, however, be greater accountability. Proper accountability structures and systems will have to be established.

These structures should involve boards reporting regularly to the Department on the progress made in implementing national objectives. One possibility is that boards would agree an annual management contract with the Department. At the end of the year, performance against contract would be assessed at a review meeting, and a contract for the following year would be negotiated. In this way, the Minister would be able to discharge his national responsibility and boards would be clear about the parameters within which they are required to function.

It is clear however that the Department of Health cannot confine itself solely to policy making. Certain executive decisions will continue to have to be made centrally e.g. the location of national medical specialties. There is also the crucial issue of the management of the multiplicity of health agencies other than health

boards. There is a need to rationalise their operation. They should continue to report to the Department of Health where they provide a national service, but to their local health board where the service they provide is primarily local. The general policy trend should be to strengthen over time the managerial responsibilities of the health boards for the healthcare of the population within their area.

Turning to the role of health boards, the inherently political nature of policy making in the health services means that decisions cannot be taken by managers alone. There is a need for representatives of the local community to work with managers in implementing and interpreting national policies in each area. This is the principal raison d'etre of health boards.

The Commission's proposals for the future of health boards would turn them into the equivalent of English community health councils. These are advisory bodies and have powers to delay hospital closures or major changes in services. English experience suggests that the performance of community health councils is very variable. At a minimum, they need to be adequately funded and to have sufficient staffing to enable them to act as independent advocates of the community's views. The powers and rights of such bodies also need to be specified clearly to avoid misunderstandings and disputes. Given this experience, transforming health boards into health councils would not greatly increase their effectiveness. Indeed, the reverse is likely.

A preferable course would be to retain health boards and to clarify within each board the respective role of board members and managers. Health board members should decide matters of general policy for the healthcare of the local population. They should not, however, participate in executive decision making although they may advise on the implications of services for the health outcomes of the population. Thus, whilst health board members could decide in general terms on the services to meet the needs of the population, managers would have the responsibility for deciding where these were to be located or how they were to be provided. As we discuss below, an essential element in this process is the introduction of a clear general management function. The development of a coherent policy and management framework at the centre, together with a strengthening of management arrangements locally, would enable many of the Commission's objectives to be achieved without the need for major structural reorganisation.

3.Management in the Health Services

The Commission's View

The Commission is clearly of the view that health services will need to be managed rather than administered. By that it means that individuals will in future be accountable for the results achieved rather than for their adherence to

uniform procedures. Managers will therefore have explicit responsibility for achieving pre-determined objectives but they will be able to exercise executive freedom as to the procedures they will follow and the structures they may use to achieve those objectives.

The price of greater operational freedom will however be greater accountability. All service providers will be funded on the basis of explicit roles, objectives and service requirements. Information and evaluation systems are to be developed to facilitate the planning, organisation and delivery of health services. Budgetary cycles will be lengthened to encourage forward planning.

Management training programmes are to be developed to enable the necessary new skills and competencies to be developed. In future, professionals will be encouraged to compete for managerial posts and mobility between such posts will be encouraged.

Commentary

We accept that the managerial capacity of the health service needs to be developed. To strengthen healthcare management, the minimum requirements are:

- the establishment of a clear general management function
- the development of a personnel package to give managers the incentive to manage
- significant investment in management training and development.

These are based partly on the experience in the UK in introducing general management into the National Health Service.

General managers must be appointed who are clearly responsible for the delivery of hospital and community care services. Management responsibilities at present tend to be diffused through the system. Clear line relationships need to be established. One manager should be responsible for the performance of specified units. Both professional and administrative staff should report to the general manager. Whilst both professional and administrative staff may compete for general management posts, these posts should be purely managerial with no professional component.

There is also a need to alter the statutory position of the CEO and the health board, giving the CEO a wider range of statutory responsibilities, subject to the board's advice.

Under the 1970 Health Act which established the health boards, decisions relating mainly to eligibility and personnel are reserved to the Chief Executive

Officer of a health board. Apart from these matters, the CEO and his staff are specifically required to act in accordance with the decisions and directions of the board. This contrasts with the legal situation for county managers in relation to their county councils. Under the County Management Acts, the county manager has statutory responsibility for almost all the functions of the county council although he is subject to restrictions and direction by the council. In fact, health boards have delegated the day-to-day management of the local health service to a considerable degree to their CEOs, while retaining ultimate control themselves. Nevertheless, the statutory position does not support strong management action, particularly, for instance, in situations where attempts are made to rationalise hospital services thus encountering local opposition.

A personnel package needs to be developed for general managers which will attract good people and which will give them the incentive to innovate and to manage proactively. Fixed term contract appointments should be introduced and staff mobility should be encouraged. Performance appraisal and performance related pay should form part of the package to encourage and reward good management.

In assuming a challenging new role, health care managers will require a range of new skills and competencies. They will also need to be supported and encouraged in these new roles. Management training and development will have to be increased significantly both for existing general managers and to develop managers for the future. The Commission's proposals on management will require a major cultural shift for the health service which will require a coordinated programme of management and organisation development.

A further key issue in the management of the health services is the relationship between doctors and management. We endorse the Commission's view that doctors must take more responsibility for the planning and control as well as the delivery of health care. There are a number of ways of achieving this. One approach is to introduce tighter managerial control of doctors. This is the approach which has mainly been followed by the Commission in its proposals to move towards fixed-term contracts for consultants which specify in more detail the nature of their obligations.

A complementary approach is to involve doctors in management through clinical budgeting and clinical directorates. Experience in the UK suggests that action is needed on a number of fronts to make this happen. First, hospital information systems must be developed to give doctors and nurses accurate and timely information on the cost and quality of services. Second, budgets for clinical services must be devolved to doctors and nurses and workload agreements must be negotiated with budget holders. Third, hospital management structures must be developed whereby doctors take responsibility for the planning and control of their services. One model is that of the clinical directorate whereby in each speciality area a clinician is appointed director and manages the directorate, supported by a business manager and a nurse manager.

Developing management arrangements of this kind takes time. Effective support in terms of training and organisation development is needed. The best results are likely to be achieved when a participative approach has been adopted involving doctors and nurses in the development of information systems and structures. There is no one right model for the management of clinical activity. Models have to be developed in an evolutionary manner, and need to be tailored to fit local circumstances and attitudes. Doctors have to be given incentives to participate in the process and these must include both rewards and sanctions. As resource constraint is here to stay, for doctors, the price of clinical freedom is financial responsibility and managerial involvement.

We suggest that moves to involve doctors more in management will require action on both fronts - by managing doctors through control of their contracts, and also by giving them management responsibility through clinical budgeting and clinical directorates. In the long term, the latter is likely to be more important in achieving greater efficiency and effectiveness in service delivery. International evidence suggests that a number of countries are seeking to strengthen the management of clinical activity by involving doctors and nurses in management. In addition, in their initial training, doctors and nurses are being made aware of their responsibility for the use of resources. Action in these areas is a high priority in the Irish health service.

4.Accountability and Competition

The Commission's View

The Commission distinguishes clearly between the funding and delivery of health services. Whilst it opts for public funding, it is in favour of competition, wherever possible, between providers in the delivery of services. The Chairman expresses it as follows in the preface:

> We believe that competition in supply is the best spur to efficient delivery of healthcare. Competitive suppliers, both public and private, would make better use of resources. Such competition will require sophisticated management to ensure that the best quality of care is obtained.

The report identifies areas in which competitive tendering for service delivery could be introduced. These include specified procedures such as hip replacements, day care service, long term services for the elderly and diagnostic testing. It recognises that the scope for introducing widespread competition is limited by the geographic location of services and the difficulty of closing down inefficient providers. Nevertheless, it believes that there are opportunities for greater competition in delivery and that this could lead to greater efficiency and lower costs.

On the more general level, the Commission recommends that all agencies in receipt of public funds, whether public or private, should be subject to clearly specified contracts for an agreed level and type of service. Local managers would be charged with finding and contracting for the most cost-effective form of service provision, whether that be within the health board, from another area, or from a voluntary or a private provider. In this way, the Commission believes that providers will be made more accountable for their performance.

Commentary

Despite a general endorsement of the benefits of competition, the Commission places much greater emphasis on introducing greater accountability into healthcare management. If local managers are to take a more proactive role in regard to getting the most cost-effective forms of service delivery, then what needs to happen to facilitate this process?

First of all, as argued above, it will be necessary that health boards have clearly devolved functions. This will empower local managers to take strategic decisions on forms of service delivery appropriate to local needs and to seek the best deal for the people they serve.

Second, within health boards, a split needs to occur between purchaser and provider functions. This is to ensure that purchasers are not tied to any particular set of providers but can select those providers who offer the best value for money. The principal function of boards and their top managers should be to purchase services for their residents using the resources allocated by the Department of Health. Responsibility for service provision would rest with hospital managers. The managers of public hospitals would have an arm's length relationship with health boards and would provide services negotiated in contracts with boards.

Private hospitals and public voluntary hospitals would also enter into contractual arrangements with boards. These arrangements would enable boards to concentrate on analysing current and future needs for care and developing a purchasing strategy to meet these needs. Operational management would be firmly in the hands of service providers rather than boards.

Separating purchaser and provider functions and making use of contracts would assist in achieving the Commission's objectives. In particular, these instruments would enable budgets to be tied to a specific level and standard of service delivery, and for the roles of hospitals to be clearly defined. It should also be possible to introduce budgetary incentives to reward productivity and excellence. Much will have to be done to improve information systems to enable boards and their managers to cost services accurately and to compare the quality of hospitals, but over time the gains from more explicit contractual arrangements could be considerable.

To function effectively, these arrangements require boards to act as the purchasers of all services for their residents. The implication is that the Department should transfer to boards the resources it currently allocates to public voluntary hospitals. These hospitals would operate alongside board hospitals and private hospitals and would compete for funding on the basis of the cost and quality of their services.

Part III: Further Issues

The Commission's report is a thoughtful and comprehensive document. It covers a wide range of issues and summarises the arguments for reform in an objective fashion. Nevertheless, there are two major issues which the Commission was only able to touch on and which are likely to be of continuing and indeed growing importance as the debate about healthcare reform proceeds. These are the future of primary health care and the role of public health policy.

1. The Future of Primary Health Care

The primary health care system is recognised worldwide as being the essential foundation for a good health service. The GP is central to it. Usually the patient's first point of contact, the GP is the gatekeeper to other services. Irish general practice has its strengths, e.g. choice of doctor, lack of public/private distinction between patients, service in remote areas, house calls, etc. It is however acknowledged to be underdeveloped and not well integrated with other parts of the health service in Ireland. The Commission may have experienced difficulty in commenting in depth because it was unable to evaluate the practical effects of the recent changes in the General Medical Services scheme from a fee-per-item of service to a capitation scheme for GPs.

Nevertheless, it is surprising that the Commission did not take a more detailed look at the needs of primary health care in the future, particularly as a strong primary health care system can reduce the reliance on more expensive hospital services. Whilst adverting to the need for GPs to be integrated more with other community services and given access to hospital facilities it does not say how this is to be done. There is also a need to address the variable standards in primary care in different areas and to consider the development of local delivery structures where GPs could participate with other health professionals in service delivery.

The Irish system is different from that in many other European countries in not having a universal free general practitioner service.

Although rejected by the Commission on the grounds that it would be unlikely to lead to increased efficiency, we believe that it is an issue that should be considered further.

Making it easier for people to go to their GP, making it easier for GPs to provide a wider range of services and promoting better liaison between hospital and community services, could be major factors in reducing the utilisation of hospital services.

2.Public Health Policy

The Commission has relatively little to say on public health policy, which has become a major concern in a number of European countries. This may have been due to the imminent publication of the Working Party on Community Medicine's report.

The Department of Health and the health boards need to lead the field in the promotion of better health. That is not to say that they need to do all the work themselves, however. They should form alliances with, and influence, other agencies whose activities impact on public health, to take positive action to improve the health status of the community. Health boards and local authorities in particular need to work closely together and their respective roles in relation to environmental health must be clarified.

There is a need for a stronger public health input into strategic decision making within health boards. Annual reports on health status should be produced both to inform the public and stimulate debate on public health issues. These reports would also help boards in deciding which services to purchase for the local population.

Conclusion

The report of the Commission on Health Funding is centrally concerned with the management of the health services and with establishing the appropriate structures and systems to enable managers to manage more effectively.

A central issue is the establishment of a Health Services Executive Authority. This is one of the more controversial recommendations. However, the Commission's report does not stand or fall on that recommendation. Many of the accompanying proposals e.g., clearer delegation of functions to central and regional levels, greater accountability at all levels, contractual relationships with providers, multi-annual budgets, better information and evaluation, etc. can all be implemented with or without the new authority, and have a major contribu-

tion to make towards a better health service. Better management means better health.

In summary our principal conclusions are:

- the health services should continue to be publicly funded but the case for social insurance funding should be further considered,
- major organisational reform is not essential; the Commission's objectives can be achieved by adapting and developing existing structures,
- the policy-making role of the Department of Health needs to be strengthened enabling it to specify clearly what needs to be done by health boards,
- health boards should have greater freedom and greater accountability to identify and address local healthcare needs; one option is for each board to agree an annual management contract with the Department of Health,
- a clear general management function needs to be introduced, supported by an appropriate personnel package and a significant investment in management training and development,
- health board members should continue to provide a local political and professional input to decision making but the respective roles of boards and CEOs should be clarified statutorily,
- clinicians must become more involved in management through clinical budgeting and clinical directorates,
- health boards should use the resources allocated to them to purchase healthcare services for their residents thereby increasing the accountability of providers and, where appropriate, encouraging competition in service delivery,
- further debate and discussion on the future of primary health care and public health policy is needed.