Comptroller and Auditor General
Report on Value for Money Examination

Health Service Executive

Provision of Disability Services by Nonprofit Organisations

December 2005

This report was prepared on the basis of information, documentation and explanations obtained from the public bodies referred to in the report. The draft report was sent to the Health Service Executive and the Department of Health and Children. Where appropriate, the comments received from the Executive and the Department were incorporated in the final version of the report.

Report of the Comptroller and Auditor General

Provision of Disability Services by Nonprofit Organisations

I have, in accordance with the provisions of Section 9 of the Comptroller and Auditor General (Amendment) Act, 1993, carried out a value for money examination on the provision of disability services by nonprofit organisations.

I hereby submit my report on the above examination for presentation to Dáil Éireann pursuant to Section 11 of the said Act.

John Purcell
Comptroller and Auditor General

12 December 2005

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Summary of Findings

Summary of Findings

A person is regarded as having a disability if that person has a substantial restriction in their capacity to carry on a profession, business or occupation or to participate in social or cultural life by reason of enduring physical, sensory, mental health, or intellectual impairment. An estimated 25,000 people with intellectual disabilities and 40,000 people with physical or sensory disabilities avail of services which are funded by the health services.

The obligation to provide health services to persons with disabilities rests with the State. However, most of these services are provided by nonprofit organisations under arrangements with the Health Service Executive (HSE). In 2004, the State provided funding of €877m to nonprofit organisations involved in the provision of disability services. Twenty-five of the organisations each received more than €10m, a further 75 organisations received between €1m and €10m. In addition, 683 grants, averaging slightly over €100,000 were awarded to a range of smaller nonprofit organisations.

This examination focused on the arrangements between the State and the nonprofit sector for the provision of these services and, in particular, on the larger nonprofit organisations. The examination sought to establish

- how the need for disability services is determined and responded to
- the service framework within which the nonprofit organisations deliver these services
- how services actually provided by the nonprofit sector are monitored and evaluated
- the change management issues arising out of reforms and legislative change impacting on the sector.

Responding to the Needs of Persons with Disabilities

Recent legislative changes make provision for an assessment of personal needs arising out of disabilities and the drawing up of a service statement specifying the services to be provided. However, standards have not yet been set for the administration of those assessments and no mechanism has yet been put in place to capture the data from the service statement.

There are deficiencies in the way data on disabilities is captured and, in particular, the current database on physical and sensory disabilities only captures information on half the people with such disabilities.

However, if the available data is representative it seems that

- over 60% of persons with intellectual disabilities are awaiting new or enhanced services or will require such services before 2010
- around half of all physical and sensory disability cases are either not getting the desired level of service or are awaiting assessment.

Consequently, the existing levels of demand and the changes necessary to bring the new legislation into operation pose a considerable challenge to the service and, in particular, in regard to how services from the nonprofit sector might be cost-effectively integrated into the service framework.

Service Framework

The State's relationship with nonprofit organisations has evolved into one where services to persons with disabilities result from a historical pattern of provision and are largely negotiated rather than the result of contested procurement.

The current approach to the funding of nonprofit organisations is based on incremental increases and the cost of new placements. The risk with this approach is that the core funding allocation will over time become weakly linked to levels of identified need and as a result that funding may not always be targeted to areas of greatest need.

From a financial perspective a starting point should be the comparative cost of procuring services through nonprofit organisations compared with the cost of direct provision. No costing system has been established which is capable of yielding costs for directly administered services for persons with different care requirements.

Attention needs to be given both to the formal specification of services in agreements and to relationship building with the aim of effective system operation.

While service agreements operated for all organisations funded directly by the former Eastern Regional Health Authority (ERHA), six former boards (including the three former area boards of the ERHA) did not operate any agreements with disability service providers. The remaining former boards generally, operated service agreements for the larger service providers only.

Service agreements were generally high-level framework documents leaving specific details to be negotiated annually between the parties. Many of the service agreements reviewed as part of this examination, had not been signed for considerable periods after the funding had been provided and service provision commenced.

In the future, while major procurement of services needs to be better specified a distinction needs to be made on the basis of scale. The report suggests levels of monitoring and formality of arrangements based on the nature and scale of services.

Monitoring and Evaluation

The procurement of services from the nonprofit disability sector has not been the subject of evaluation or review within any HSE region or on a national basis. Evaluation of outcomes would be facilitated if desired outcomes were specified in service agreements.

In regard to the monitoring of services provided the health service currently do not have any legislative power to enter nonprofit organisations to check delivery, either in terms of quantity or quality.

Access is important in the context of the verification of service delivery. Two cases noted in the course of the examination highlight this

- in one organisation a custodial culture had developed largely due to constrained resources
- in another, the failure to align funding with service requirements resulted in excessive costs.

As part of this examination a review conducted from November 2004 to January 2005 of 42 nonprofit organisations in three former Health Board regions showed that audited financial statements for 2003 had not been provided in 12 cases and that only six reconciliations of funding to reported income had been carried out. In the case of one large organisation which received funding of €288m over the period 2000-2004 financial statements for four years had not been provided.

Greater transparency in financial reporting would provide assurance regarding the application of funds provided by the State. In the shorter term, the health service will need to establish financial reporting norms and key disclosure requirements in order to obtain satisfactory assurance regarding the use of the funds provided and the management of the related services.

Implementing Change

The State is embarking on a substantial change agenda for delivery of disability services. The transition to the specification of individual needs in service statements, the establishment of comprehensive client databases to record these assessments, as well as the implementation and monitoring of standards, will coincide with significant annual increases in funding for the provision of the services.

At the same time, it is likely that for the foreseeable future nonprofit organisations will continue to provide most disability services. However, the capacity of nonprofit organisations to initiate new services and expand and develop existing ones is constrained and it may be opportune to assess the long-term sustainability of the procurement approach and to examine the consistency between the organisational missions and State service provision intentions.

Any restructuring of the service should be based on clearly articulated agreements setting out the respective roles of the health service, as funder, and the service providers. The capacity of nonprofit organisations to meet the additional requirements relating to the implementation of the standardisation of services, good governance and greater accountability will need to be addressed.

Provision of Disability Services by Nonprofit Organisations

1 Introduction

1.1 Nonprofit organisations contribute to the delivery of health services in a variety of ways including the direct provision of services, rehabilitative care and respite. They are also involved in advocacy and the provision of information and support.

1.2 The health strategy documents published by the Department of Health and Children[1] (the Department) acknowledge the unique role and contribution of nonprofit organisations in the provision of health and personal social services and confirm a commitment to the development of the State's relationship with them. In 2004, the former health boards and the former Eastern Regional Health Authority (ERHA) collectively paid €877m[2] to nonprofit organisations providing services to disabled persons.

1.3 Each nonprofit organisation's relationship with the health service is influenced to some extent by the materiality of the funds provided to the organisation and the nature of the services it provides. Managing that relationship poses particular challenges since

- the services, while forming part of the overall health service, are largely negotiated rather than the result of contested procurement
- they result from a historical pattern of provision in particular areas contrasting with other delivery methods in other regions
- the scope of the services provided on the ground may be more extensive in the case of nonprofit organisations
- there are tensions between the demands of accountability and partnership.

Persons with Disabilities

1.4 Persons are regarded as having a disability when they have a substantial restriction in their capacity to carry on a profession, business or occupation or to participate in social or cultural life by reason of an enduring physical, sensory, mental health, or intellectual impairment.

1.5 Overall, more than 25,000 people with an intellectual disability and an estimated 40,000 people with physical and sensory disabilities avail of services funded by the health service.[3] Much of these services are provided by nonprofit organisations under arrangements with the Health Service Executive (HSE).

1.6 Disability services are regarded as specialist services allocated on the basis of assessed need. However, in the normal course, persons who have been given medical cards are entitled to a full range of services including general practitioner services, prescribed drugs and medicines, in-patient public hospital services in public wards including consultants' services, out-patient public hospital services including consultants' services, dental, ophthalmic and aural services and appliances, and a maternity and infant care service.

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[1] Department of Health, *Shaping a Healthier Future*, 1994. Department of Health and Children, *Quality and Fairness – A Health System for You*, 2001.

[2] Analysis by Office of the Comptroller and Auditor General of payments data supplied by the former health boards and ERHA.

[3] Health Research Board 2004.

Payments to Nonprofit Organisations

1.7 Up to 2005 payments to nonprofit organisations were made under three main legislative provisions. These arrangements are now regulated under the Health Act, 2004. An analysis of this funding is in Appendix A. The principal patterns in the expenditure are

- 69% of all funds went to 25 organisations who each received more than €10m annually - an average of €24.2m
- 75 organisations received between €1m and €10m
- at the lower end of the scale, 683 grants were made to nonprofit organisations. In none of these cases did the grant exceed €1m (the average being slightly over €100,000).

1.8 This payment profile would suggest that, in administering these payments, different criteria should apply in instances where the State is purchasing services as opposed to where it is supporting voluntary bodies by way of grants. The size of the funds involved and the degree to which the services are comparable with directly provided services should influence the rigour of the administrative regime put in place.

1.9 The total payments of €877m in 2004 to nonprofit organisations providing disability services were applied as follows

- Intellectual Disability Services €700m
- Physical and Sensory Disability Services €177m.

Accountability

1.10 With effect from 1 January 2005 the health boards were abolished and consolidated along with six other health agencies into the HSE. Consequently, accountability now rests with the Accounting Officer of the HSE. The HSE is responsible for ensuring a consistent national approach to the delivery of health services and with ensuring that best practices within the existing health service delivery structures are replicated across the country.

Background to the Examination

1.11 In deciding to examine this issue, I was influenced by the following

- The extent of nonprofit organisation activity in the area of disability services is such that it is estimated that they currently provide approximately 90% of all intellectual disability services and approximately 60% of physical and sensory disability services.
- The fact that the advent of the HSE provides an opportunity for reflection and possible reorganisation of relationships with nonprofit providers to a uniform standard.
- The amount of funds allocated to the procurement of disability services from nonprofit organisations is material. It represented about 70% of the direct health spend on disability services in 2004.
- Financial audits of the former health boards had revealed deficiencies in administration. Appendix B provides a summary of those deficiencies.
- The 2005 Budget allocated an additional €34m in capital and €55m in revenue finance for disability services delivered through the health system.
- In 2004 the Government announced the introduction of a multi-annual investment programme to support the development of high-priority disability support services over the period 2006-2009. In

cumulative terms, this will result in an additional investment of almost €720m over those four years.

International Comparison

1.12 Different welfare regimes adopt different forms of relationship between the statutory providers of disability services and nonprofit deliverers. These have been classified for purposes of comparison into

- liberal welfare regimes which seek to minimise State intervention, individualise risks and promote market solutions
- social democratic regimes which are characterised by values such as universalism, comprehensive risk coverage, generous benefit levels and egalitarianism
- conservative regimes which seek to distribute resources according to elementary needs and the subsidiarity principle.

1.13 Appendix C draws a comparison between the attributes of each such regime in terms of

- the responsible agency
- the relationships between the service provider and the statutory body
- the formal role of the client in the delivery system
- the basis on which clients access services
- current shifts in the service delivery system
- mechanisms for quality assurance and service evaluation.

1.14 A particular trend in a number of countries is a move to formalise relationships between the State and third sector organisations. One of the drivers behind this increasing formalisation is the contracting of services by the State to third sector organisations, particularly in the area of social care provision, with the objective of seeking to contain costs in what is perceived to be an environment that is becoming more resource constrained.

1.15 Ireland could be loosely classified as a liberal welfare regime[4] because of its historical relationship with the United Kingdom and the inheritance of many structures from that regime with the arrival of independence in 1922.

1.16 A common feature of liberal welfare regimes is seeking to minimise the State's role, the individualisation of risk and the promotion of market solutions. The recent Strategic Management Initiative, promoted since the late 1990s as a form of New Public Management informing the administration of statutory services, could be seen as one element of this kind of liberal thinking. In the area of social care, therefore, while responsibility ultimately rests with the State for the delivery of services, many are delivered through third sector providers and increasingly under contractual arrangements with the State in return for financial resources.

1.17 Movement towards a contracting model has provoked debate about the level at which services ought to be specified, whether to maximise the flexibility available from nonprofit provision and specify them in terms of outcomes or to be clear about the exact services being purchased so as to maintain overall equity and balance in the health service. A particular trend in the development of the relationship between service providers and the statutory agencies has been for a move to a contract model and away

[4] Esping-Andersen, G. *The Three Worlds of Welfare Capitalism*, 1990.

from the grant funding model as nonprofit services became more integrated into the overall service and resource costs converged in the government and nonprofit sectors.

Legislative and Policy Framework

1.18 In Ireland, the effective operation of health service delivery in general, and services to people with disabilities in particular, is dependent upon relationships between statutory and nonprofit organisations. The interaction and dynamics between these two sets of parties contribute to the way in which the health care system operates. As well as these interactions, service delivery is shaped by the legislative and policy frameworks in place. Both the legislative and policy frameworks are undergoing change at present and this has consequences for development and management at both organisational and systemic levels.

1.19 Current policy on the relationship between the State and nonprofit organisations dates from 2000 when the White Paper[5] was published which took some guidance from consultation within the sector,[6] a previous Green Paper[7] and developments at EU level and in Northern Ireland.[8]

1.20 The input of nonprofit organisations to the delivery of health care in the disability sector is recognised at the level of specific policy on disability[9] but, as with other policy documents on health care in general, systemic thinking about the relationship between the State and nonprofit disability organisations is still underdeveloped. The legislative and policy frameworks and, in particular, their development over time are set out in Appendix D.

Objectives and Scope of the Examination

1.21 The general objectives of the examination were to establish

- how the need for disability services is determined and responded to
- the service framework within which the nonprofit organisations deliver those services
- how services actually provided by the nonprofit sector are monitored and evaluated
- the change management issues arising out of reforms and legislative change impacting on the sector.

1.22 The examination focused on the arrangements which the State has made with the nonprofit sector in the area of services to persons with disabilities. For the purpose of this report, social service providing nonprofit organisations will be called nonprofit organisations and will include those organisations involved in the provision of services to people with disabilities.[10] These nonprofit organisations, even if they are in receipt of 100 per cent funding from the State, are defined as nonprofit according to a number of criteria. The organisations defined as nonprofit organisations are those that are formally established with an institutional presence and which

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5 Department of Social, Community and Family Affairs. *Supporting Voluntary Activity - A White Paper on a Framework for Supporting Voluntary Activity and for Developing the Relationship between the State and the Community and Voluntary Sector*, 2000.

6 Colgan, A. and Tubridy, J. *Report to Department of Social, Community and Family Affairs on White Paper Consultation Process*, 1999.

7 Department of Social Welfare, *Supporting Voluntary Activity. A Green Paper on the Community and Voluntary Sector and its Relationship with the State*, 1997.

8 European Commission, *Promoting the Role of Nonprofit Organisations and Foundations in* Europe, 1997. Home Office, U.K., *Compact: Getting it Right Together*, 1998. Department of Health and Social Services, Northern Ireland, *Compact between Government and the Voluntary and Community Sector in Northern Ireland*, 1998.

9 Department of Health and Children, *Enhancing the Partnership. Report of the Working Group on the Implementation of the Health Strategy in Relation to Persons with a Mental Handicap*, 1996.

10 Donoghue, F. *Defining the Nonprofit Sector: Ireland.* Working Papers of the Johns Hopkins Comparative Nonprofit Sector Project, no. 28: The Johns Hopkins Institute for Policy Studies, 1998.

- are private and non-State
- are self governing
- do not distribute profits
- include some element of voluntary contribution (either financial or human resources such as volunteers).[11]

1.23 Because the greater risks to public funds are in the area of higher spend this examination focused specifically on the provision of services in the area of physical and sensory disabilities and in the intellectual disability area where annual payments to nonprofit organisations were significant, frequently exceeding €10m. However, Appendix E sets out the criteria which might apply to the administration of payments based on whether services are being procured or supported.

Methodology

1.24 The examination was carried out by staff of the Office of the Comptroller and Auditor General. Evidence was gathered through

- audit questionnaires sent to former health boards and the validation of responses through audit procedures
- examination of HSE records in relation to the allocation of funds, the monitoring of service delivery and management of the relationships with the nonprofit organisations
- interviews with officers of the Department, the HSE, representatives of the nonprofit organisations, the National Disability Authority and the Health Research Board
- reviews of recent reports on the provision of health services.

1.25 The Centre for Nonprofit Management of the School of Business at the University of Dublin provided advice and research on the State-nonprofit relationship in Ireland and other jurisdictions and acted as a reference partner for the examination.

1.26 The report considers the issues outlined above in the following chapters. Chapter 2 examines how the State responds to the needs of persons with disabilities and the role of nonprofit organisations in that response. Chapter 3 reviews the service framework within which nonprofit organisations operate in delivery of services to people with disabilities. Chapter 4 examines how delivery of service is monitored and evaluated and Chapter 5 looks at the implications for the implementation of change arising out of recent reforms and legislative change.

[11] Salamon, Lester M. and Anheier, Helmut K. *Defining the Nonprofit Sector - A Cross-National Analysis.* The Johns Hopkins Nonprofit Sector Series 4, 1997.

2 Responding to the Need

2.1 Although the major portion of disability services are delivered through nonprofit organisations, ultimately, the obligation to provide these services rests with the State. This chapter examines how the State's relationship with nonprofit organisations has developed, how needs of disabled persons are assessed, service provision determined and standards of care and performance specified.

2.2 The health service delivery system in Ireland is complex and comprises multiple parties engaged in the provision of services. These parties are the State, nonprofit organisations and forprofit private companies. This type of mixed economy of welfare is not unusual in Europe.

2.3 The present interdependent health service delivery system has long antecedents and has some roots in the establishment of voluntary hospitals and social services in the 19th century. In these cases the aims were charitable in nature and were focused on the alleviation of illness amongst those who were poverty stricken.[12] After the establishment of the State, the principle of subsidiarity was important in guiding State-nonprofit relations as the State adopted a hands-off approach and was regarded as only needing to step in as a last resort when other service providers, such as the parish, local community or voluntary organisation, were seen to 'fail'.

2.4 Over the decades, State-nonprofit relationships began to grow and become more firmly established. In the 1930s, for example, State funding began to be provided to voluntary hospitals. Almost two decades later, under the terms of the Health Act, 1953, State funding of nonprofit organisations was given formal recognition under Section 65 of that Act, which states that funding will be granted to nonprofit organisations providing 'similar or ancillary' services to those of the State. Section 65 funding, and more recently the funding arrangements as set out in the Health Act, 1970, the Childcare Act, 1991 and the Health Act, 2004 form the financial basis of the State-nonprofit relationship in the healthcare system, including disabilities organisations.

2.5 The health boards, on their establishment in 1971, assumed responsibility for Section 65 grants and for other funding of nonprofit organisations in their regional areas. Larger disabilities nonprofit organisations, with a national remit, remained the responsibility of the Department. This situation changed on foot of *Enhancing the Partnership*[13], which saw funding relationships move from the Department to the health boards. In January 2005, responsibility for the administration of funding nonprofit organisations, including the larger disabilities organisations, moved to the newly-established HSE.

2.6 The wider healthcare system is undergoing change at present with the establishment of the HSE and the abolition of the health boards from January 2005.

Constituent Parties of the System

2.7 The current healthcare system in the area of disabilities is best characterised as interdependent and relational. Organisations in receipt of State funding interact with the State within an interdependent and complementary relationship.

2.8 Outside of the funding relationship the State and nonprofit organisations have their own separate agendas. Nonprofit organisations do not exist solely for the purposes of welfare delivery on behalf of the State. These organisations have arisen for a multiplicity of purposes, sometimes to provide services for unmet needs that they have identified, sometimes to provide services that complement statutory services,

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[12] Donoghue, F. Anheier H.K. and Salamon, L.M. *Uncovering the Nonprofit Sector in Ireland. Its Economic Value and Significance*, Johns Hopkins University/National College of Ireland, 1999.

[13] Department of Health and Children, *Enhancing the Partnership*, 1996.

sometimes to advocate for services that are as yet undeveloped or underdeveloped, or sometimes to advocate for the rights of their constituents. This last agenda, the rights-based agenda, has become increasingly important and is gaining increasing recognition at State level as part of a vibrant democracy. This is an important strand within the disabilities arena and one that is becoming more prominent.[14]

Access to Services

2.9 Access to services depends on

- an assessment of personal needs
- the prioritisation of those needs based on the available resources.

2.10 The environment in which disability services are delivered is set to alter considerably in the near future. The Disability Act, 2005, together with other recent developments in the health sector, will impact on entitlement and eligibility, standards of care, maintenance of a sufficiency of records to inform planning and management and accountability obligations.

2.11 To the extent that health and education needs arise out of disabilities, the Act provides for an assessment of those needs. It also enables, within the limitations of available resources, the provision of services to meet those needs. Specifically, provision is made for

- A process to assess the needs of disabled persons which is independent of financial capacity to meet those needs.
- Following on from the assessment, the drawing up of a service statement specifying services to be provided and the time within which they will be provided.
- The management by the HSE of records which include the identification of persons receiving assessments or services and the service providers. The HSE is also required to specify the aggregate needs identified but not included in service statements, the numbers assessed but not receiving the services identified and to plan for the provision of services to persons with disabilities.

2.12 Standards have not yet been set for the administration of the assessments and no mechanism has yet been put in place to capture the data contained in the assessments or in the service statements.

Information on Disability and Assessed Needs

2.13 The National Intellectual Disability Database (NIDD) and the National Physical and Sensory Disability Database (NPSDD) are sets of information that outline the health service's requirements of those registered. The NIDD was established in 1995 and has approximately 25,000 registrations. Implementation of the NPSDD has been underway since January 2002 and there are almost 20,000 people registered. The databases are used to inform regional and national planning by providing information on the demographic profile of persons with disabilities, current service provision and future service needs over the next five years.

2.14 While the databases provide the principal source of data on service provision and projected needs, there are deficiencies in the completeness and reliability of the data collected in that

- Participation is voluntary so there will always be some element of under reporting.

[14] Breen, O.B. *Report on the Public Consultation for the Department of Community, Rural and Gaeltacht Affairs*, 2004.

- It is estimated that there are about 40,000 persons with a physical or sensory disability. The NPSDD captures about 50% of the population receiving assistance and has almost no information in respect of two former health board regions.
- The assessment process to identify needs is not standardised.
- The assessment process is not independent. It has been criticised for the tendency to identify needs from a narrow perspective and in terms of capacity to deliver.

2.15 Apart from the disability databases, other data exists on persons with disabilities and the services provided to them, but the use of this data as a planning tool is limited as there is an absence of national and uniform systems for data collection across the statutory and non-statutory providers.

2.16 A third database, the Rehabilitative Training Database (RTD), also exists. It provides Occupational Guidance Officers in the HSE regions with a means to record and manage details of clients and any rehabilitative training undertaken. The Health Research Board administers the two principal databases while the RTD is administered by the HSE.

2.17 A review of information systems and databases, undertaken in 2004 as part of a disability strategy review, included a survey of local and regional systems to ascertain the extent and content of these systems. This survey identified thirty-two information systems.

2.18 The review found that the extent to which data maintained on each system was comparable is questionable and recommended the movement towards a more integrated system which will facilitate improved services for clients in addition to providing the evidence-base for management, planning and research.

Demand for Services

2.19 Figure 2.1 shows that of the total number of currently registered persons with an intellectual disability on the NIDD in 2005, 64% require either new services or will require some change to the services they are currently receiving before 2010. The remaining 8,442 persons identified on the NIDD are deemed to be in receipt of adequate services.

Figure 2.1 Needs of Persons with an Intellectual Disability

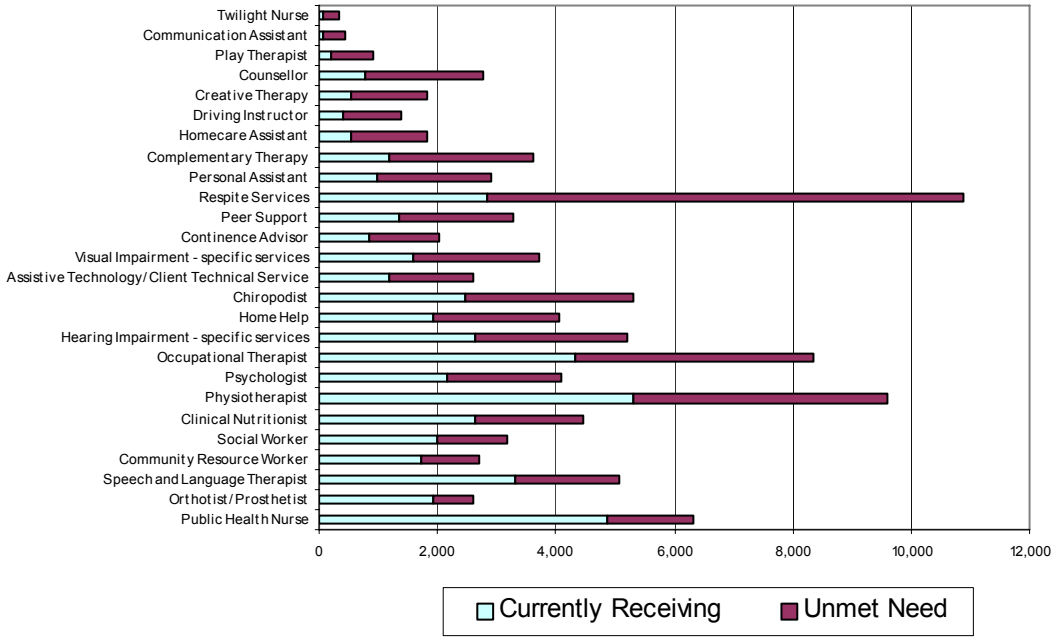
Service Requirement	Number of Persons	Percentage
Persons currently without major component of service	2,270	9%
Persons requiring service enhancement / change	11,590	47%
Persons with unmet need for residential support services	1,803	7%
Persons within Psychiatric Services requiring Intellectual Disability Services	296	1%
Total requiring new or amended service	**15,959**	**64%**
Persons in receipt of adequate services	8,442	34%
Persons with no identified service requirements in period to 2010	516	2%
Total persons registered on NIDD database	**24,917**	**100%**

Source: Annual Report of the National Intellectual Disability Database Committee 2005

2.20 While the database on physical and sensory disability is incomplete, analysis of the available data suggests that almost the same number again as are assisted are either awaiting assessment or services for

the main categories of therapy intervention, respite, rehabilitation, personal assistance and support services. The result of this analysis is set out in Figure 2.2.

Figure 2.2 Relationship between persons assisted and those awaiting assessment or services



Source: National Physical and Sensory Disability Database – A Preliminary Analysis – June 2004

Standards of Care

2.21 The National Disability Authority (NDA), in collaboration with the Department, the HSE and the nonprofit sector has developed draft National Standards for the Disabilities Services. The NDA recommended the standards to the Department in October 2004. The date for the introduction of the standards will be determined by the Minister for Health and Children. The HSE National Service Plan 2005 has identified compliance with these standards as a key issue.

2.22 The standards are intended to apply to all statutory and non-statutory agencies that provide health related disability services for children and adults with intellectual, physical and sensory disability or autism and which are funded by the State.

2.23 The standards cover

- person centred services
- good governance and committed leadership
- dignity at work
- effective information and communication systems
- safe environments.

There are also service specific criteria for rehabilitative training services, residential services and sheltered occupational services.

2.24 Under each of the areas listed above, a set of essential criteria must be achieved in order to become recognised as an approved service provider. There are also sets of quality improvement criteria to promote continuous improvement. It is intended that external assessment by an independent body will measure attainment of the criteria.

2.25 Several nonprofit organisations have obtained accreditation from foreign standard setting institutes and some agencies, both statutory and non-statutory have begun the process of putting in place structures which will enable them to become recognised as an approved service provider under the standards.

Conclusions

2.26 The changes taking place in the health sector generally and in the disabilities sector in particular, present challenges to the Department and the HSE to provide a clear policy statement on access to services, to plan for the gap between assessed needs and delivery capacity and to put into practice standards of care for persons with disabilities.

2.27 Standards of care will focus attention on service outcomes and consistency in quality and performance on a national basis. The most effective approach to standards enforcement is to build them into agreements with nonprofit organisations and provide for independent monitoring.

2.28 The Disabilities Act, 2005 will require that standards are set for the administration of individual assessments and that comprehensive data is in place to inform the planning and management of disability services.

2.29 The existing databases on disabilities are not complete and the information capture is not always reliable. An integrated national database would facilitate better planning, management and research.

2.30 However, even in their current state, these databases indicate that significant unmet needs exist in both the intellectual disability and physical and sensory disability areas.

3 Service Framework

3.1 The State's relationship with nonprofit organisations in the health service is one which has developed over time and evolved as the State has taken greater responsibility for the healthcare of citizens. Much of the nonprofit healthcare activity predates the current strategy-driven delivery mechanisms provided in recent decades.

3.2 The Government's overall Health Strategy[15] recognises that all health funding should be allocated on the basis of the strategic aims of the service and clearly applied towards service outcomes.

3.3 A major challenge at this point is to ensure the alignment of services with national health objectives and so maintain overall equity in provision while maximising to the extent possible the flexible outcomes potentially available from the nonprofit sector.

3.4 This chapter examines the extent to which the health services plan for service delivery by the nonprofit sector, establish the costs associated with that provision, allocate funds, contract for and agree services.

Planning

3.5 Service plans prepared by the former health boards did not indicate how services procured from nonprofit organisations would be aligned with those directly provided. Likewise, the National Service Plan prepared by the HSE for 2005 does not distinguish between services to be provided directly by the health services and those to be provided by the nonprofit organisations.

3.6 The alignment of services between the public and nonprofit sectors depends on operational decisions at regional level. However, in general, the services provided by the nonprofit organisations and State system tend to differ in terms of type and range and so avoid any major duplication of provision.

3.7 In both the physical and sensory and in the intellectual disability areas, regional committees with representatives from both the nonprofit and State sectors have been established to assist in the planning, development and management of the services. The work of these committees primarily involves prioritising clients for placement with service providers, recommending the associated funding allocations and assisting in planning for future service provision. The committees which can be chaired by representatives from either the health services or the nonprofit organisations can contribute to the partnership ethos.

Costing the Service

3.8 While currently the criterion for determining how services are to be provided is based on capacity to deliver, a key consideration in procuring services through nonprofit organisations should be their cost compared with the cost of direct provision. Achieving a measured service calls for more sophisticated costing methods applied to both sectors and capable of distinguishing different categories and intensity of care so that meaningful comparisons can be made between the cost of directly provided care and care provided by nonprofit organisations. Only when these bands have been established can the discussion with nonprofit organisations focus on matching provision with the service being procured. This has not been put in place.

[15] Department of Health and Children, *Quality and Fairness - A Health System for You*, 2001.

3.9 Since the late 1990s the funding of client placements with nonprofit organisations has generally been based on service costs estimated by those bodies. These costs become assimilated into the overall annual allocations for core funding to those bodies in each subsequent year.

3.10 The existing incremental funding arrangement, with its weak linkage to levels of identified needs, means that funding may not always be targeted to areas of greatest need. Costing methodologies should accurately model activity-based costs of service delivery.

3.11 In 1996, The Report of the Working Group on the Implementation of the Health Strategy in Relation to Persons with a Mental Handicap titled *Enhancing the Partnership*[16] formalised the arrangements to govern the funding of nonprofit organisations in that area. The Minister endorsed these arrangements in 1997. The protocols laid down in this document have since governed dealings between nonprofit disability service providers and the former health boards.

3.12 The report recommended the development of a service costing mechanism for persons with differing levels of dependency. Officers within the Disability Directorate of one HSE region (the former Midland Health Board) attempted to establish costs for delivery of several types of disability services. While, this exercise did not capture all relevant costs associated with the provision of disability services, it was an initial attempt to establish a dependency unit cost and provide a first step towards development of a methodology to do this. The framework took account of estimates of nursing and disability care staff costs and other non-staff costs but omitted some cost items, most notably HSE regional management and overhead costs. Several other HSE regions took the results of this exercise and attempted to apply them to their own operations. However, very little progress has been made by any HSE region in establishing a mechanism for costing services.

3.13 If the health service is to move to a needs based service there will be a need for greater clarity around the cost of services and the services rendered to the clients supported. It is unlikely that simple head counts will supply this need. There is, however, a need to evolve a costing and funding mechanism which is sensitive to the mix and cost of inputs associated with the various levels of care given to persons maintained by both public and nonprofit organisations.

Financial Allocations

3.14 The Health Strategy noted that the implementation of sound strategic plans with funding related to service outcomes was dependent on allocations being transparent and evidence-based. It is important to ensure that allocations and expenditure are periodically matched and related, in terms of numbers and services, to the population served.

3.15 Currently, the allocation process is almost entirely focused on agreeing development monies for new placements and initiatives. Accordingly, costs associated with new client placements and enhancements to current services may be shown separately in the nonprofit organisations annual provider plan and are subject to review by the relevant regional committees before the annual allocations are finalised. New service developments, therefore, attract more consideration of costs than the core-funding element.

3.16 In respect of the core-funding element, nonprofit organisations provide aggregated estimates in respect of ongoing services. The examination found that, with a few exceptions, the level of supporting detail generally provided is minimal.

3.17 The Health Strategy recognised the need to reduce dependency on incremental approaches which are influenced significantly by the allocation given in a previous year. It also recognised that the

[16] Department of Health and Children, *Enhancing the Partnership*, 1996.

allocations must take full account of all relevant local factors so that the available funding is distributed fairly and to best effect. The Health Strategy signalled an intention to move towards multi-annual service and support agreements with organisations funded by health agencies. This would be carried through in the context of multi-annual planning and budgeting. While this has yet to be achieved the Government's announcement in September 2004 that it would set up a five year revenue and capital investment programme for high-support disability services represents a step towards that position.

3.18 This examination noted instances of inconsistent practices between the former health boards. In some cases health boards did not fund pay increases in line with public sector wage agreements or recognise other cost pressures such as insurance.

3.19 It was also noted that while, in some instances, formal contractual arrangements existed between the HSE and the nonprofit organisations and the HSE provided the funding, it was the Department that determined the amount of that funding.

Selection and Funding of Service Providers

3.20 In September 2005 the Competition Authority, in a submission to the Department, signalled its concerns regarding the manner in which service providers are currently selected and funded. In particular, the Authority was concerned that

- Services for people with a disability are currently contracted to service providers with no tendering mechanisms for what often turns out to be contracts of indefinite length. This means that service providers face little incentive to honour their contracts in a satisfactory fashion.
- The provision of new investments and services are bundled which means that there is little scope to allow a new service provider to take over from a service provider that does not provide satisfaction.
- There is no clear mechanism to allow new service providers to access funding, which means that it is extremely difficult for new service providers to offer services – potentially, more innovative services.
- Service providers are given "catchment areas" by the health services which hinders service users' ability to switch service provider.

Agreeing the Service

3.21 It is particularly important that the understanding of both parties coincide and is documented in a suitable format. Agreements, which specify allocations, the population to be served by disability bands or levels of dependency and desired outcomes are a prerequisite for monitoring and evaluating the performance of nonprofit organisations.

3.22 *Enhancing the Partnership* focused on arrangements with larger disability service providers, while smaller service providers were considered in the *White Paper, Supporting Voluntary Activity*. Taking its cue from *Enhancing the Partnership*, however, *Supporting Voluntary Activity* also suggested the introduction of service agreements and more formalised monitoring arrangements between the State and nonprofit organisations.

3.23 A template for service agreements, as set out in *Enhancing the Partnership*, included the joint agreement of principles between the two parties (health boards and nonprofit organisations), the individual obligations of both parties and a system for resolving differences.

3.24 *Widening the Partnership*[17] extended the application of the principles set out in *Enhancing the Partnership* to other nonprofit health service agencies. A key recommendation in this document was that service agreements should be introduced for all nonprofit organisations funded under Section 65 of the Health Act, 1953 provided they were in a position to meet agreed criteria in relation to good practice, accountability and organisational structures.

3.25 The Health (ERHA) Act, 1999 required written agreements to be put in place for arrangements for the provision of services on behalf of the ERHA or its Area Boards by large nonprofit organisations specifically listed in that Act.

3.26 The 2001 Health Strategy stated that service agreements between the former health boards and the nonprofit sector would be extended to all service providers and associated performance indicators introduced.

3.27 A survey carried out in the course of the examination indicated that the introduction of service agreements varied in the geographical areas administered by the former health boards

- the three former area boards in the eastern region and three other regions (the former Southern, South Eastern and North Eastern Health Boards) did not operate any service agreements with funded disability service providers in 2004
- two other boards (the former Mid Western and Western Health Boards) operated service agreements with large providers only.

3.28 The ERHA operated service agreements with all funded nonprofit organisations in accordance with the Health (ERHA) Act, 1999. As this agency funds the largest nonprofit organisations, the survey results suggest that up to 61% of the total value of funding to nonprofit organisations in 2004 was covered by service agreements.

3.29 The examination found many cases where service agreements were not signed for a considerable period after the commencement of services and funding.

Content of Agreements

3.30 In funding the delivery of disability services, it is particularly important to clarify the expected outputs so that health service plans can be translated into contractual terms. Clearly specified outputs are essential to ensure that nonprofit service providers have a clear understanding of HSE expectations. Poorly specified outputs increase the risk that the State will not receive the required services or value for money services.

3.31 In practice, the service agreements that exist are high-level framework documents describing in broad terms the services to be delivered, the principles according to which they are to be delivered and indicating information required for monitoring purposes. They operate for a number of years (usually five) with provision for annual allocations to be subject to negotiation between the two parties. Few service agreements reviewed provided specific details regarding expected service delivery levels, but such details were, to a greater or lesser extent, contained within supplementary documents (generally referred to in this report as provider plans).

3.32 A sample of twenty-three arrangements was examined where a service agreement or provider plan existed to govern annual service provision. Almost two thirds of the documents reviewed specified the number of persons to be assisted and over four-fifths outlined the staff numbers and grades involved in

[17] Department of Health and Children, *Widening the Partnership. Report of the Working Party to Examine Financial and Other Issues Relating to Section 65-Funded Mental Handicap Agencies*, 1997.

the service. In general, the agreements did not relate the allocation to any measure of the service provided.

3.33 The examination found that service agreements and provider plans

- differ substantially in format, content and detail of services to be provided from one nonprofit organisation to another
- concentrate on service developments attracting additional funding
- have weak or no links between core activity and funding
- do not allow for the calculation of a unit cost for each type of service provided.

3.34 Service agreements need to be precise and sufficiently comprehensive to enable effective management and monitoring of service delivery. Poorly drafted agreements reduce the effectiveness of the contract management process and may result in both parties having limited recourse in the event of a dispute.

3.35 Although a variety of service agreements and provider plans are used there is a need to ensure that a certain basic content is included in each agreement. Appendix F sets out the essential provisions which the documents should cover.

Implications of Deficiencies in Agreements

3.36 The different experiences of the adoption of service agreements across the regions has led some researchers to point to an absence of systemic thinking about the health care system. Despite the inclusion of references to the importance of the nonprofit sector in service delivery in various health policy documents over the years, some commentators maintain that recognition of the role played by nonprofit organisations and the adoption of a systemic view of health care delivery have not been given sufficient prominence at Departmental or health board level to date.[18]

3.37 Poorly-developed structures for monitoring, measuring and assessing performance levels in the context of statutory funding could, therefore, be said to exist. Thus, relationship building with the aim of effective system operation has not been given sufficient attention, and consequently information gathering in order to contribute to such effective and efficient relationships is underdeveloped.[19]

Arrangements with Smaller Nonprofit Organisations

3.38 The examination noted that funding for many smaller nonprofit organisations was not based on the submission of applications from one year to another. In some HSE regions, the annual funding decision was based on the assumption that service provision would continue as heretofore without any evidence to confirm this. Where additional funding was sought by the nonprofit organisations, in most cases, evidence of service delivery existed in correspondence between the funding and provider bodies.

3.39 There is a need to rationalise the approach to administration in these cases. Where smaller bodies are assisted different considerations apply compared with those that might pertain in cases where the State is procuring services on an ongoing basis. In the former situation, the State is largely supporting small bodies providing niche services by means of grants. It is suggested that, in order to ensure that

[18] Donoghue, F. *Reflecting the Relationships; An Exploration of Relationships between the former Eastern Health Board and Voluntary Organisations in the Eastern Region*, 2002. Boyle, R and Butler, M. *Autonomy vs Accountability – Managing Government Funding of Voluntary and Community Organisations*, Institute of Public Administration, 2004.

[19] As in Footnote 18.

administration is at a level which is cost-justified, the level of monitoring and the formality of the arrangements might be on the lines of those set out in Appendix E.

Conclusions

3.40 There is scope for a more holistic approach to planning the provision of services to persons with disability and there is a need to integrate services procured from nonprofit organisations into national plans.

3.41 The comparative cost of services provided by nonprofit organisations needs to be assessed by reference to the cost of direct provision. To facilitate this a costing mechanism for both types of provision needs to be established. This mechanism needs to distinguish between the different categories of care based on the intensity of need.

3.42 Almost ten years ago, the Department announced that changes in the funding relationship between itself and the agencies would be accompanied by the introduction of service agreements between agencies and the then health boards. These service agreements were to apply to the larger nonprofit organisations and were intended to link funding to agreed service provision. The examination found that 61% of funding was covered by service agreements.

3.43 The content of agreements was variable. Agreements were often covered in two documents – a high level service agreement and a supplementary provider plan. There would be merit in rationalising the arrangements. While it is not suggested that agreements can be fully standardised, there is a need to set out their core provisions and proposed key terms, as outlined at Appendix F.

3.44 In regard to the agreements that are in place (including both service plans and provider plans), the examination noted that

- while almost two-third of agreements specified the number of clients to be served, none made a link between funding and numbers served by category of care
- over 80% of agreements examined specified the resource inputs.

3.45 In order to be cost justified the arrangements also have to take account of scale. Accordingly, there is a need to distinguish grant assistance for local effort from the procurement of what are effectively mainline health services and set out an administrative regime appropriate to the category of payment involved. Appendix E suggests one approach to addressing this.

4 Monitoring Delivery and Evaluating Outcomes

4.1 This chapter examines the arrangements for monitoring delivery and financial performance and evaluating outcomes.

Monitoring Delivery

4.2 The Health Strategy 2001, *Quality and Fairness*, indicated that the responsibilities of the Social Services Inspectorate, which currently are restricted to inspecting residential childrens centres, would be extended to centres for adults including centres for adults with a disability. This has not yet been done. As a result, the health services do not have any legislative power to enter nonprofit organisations to check service delivery, either in terms of quantity or quality. Standards of care have not yet been introduced and there are no independent statutory bodies to carry out inspections in the area of disability. Notwithstanding this, in the past nonprofit organisations have facilitated access by Departmental and other commissioned consultants. The general aim of these consultancy engagements was to review resources.

4.3 There are three major interests to be safeguarded in the delivery of health services through the agency of nonprofit organisations. These interests are

- ensuring that quality services are provided to persons with disabilities
- ensuring that the taxpayer gets value for the money utilised
- ensuring that the taxpayer is not exposed to possible liability by any breach of fiduciary duties in regard to the financial entitlements and obligations of clients.

4.4 There is an inherent risk attaching to the incremental funding approach that without proper monitoring of service provision and dependency levels the quality of service provided may be deficient or the population served could change over time as is demonstrated in the following two cases.

Case 1: Risk to Quality of Service

4.5 In the case of one large specialist facility providing services for 250 residents with learning and intellectual disabilities the funding arrangements between the State and the service provider had not been formalised in a service level agreement and there was no direct linkage between the funding and the service provided.

4.6 In 2002, the service provider notified the HSE (former North Eastern Health Board) of its concern regarding the care provided to the residents and sought agreement to the commissioning of an independent review of the numbers employed. A consultancy firm was appointed to examine and report on the adequacy of staffing and the skills mix required, having regard to assessed dependency levels. The examination was completed in October 2002.

4.7 The consultants found that

- The funded establishment was 203 WTE[20] but the actual establishment was 197 WTE.
- The number of staff required to meet the needs of residents was 287 plus 4 to cover administration duties making a total of 291 WTE numbers.
- The skills mix ratio between qualified nursing staff and other care staff was 89:11. It recommended an alteration in the skills mix to 60:40 in areas of high dependency and a 55:45 mix for lower dependency residents.

[20] Whole-time equivalent.

- There was a need to change the culture from one that is custodial to one that supports the residents in meeting their full potential in all aspects of life.
- Unqualified staff should be trained to meet the needs of residents with particular reference to activation programmes and activities of daily living.

Case 2: Risk of Overprovision

4.8 There is a risk that funding based on historic levels of provision may get out of line with the number of residents accommodated. This is illustrated in the case of a home in the former Western Health Board area.

4.9 At the home in question there was historically a reliance on voluntary funding but this changed throughout the 1990s to a situation where public funding gradually replaced the voluntary contribution. This was reflected in an increase in public funding from €127,000 to €652,000 in the period 1994 – 2001 while the number of residents in the home fell from 45 to 23 in the same period.

4.10 By 2001 the level of public funding was acknowledged to be sufficient to meet the cost of staff employed at the home. However, in the period 2001 – 2004 public funding increased to €959,000 while the number of residents fell further to 12. At end-2004, the annual cost per resident had increased to €80,000.

4.11 Currently, there is little demand for the services provided at this home and the existing residents are mostly categorised as low dependency. By late 2004 the organisation was pointing out that the dilemma of a well funded and well staffed 'supported accommodation service', with declining numbers and no seeming demand, provided an opportunity to develop a new model of accommodation services in the area.

4.12 While it is acknowledged that this type of situation is more likely to occur in circumstances where a service is in the course of transformation the experience suggests the need for a more proactive approach to the alignment of funding with service requirements.

Fiduciary Duties of Bodies

4.13 In the recent past the State has become liable to refund certain payments levied on persons receiving care without the necessary statutory authority for their imposition. This episode highlights the need to have a system of monitoring in place sufficient to guarantee that

- charges levied on clients by nonprofit organisations do not exceed the amounts specified
- pocket money allowances are actually available to clients
- rehabilitative training payments paid in block to nonprofit organisations in respect of clients are passed on to them.

4.14 Concerns were expressed during the examination that administration needs to be tightened up in these areas and a transparent system for validating the handling of these funds put in place.

4.15 A further exposure is the risk of double funding when clients are involved in FÁS programmes or where funds are received by organisations from the Dormant Accounts Fund or other projects.[21] Again, there needs to be greater coordination of State assistance in respect of individual clients so that there is transparency between the allocation of State funds and their application.

[21] Other projects, include The European Year for People with Disabilities Project and the Enhancing Disability Services Project.

Reporting and Information

4.16 Statistical returns known as Integrated Management Returns (IMRs) are required from some of the larger nonprofit organisations. The IMRs require nonprofit organisations to submit

- quarterly activity reports identifying new admissions and discharges for the various types of service
- financial reports showing pay, non-pay and income against budget for each month and for the year to date
- a monthly employment control/staff report for designated grades.

4.17 HSE regional staff meet with the larger nonprofit organisations several times a year. At these meetings current, past and future trends in service provision are discussed in line with provider plan agreements.

4.18 Larger nonprofit organisations provide data to HSE regions through IMR Activity Reports on changes to the numbers of clients for which services are being provided. Changes may occur due to new admissions, discharges, deaths and transfers. Visits to three HSE regional offices found that the information captured from these processes were not systematically used for monitoring service provision in individual nonprofit organisations.

4.19 Information systems available to management within the health service are generally underdeveloped and the quality and completeness of data varies from one HSE regional health office to another. Basic financial information, such as the sum of payments to nonprofit organisations within each budgetary year and the amount of the allocation remaining to be paid was not readily accessible in some regions by those administering the arrangements.

4.20 As set out in Chapter 2 national, regional and local databases are neither complete nor integrated.

Monitoring Financial Outturn

4.21 During the period November 2004 to January 2005 this examination reviewed the evidence available regarding the health service's use of the financial statements of nonprofit organisations to monitor financial performance and to provide assurance that the funding provided was applied for the delivery of services. In all cases, submission of audited financial statements was a condition of funding. The findings in this regard are set out in Figure 4.1.

Figure 4.1 Use by the health services of Annual Financial Statements for 2003 of Nonprofit Organisations

Former Health Board Region	Case Files Reviewed		Annual Financial Statements on File		Reported Income Reconciled to Health Services Funding Records	
	Number of organisations	HSE Funding €m	Number of organisations	HSE Funding €m	Number of organisations	HSE Funding €m
ERHA	14	338	12	266	0	0
NAHB	16	25	13	21	3	8
WHB	12	96	5	70	3	68
Total	**42**	**459**	**30**	**357**	**6**	**76**

Source: Analysis by the Office of the Comptroller and Auditor General

4.22 In twelve of the forty-two cases examined, the financial statements for 2003 were not on file. These bodies had received approximately €100m in HSE funding in that year. Reconciliation between reported income and HSE funding was only performed in six of the forty-two cases.

4.23 The type of checks of the annual financial statements carried out by the health service varied. In no area visited was there a formalised review procedure and the extent of examination undertaken was not generally evidenced in HSE records. Discussions with health board staff indicate that, in general, the focus is not on governance and accountability issues but rather on whether significant bank balances exist, whether large surpluses were reported and generally to confirm a need for funding.

4.24 Several cases were noted where the financial statements carried qualified audit opinions due particularly to uncertainties regarding pension funding deficits and verification of fundraising amounts. In a number of cases there was also a delay in the receipt of audited accounts and in the case of one significant nonprofit organisation, although financial statements for four years had not been received, there was no alteration in funding or the application of any sanction. This organisation had received €288m over the five years 2000 - 2004.

4.25 In addition, it was noted that expenditure in the nature of headquarters costs and overheads was not generally reported within the financial statements in a transparent manner so that health service bodies could identify the apportionment of central costs to the activities being funded. Similarly, remuneration packages of the executives and management of nonprofit organisations were not generally disclosed. Greater transparency in financial reporting would provide assurance that charges were reasonable and would assist in allaying any concerns that funds might be absorbed by administrative costs rather than applied to front line services.

4.26 Some improvements in nonprofit organisations' financial reporting have occurred in recent years, notably, separate disclosure of funding amounts from different HSE regions and from other public bodies. These improvements occurred as a result of health service's requests for greater transparency in this area. However, there is further scope for increased transparency in the accounting for income, including fundraising activities.

Effectiveness of Service Procurement

4.27 The effectiveness of services delivered through the nonprofit disability sector should be evaluated with reference to their contribution to the overall effectiveness of national disability services.

4.28 Evaluation of outcomes is hampered by a failure to specify desired outcomes in service agreements. In addition, the lack of integration at the level of overall service planning militates against the evaluation of the overall effectiveness of procurement through nonprofit organisations.

4.29 The procurement of services from the nonprofit disability sector has not been the subject of evaluation or review within any HSE region or on a national basis.

4.30 A strategic review of disability services was established by the Department in 2004. This review is being carried out in partnership with the HSE and the nonprofit disability sector. The purpose of the review is to enhance health and personal social services in order to meet the needs of people with disabilities. It is not anticipated that the review will include an evaluation of the effectiveness of disability services.

Strategic Management and Performance Reporting

4.31 Monitoring of the system of service delivery to people with disabilities should contribute to the effectiveness and accountability of the system. Reports by both the National Economic and Social Council (NESC) in 2002[22] and by the National Economic and Social Forum (NESF) in 1997[23] stressed that monitoring processes require a policy/strategic management framework that identifies strategic aims and objectives against which spending can be applied and monitored. This is the basis for the development of business plans and more detailed work programmes. In turn, performance management systems should attempt to confirm the achievement of these strategic objectives, feeding back the information and analysis to allow for evidence based review and development of policy/strategic objectives.

4.32 The features of an effective monitoring system which is capable of responding to the dynamic ongoing management of the disability sector might include the elements set out in Figure 4.2.

[22] National Economic and Social Council, *Achieving Quality Outcomes: The Management of Public Expenditure*, 2002.
[23] National Economic and Social Forum, *A Framework for Partnership – Enriching Strategic Consensus through Participation*, 1997.

Figure 4.2 An Effective Monitoring System

- A clear definition of 'need' that the service is to address – requiring an information gathering and analysis capacity
- A clear policy statement outlining the strategic aims and objectives to enable an effective response to the identified need – requiring a policy-making and planning capacity
- The consideration of the resourcing implications to allow for the achievement of these aims and objectives – requiring a cost management and analysis capacity
- Business and work plans which will respond to the identified need in specific and measurable terms, in the context of stated policy and resource availability – requiring a strategic and operational management capacity
- Breadth and depth of quality information on the operation of the system and the implementation of the related plans, emerging issues and needs – requiring information and monitoring infrastructure
- Effective analysis of the information gathered enabling evidence-based policy development
- Communication at all levels and between all stakeholders such that they are involved in the contribution of quality information and analysis, and contributing to decision-making and future policy/strategic development as appropriate – requiring partnership development and management capacity.

4.33 These dimensions imply the existence of related expertise, and facilitating resources and 'infrastructure', within the system at all levels.[24]

4.34 The change agenda and management issues in the delivery of disability services indicates the need for the system to be considered as an integrated learning process enabling effective ongoing policy development, resourcing, capacity development, implementation of services, monitoring and evaluation. This direction is confirmed in other areas of State policy implementation.[25] The degree to which the various stakeholders in the disability services delivery system have the required competencies and supportive infrastructure to implement this at the present time is unclear.

Conclusions

4.35 The effectiveness of service provision needs to be evaluated holistically for each disability sector and at the level of desired or intended outcomes for each nonprofit organisation.

4.36 The numbers served by each nonprofit organisation needs to be monitored so that allocations do not get out of line with services provided. In one body, a custodial culture had developed due to a deficiency of staff resources. In another, the numbers served had reduced from 45 to 12 over the period 1994 – 2004, due in part to a lack of demand for the service. At the same time the level of provision had continued to increase. While in earlier years some of this increase was in substitution for voluntary funding it was acknowledged that by 2001 the State was meeting the full cost of staff at the home. In the period 2001 – 2004 the cost of maintaining each resident more than doubled.

4.37 The risk to the State arising out of any failure to deal properly with the financial entitlements and obligations of clients needs to be addressed. In addition, there is a need to ensure that funding to agencies in respect of individual clients is not duplicated.

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[24] National Economic and Social Council, *Achieving Quality Outcomes: The Management of Public Expenditure*, 2002.
[25] National Economic and Social Forum, *A Framework for Partnership – Enriching Strategic Consensus through Participation*, 1997. As in Footnote 24 also.

4.38 Within the HSE, management accounting and information systems need improvement so that information relevant to managing the relationship between the HSE and the nonprofit disability sector exists.

4.39 Performance management systems should be developed to facilitate evaluation of the achievement of strategic aims and objectives of the services.

5 Implementing Change

5.1 The State is embarking on a substantial change agenda involving transition to assessments of individual needs of persons with disabilities, implementation and monitoring of standards, and the establishment of comprehensive client databases. This is likely to extend over a number of years. This will involve a shift from the provision of services limited to those available from existing organisations to a framework based on the capacity of organisations to respond to client assessed need.

5.2 At the same time the health service must continue to deliver disability services to the existing and emerging population while managing changes in the health delivery system, the rational application of increased funding for the disabilities sector and the effect of the withdrawal of certain nonprofit organisations from the network. All these developments will present major challenges to the Department and the HSE.

5.3 In these circumstances, delivering change in the disability sector is a particularly complex undertaking because the delivery system is

- multifaceted
- involves multiple stakeholders, including nonprofit organisations
- impacted upon by a variety of environmental factors
- multi-layered and multi-tasked.

5.4 In attempting to achieve common performance, standards and delivery levels, the HSE needs to consider and articulate the future type and depth of role it envisages for nonprofit organisations. One issue to be considered is what part of the service activities will be integral to the State's healthcare system.

5.5 In addition, the multiple roles performed by nonprofit organisations including mainstream delivery, innovative and flexible responses to new and emerging needs, interacting with and supporting policy development or service design, and providing feedback on service provision are of value and the HSE will need to consider the extent to which these should also be supported.

Responsiveness and Resources

5.6 The complexity of the system and the level of change involved highlights the need for effective change management. This requires competencies and capacities at all levels of the system to enable flexible, responsive and effective delivery of services.

5.7 At present, the package of care delivered for a particular level of disability is not standardised within different levels of dependency. Individual assessed need, within each level of dependency, should determine the level of supports or interventions that are required. Attention will need to focus on the validation of levels of dependency to ensure that there is a robust connection between funding provisions and those dependency levels.

Partnership Issues

5.8 Change, if it is to contribute to the successful transformation of services to people with disabilities will entail coordination of the required adjustments both within the HSE and within the nonprofit organisations. The challenge is to manage this coordination within the wider system while, at the same time, implementing a system with greater transparency and accountability for the measures undertaken.

5.9 There can be difficulties arising in 'partnership' relationships which may have an impact on the ongoing delivery of services through partnership arrangements. A review of relationships between the former Eastern Health Board and nonprofit organisations in the Eastern region, concluded that significant difficulties existed in such relationships.[26]

The difficulties stemmed from

- the lack of formal policy and procedures governing the relationship
- the fact that the success and effectiveness of the relationship appeared dependent on individuals rather than formal structures
- the absence of formal reporting procedures
- a lack of transparency in decision making on grants
- the lack of a central location or unit for the relationship.

5.10 The setting up of Voluntary Activity Units within appropriate Departments, as recommended in the White Paper, *Supporting Voluntary Activity*, was regarded as one way in which this relationship could be effectively planned and managed. This would contribute to more effective and long-term relationship building. The establishment of a Voluntary Activity Unit within the HSE could help to further these aims in the area of healthcare provision as well as promoting greater consistency in arrangements with nonprofit bodies across the health service.

Challenges and Constraints

5.11 While larger organisations may be well established, and at times quite institutionalised, many others are smaller in size and narrower in scope or sphere of operation. Many of the smaller organisations have been established in response to a recognition or understanding of 'need' that is not currently catered for, or is not adequately catered for, and so are engaged in a process of needs identification and innovatory response.[27] These organisations may be dependent on a very high level of voluntary involvement.

5.12 The governance and administrative processes and capabilities of many nonprofit organisations reflect this. They may be highly dependent on State funding from a number of sources in addition to their own independent fundraising activities. Their agenda may not coincide entirely with State policy given that they may be responding to a newly identified need, or they may be responding in a flexible or innovative manner. This may result in their having to seek funding from many sources with a corresponding variety of agendas. This type of resource dependency can cause conflicts and/or difficulties impacting on the sustainability of services.[28]

5.13 Historically a crucial issue was cost of service. Nonprofit organisations were perceived as less expensive because of voluntary contributions (in-kind, personnel or finance), often denominationally based, which they brought to the service. Where funded services have been provided by religious communities, the drop in vocations to these communities and their current age profile will present a challenge in structuring future arrangements. In circumstances where continuity and uniformity of service across a national population is sought by the State there may be little basis for assuming that a nonprofit organisation is in a position to deliver such a service at a relatively lower cost.

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[26] Donoghue, F. *Reflecting the Relationships*; *An Exploration of Relationships between the former Eastern Health Board and Voluntary Organisations in the Eastern Region*, ERHA, 2002.

[27] Department of Social, Community and Family Affairs, *Supporting Voluntary Activity*, 2000.

[28] Donnelly-Cox, G. and O'Regan, A. *Resourcing Organisational Growth and Development: A Typology of Third Sector Service Delivery Organisations*, 1999.

5.14 The capacity of nonprofit organisations to sustain themselves is influenced by the wider environmental context in which they operate and the degree to which that environment is supportive of the organisation. For example, aspects such as relevant legislation, policy, regulation, fiscal frameworks, levels of disposable income, attitudes to giving and volunteering etc. all interact to create a more or less supportive environment. The State also has a role in supporting and facilitating the development of an enabling environment.

5.15 An organisation's capacity to initiate and implement service development in the medium to longer term is linked to its capacity to plan to longer time horizons. This in turn is linked to resource security. Nonprofit bodies providing substantial, resource intensive services for populations to which the State has a specific commitment therefore require some certainty with regard to future funding.

5.16 The potential of nonprofit service providers to increase their output capacity, even if provided with appropriate resources, remains problematic. Scale is a question of organisation and systems as much as of resources. Because of the uncertainty over future funding the nonprofit sector's capacity to expand, whether in terms of organisational growth or in terms of absolute number of organisations is constrained.

5.17 Consequently, it may be opportune to identify the long-term sustainability of the present domain of nonprofit organisation service deliverers in the intellectual and physical / sensory disability sectors, and to examine the consistency between stated organisational mission and State service provision intentions.

Developing Standards and Capacities

5.18 The implementation of best practices, and standardisation of services nationwide, requires consideration of the criteria against which these are to be carried out.

5.19 While the proposed standards of care form part of a wider programme to reform health services, their introduction will focus attention on organisational competencies at the level of the system and the service deliverers and, in particular, on capacities including

- service outcomes and consistency in quality and performance on a national basis
- organisational governance and accountability
- relationship between the State and nonprofit organisations
- information capture, management and storage.

5.20 The achievement of standards and organisational competencies may have resource and other implications for nonprofit organisations involved in the delivery of services to people with disabilities, and for the relationships between such bodies and the State in relation to these services.

Structuring the Relationship

5.21 In the UK, a recent review[29] recommended that four key principles should govern the financial relationship between public sector funders and the nonprofit sector

- longer term funding frameworks
- an appropriate balance between risks borne by the two sectors
- full cost recovery
- streamlined monitoring and reporting.

[29] National Audit Office, U.K. *Working with the Third Sector*, 2005.

5.22 The rationale was that implementation of these principles would promote efficiency particularly because longer term funding frameworks, designed to sustain and improve services, would aid staff retention and investment by nonprofit organisations.

5.23 Longer-term funding frameworks also serve to support the development of a sound financial structure by organisations charged with substantial service delivery roles.

5.24 For the larger nonprofit organisations, the HSE approves staffing establishments and, in determining annual allocations, takes cognisance of salary costs and linkages to consolidated pay scales. Thus, nonprofit organisations are assisted in retaining staff and continuing their activities. Notwithstanding this arrangement, this examination noted that certain service providers considered that the funding received from the State was inadequate. Some providers outlined in their service agreements, the diminution in planned service that would occur because the amount of funding allocated was less than that sought.

Corporate Governance and Financial Reporting

5.25 Nonprofit organisations in the health sector are not subject to codes of governance or specific standards for financial reporting. However, a guide to corporate governance for board members of health service organisations[30] was published by the ERHA in December 2004. Recent draft standards prepared by the NDA, nonprofit disability service organisations and the Department contain criteria related to governance and financial reporting. The nonprofit sector itself recognises the need for better accountability, transparency and governance and views correction of this weakness as a matter of priority.

5.26 Nonprofit organisations operating as limited companies must comply with governance and financial reporting standards generally required under Companies legislation.[31] However, the charities sector, of which many nonprofit organisations are members, is currently unregulated. Legislation on regulating the charities sector is being drafted.

5.27 Under the terms of the *Enhancing the Partnership* agreement, nonprofit organisations undertook to develop internal audit and service evaluation functions. However, these have yet to be developed. While some regions had commissioned evaluations of services provided by individual providers these addressed quality of service rather than financial evaluation. None of the former health boards had carried out an evaluation of all disability services within their catchment area.

5.28 Attention also needs to be given to establishing financial reporting norms. In order for the health service to receive satisfactory assurance that funds provided are transparently accounted for, the format and content of accounts of nonprofit activity should be specified. Key disclosure requirements also need to be set out, including those relating to the source of State funding, apportionments of overheads and the remuneration and pensions of key management.

5.29 The HSE has commenced a process to compile data which will form the basis of performance indicators relating to the governance and management of disability services.

5.30 The better functioning of volunteer boards in their internal oversight and governance roles and in their external inter-organisational bridging roles may require investment in the upskilling of volunteer board members. This may be the case particularly in situations where the organisation is developing a greater role in State funded service delivery.

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[30] Eastern Regional Health Authority, *Corporate Governance – A Guide for Health Service Organisations*, 2004.
[31] Companies Acts 1963 to 2005.

Future Delivery Models

5.31 The State's responsibility is to the citizen as service recipient which impacts on the State's relationship with the nonprofit service provider.

5.32 The level of investment projected for the sector at a time when some organisations are disengaging raises questions about the capacity of existing nonprofit organisations to efficiently deliver an increased programme. Consequently it may be appropriate, at this juncture, to review the sustainability of existing arrangements in terms of

- the governance models being introduced as religious communities withdraw from the running of institutions
- the merit of introducing 'shared services' for clusters of these institutions
- the quality of the infrastructure within the system.

5.33 It is likely that with the evolution to needs-based services, procurement practices will need to adjust so as to align the services being procured or delivered with the assessed needs of clients whether at individual level or on an aggregated basis.

5.34 Consequently, it may be opportune to review the possible contribution of other service delivery models including public private partnership arrangements.

5.35 In any event, it is likely that nonprofit organisations will continue to provide a major portion of services. Consequently, there is value in structuring the disability service so that there is a clearly articulated agreement of the respective roles of the funder and the service deliverer and the relationship between them. The use of clear service agreements with appropriate monitoring and reporting procedures would support the better functioning of the funder/service provider relationship. Clarity around what the State wishes to contract for need not threaten nor negate the independent role of the nonprofit organisation.

5.36 Whatever model of procurement is chosen, funding mechanisms can impact on sustainability. Within the general health services the absence of long-term funding 'contracts' has been identified as a factor in creating problems impacting on the sustainability of the delivery of services by nonprofit organisations and, sometimes, on the viability of organisations themselves.[32] Good customer guidelines included in the *White Paper, Supporting Voluntary Activity*, also adverted to these issues.

5.37 In the future service procurement may be based on some combination of a direct purchase of services and/or the continuance of relationships with nonprofit service providers as partners in service development and delivery. The latter approach would involve the State in actively working with those organisations to strengthen their organisational capacity.

5.38 Increased State investment in the development of an organisation in this way may merit consideration of the governance arrangements for such organisations. It would be important to achieve any change in governance arrangements in such a way as to safeguard the independence of the nonprofit service provider.

[32] Faughnan, P and Kelleher, P. *The Voluntary Sector and the State: A Study of Organisations in One Region*, Conference of Major Religious Superiors, 1993.

Conclusions

5.39 The changes in prospect in the disabilities sector will require a review of procurement methods, a specification of services that aligns with assessed needs of clients and mechanisms to ensure compliance with standards.

5.40 This in turn, will entail ensuring that there is a robust connection between the cost of the care being purchased for each level of dependency and the funding being provided.

5.41 Appropriately adjusting a partnership model as the system attempts to standardise service outputs in order to cater for assessed needs on an equitable basis will present challenges to the entire system and each of its component parts.

5.42 A more strategic periodic review of sustainability of relationships with nonprofit providers should be carried out. Periodic meetings in the context of funding and staffing may not be adequate to highlight trends and patterns in the quality and quantity of provision.

5.43 There is a need for greater accountability, transparency and corporate governance within the State funded nonprofit sector and for clarity in the relationship between the State and the funded organisations.

5.44 As it is likely that nonprofit organisations will continue to provide a significant proportion of disability services, clear agreements should be formulated on the respective roles of funder and service deliverer, and these should also provide for appropriate monitoring and reporting arrangements.

Appendices

Appendix A Payments to Nonprofit Organisations 2003 - 2004

The composition of payments to nonprofit organisations providing services to persons with disabilities is analysed in Figure A.1 beneath.

Figure A.1 Payments to nonprofit organisations by legislative category

Funding	2003			2004		
	Intellectual Disability €m	Physical and Sensory €m	Total €m	Intellectual Disability €m	Physical and Sensory €m	Total €m
Assistance under the Health Acts	624.98	147.73	**772.71**	654.31	165.86	**820.17**
Capital Grants	21.96	13.30	**35.26**	8.81	3.06	**11.87**
National Lottery Funding	0.25	0.42	**0.67**	0.45	0.36	**0.81**
Capitation Payments	9.43	1.82	**11.25**	15.52	5.80	**21.32**
Other Payments	19.40	1.59	**20.99**	21.09	2.11	**23.20**
Total	**676.02**	**164.86**	**840.88**	**700.18**	**177.19**	**877.37**

Source: Analysis by the Office of the Comptroller and Auditor General[33]

Figure A.2 analyses the payments by former health board region.

Figure A.2 Analysis of payments by former health board region

Former Health Board	2003			2004		
	Intellectual Disability €m	Physical and Sensory €m	Total €m	Intellectual Disability €m	Physical and Sensory €m	Total €m
ERHA	271.31	44.08	**315.39**	275.59	43.61	**319.20**
Northern Area	5.26	23.72	**28.98**	5.98	26.39	**32.37**
East Coast Area	12.16	26.49	**38.65**	15.93	33.03	**48.96**
South Western Area	9.79	8.12	**17.91**	13.62	7.33	**20.95**
Midland	29.17	4.08	**33.25**	31.32	4.61	**35.93**
Mid-Western	64.39	11.58	**75.97**	64.28	12.77	**77.05**
North Eastern	27.00	4.11	**31.11**	28.11	5.10	**33.21**
North Western	16.23	4.67	**20.90**	17.46	4.22	**21.68**
South Eastern	56.13	8.41	**64.54**	62.44	8.52	**70.96**
Southern	95.25	18.06	**113.31**	95.64	19.44	**115.08**
Western	89.33	11.54	**100.87**	89.81	12.17	**101.98**
Total	**676.02**	**164.86**	**840.88**	**700.18**	**177.19**	**877.37**

Source: Analysis by the Office of the Comptroller and Auditor General[34]

[33]/[34] Data supplied by the former health boards and the former ERHA.

Assistance Under the Health Acts

The following is an outline of the principal legislative provisions under which payments are made to nonprofit disability providers.

Provisions operating up to 31 December 2004

Assistance under Section 65 of the Health Act, 1953

Under this section a health authority may, with the approval of the Minister, give assistance in any one or more of the following ways to any body which provides or proposes to provide a service similar or ancillary

- to a service which the health authority may provide
- by contributing to the expenses incurred by the body
- by supplying to the body fuel, light, food, water or other commodity
- by permitting the use by the body of premises maintained by the health authority and where requisite, executing alterations and repairs to the supplying of furniture and fittings for such premises
- by providing premises (with all requisite furniture and fittings) for use of the body.

The section also provides that a health authority may with the approval of the Minister, contribute to the funds of any society for the prevention of cruelty to children.

Payments under Section 26 of the Health Act, 1970

The section provides that a health board may, in accordance with such conditions (which may include provision for superannuation) as may be specified by the Minister, make and carry out an arrangement with a person or body to provide services under the Health Acts, 1947 to 1970, for persons eligible for such services.

Payments under Section 10 of the Health (ERHA) Act, 1999

The section enables the Authority, having regard to the resources available to it, to make arrangements for the provision of services within its functional area, by Area Health Boards or one or more persons. Such arrangements may include

- a written agreement covering between 3 and 5 years between the Authority and the service provider specifying
    - the principles by which both parties agree to abide for the duration of the agreement, and
    - such standards relating to the efficiency, effectiveness and quality of the services to be provided as may be agreed by the parties
- a written agreement, to be renewed annually between the Authority and the service provider specifying
    - the services to be provided, and
    - the funds to be made available therefor.

The section also provides that the Authority may delegate its power to make an arrangement to an Area Health Board.

Provisions operating thereafter

Arrangements with service providers under Section 38 of the Health Act, 2004

Under this section the HSE may enter into an arrangement with service providers for the provision of a health or personal social service on its behalf. Before entering into such arrangements the HSE will determine the maximum amount of funding it proposes to make and the level of service it expects to be provided for that funding.

Assistance for certain bodies under Section 39 of the Health Act, 2004

This section enables the HSE to give assistance to bodies that provide a service similar or ancillary to a service that the HSE may provide.

Appendix B Issues noted on Financial Audits

The following matters were either reported under Section 6(4) of the Comptroller and Auditor General (Amendment) Act, 1993 or taken up with the management of the former health boards and the ERHA in post audit letters related to audits of accounts in the period 1998 – 2003.

Deficiencies in Documentary Evidence

The absence of supporting documentary evidence relating to grants to nonprofit organisations in respect of

- completed application forms
- evidence of grant approvals
- tax clearance certificates or Revenue Commissioners confirmation of charitable status
- certificates confirming satisfactory service by grantee
- registers recording the receipt of audited accounts.

Service Agreements / Provider Plans

The absence of service agreements and provider plans with grant recipient nonprofit organisations.

Receipt and Reconciliation of Audited Accounts

- the late receipt and non-receipt of audited accounts of grant-aided nonprofit organisations
- the acceptance of unaudited accounts
- failure to reconcile the grant payment with the audited accounts of the nonprofit organisation.

Monitoring and Control

- the absence of written procedures
- failure to maintain grant registers
- grant files not adequately maintained
- monitoring procedures not reviewed
- the absence of formal evaluation procedures for services provided by nonprofit organisations
- receipts to acknowledge grant payment amounts not on grant files
- instances of overpayment of grant amounts
- compliance by nonprofit organisations with conditions attaching to funding not reviewed
- register of recipients of aids and appliances not maintained.

Appendix C International Comparison

Welfare Regimes / Country Examples	Relevant Legislation	Responsibility for and Delivery of Services: Who does What	Relationship between Service Provider and Statutory Body	Formal Role of Client in Delivery System	Basis on which Clients Access Services	Any Current Shifts in Service Delivery System	Mechanisms for Quality assurance / Service evaluation
United Kingdom **Liberal** Regimes which seek to minimize the State's involvement. Individualise risks. Promote market solutions.	Community Care Act 1990; White Paper *Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards.*	*Responsibility:* Local government social service departments identify needs, set priorities, develop plans. *Services Delivery*: Mainly private and nonprofit disability sector and informal carers.	Contractual relationship funded mainly by local government.	Recipient of services. Not an active participant.	Eligibility criteria for access to services. e.g. residential facilities for elderly only available if applicant has assets < £16k; care in home more widely available.	Current policy reforms are seeking to overcome long-standing problems of poor coordination amongst parties jointly responsible for provision of services.	Case managers assess individuals and make sure that appropriate packages of care are provided.
New Zealand		*Responsibility:* Ministry of Health *Services Delivery:* A mix of public and private providers.	Ministry of Health funds service providers. Nonprofits supply the bulk of social care services.	As above	Independent needs assessment.	Increasing focus on care of older people in response to an ageing population.	Independent needs assessment; service coordination amongst health and social service partners. Needs assessment acts as a form of consumer protection.

Welfare Regimes / Country Examples	Relevant Legislation	Responsibility for and Delivery of Services: Who does What	Relationship between Service Provider and Statutory Body	Formal Role of Client in Delivery System	Basis on which Clients Access Services	Any Current Shifts in Service Delivery System	Mechanisms for Quality assurance / Service evaluation
Sweden **Social Democratic** Regimes characterised by universalism. Comprehensive risk coverage, generous benefit levels. Egalitarianism ***Denmark***		*Responsibility:* Municipal, county council funding for home care. *Services Delivery:* > 10% publicly funded social care is provided by forprofit private providers.	Municipalities may choose to contract for purchase of private services or provide them themselves. Social care is not delivered by nonprofit organisations.	Citizen with right to social care.	Municipal responsibility for delivery of services to citizens.	Cost containment; e.g. Municipality now has financial responsibility from the moment a person is ready to be discharged from an acute hospital.	Decentralisation of decision-making regarding community services means it is up to each municipality to decide how services are provided.
		Responsibility: Municipal *Services Delivery*: Mainly municipal health authorities but increasingly nonprofit organisations.	Contractual, to secure 'more efficient services.' Increasingly, cost reduction drives service delivery choices.	Citizen with right to social care.	Municipal responsibility for the care needs of citizens. Emphasis on self-care, support at home; health promotion	Cost reduction; efficient service provision; contracting with nonprofits to secure same	Municipal oversight.
Austria **Conservative** Regimes which seek to distribute resources according to elementary needs and subsidiarity principle. ***Germany***	Social Insurance Acts, 1993 *Federal Act Governing Long-Term Care Benefits.*	*Responsibility:* Statutory. *Services Delivery:* Public bodies, nonprofit organisations, private forprofit organisations.	Statutory agreements.	Budget holder; budget a function of level of social insurance.	Agreed services supplied to social insurance holders.	Lack of uniformity, coordination capacity, leading to gaps in coverage.	Catalogue of services and quality standards for outpatient and inpatient sectors.
	2001 reform of Social Code Book IX on rehabilitation; Mandatory, statutory long-term care insurance.	*Responsibility:* Länder responsible for planning. *Services Delivery:* Länder must permit open competition for service delivery, on the basis of price and quality.	Strong provision at level of state and private specialised and well-equipped institutions. Local community initiatives.	Client hasn't held concrete rights to specific community services – leading to much regional variation.	Social insurance.	Introduction of personal budgets; establishment of coordination centres to provide information to insured and coordinate the many actors involved in providing disability services.	Negotiation, based on price, between care insurance funds and associations of care providers.

Appendix D Legislative and Policy Framework

Legislative Framework

The legislative framework governing statutory nonprofit relationships in Ireland is relatively underdeveloped.[35] There is no statutory definition of charity and charitable status does not exist, as yet. Organisations apply to the Revenue Commissioners for Charity (CHY) numbers which allow them exemption from certain taxes. The criteria under which nonprofit organisations are granted charitable recognition date from 1891 (Pemsel Criteria)[36] and include relief of poverty, advancement of education, advancement of religion and 'other purposes beneficial to the community'. The 1967 Income Tax Act updated these to include 'any body of persons or trust established for charitable purposes only'.[37] Charitable recognition does not confer a legal status on the organisation.

This situation is set to change during 2006 as legislation on the regulation of charities is proposed and will include measures to provide a legal definition of charity, a system of registration of charities and the introduction of more formal procedures with regard to financial and performance accountability.[38]

A consultation process led by the Department of Community, Rural and Gaeltacht Affairs to get stakeholder feedback and input into the proposed legislation highlighted a number of pertinent issues including the recognition of State-nonprofit relationships, structures to improve the effectiveness of those relationships such as establishing a sectoral representative body, the need for a statutory definition of charitable status and a register of charities, and for improved transparency and accountability.[39]

Despite the lack of a regulatory framework for nonprofit organisations, the funding relationship with the State in the area of health service delivery has been subject to legislation, most notably the Health Act, 1953, the Health Act, 1970, the Childcare Act, 1991 and most recently the Health Act, 2004, which now supersedes those former Acts. All of these Acts recognise the input of nonprofit organisations in the delivery of vital health services and the funding relationship that underpins the State-nonprofit relationship.

Although a large proportion of services, including disability services, are delivered through nonprofit organisations, the legal obligation to provide those services rests with the State. Section 65 of the Health Act, 1953, states that the State will fund nonprofit organisations providing services 'similar or ancillary' to those delivered by the State. This wording has not changed in essence since that Act and serves to indicate the development that is needed in political philosophy since research on State-nonprofit relationships[40] has shown that such services are not similar or ancillary.[41]

General Policy Framework

The core principles shaping the relationship between the State and the nonprofit sector, according to the White Paper,[42] are the recognition of

- the nonprofit sector as a core component of a vibrant civil society

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[35] Department of Community, Rural and Gaeltacht Affairs, *Establishing a Modern Statutory Framework for Charities,* 2003.
[36] Cousins, M. *A Guide to Legal Structures for Voluntary and Community Organisations*, Combat Poverty Agency, 1994.
[37] Ryan, J. *Reliefs from Tax on the Income and Property of Charities*, paper presented to the Institute of Taxation, 1995.
[38] As in Footnote 35.
[39] Breen, O.B. *Report on the Public Consultation for the Department of Community, Rural and Gaeltacht Affairs*, 2004.
[40] O'Ferrall, F. *Citizenship and Public Service: Voluntary and Statutory Relationships in Irish Healthcare*, The Adelaide Hospital Society, 2000.
[41] Donoghue, F. *Reflecting the Relationships between the former Eastern Health Board and Voluntary Organisations in the Eastern Region*, 2002.
[42] Department of Social, Community and Family Affairs, *Supporting Voluntary Activity. A White Paper on a Framework for Supporting Voluntary Activity and for Developing the Relationship between the State and the Community and Voluntary Sector*, 2000.

- the need to consult nonprofit service providers and other groups in receipt of State funding about service design and delivery
- the diversity and autonomy of the sector
- the role of the sector in contributing to policy and relevant legislation
- the legal obligation that rests with the State for the delivery of services.

Key recommendations arising from the White Paper were the establishment of and support for an infrastructure to underpin the State-nonprofit relationship including Voluntary Activity Units in relevant government departments, the development of legal and regulatory issues, training support, and fostering and supporting volunteering.

Key recommendations with regard to funding included the recognition that statutory funding would be made available for mutually-agreed programmes of activities which were consistent with government policies and objectives, the publication of clear eligibility, selection criteria and funding procedures and improved co-ordination and clarity regarding roles and responsibilities between the parties to the funding relationship.

As a consequence of the recognition of the nonprofit sector's role in service delivery along with statutory agencies, the Department of Health and Children was given co-responsibility along with the Department of Community, Rural and Gaeltacht Affairs for leading the White Paper's Implementation and Advisory Group to ensure that the White Paper's recommendations were implemented.

While there have been several issues in relation to the implementation of the White Paper[43] the inclusion of the Department of Health and Children as a lead Department points to the recognition of the importance of nonprofit organisations in the delivery of health care services in the Irish health care system.

Health Sector Policy

Turning to the health services area and that of disabilities, various policy documents over the years have noted the importance of nonprofit organisations in service delivery.[44] The *Report of the Commission on Health Funding* recommended the introduction of agreements between the State and nonprofit organisations subject to continuing evaluation of the level and quality of services provided. *Shaping a Healthier Future* paved the way for the introduction of more formal funding agreements between statutory agencies and nonprofit organisations which were to be operated through the former health boards. Two years later, *Enhancing the Partnership*, which dealt specifically with larger intellectual disabilities organisations, sought to formalise these service agreements and transfer responsibility for funding the larger disability organisations from the Department of Health to the individual health boards'.

Key principles governing the State-nonprofit sector relationship in the area of disabilities included the introduction of service agreements between the statutory funder and the nonprofit grantee in order to address issues such as accountability and transparency. Recommendations included the introduction of multi-annual funding, clear monitoring procedures, and the need for organisations in receipt of statutory funding to publish annual reports and accounts, maintain high standards of governance and accountability and commit themselves to relevant legal obligations and standards.

[43] Acheson, N., Harvey, B., Kearney, J. and Williamson, A. *Two Paths, One Purpose. Voluntary Action in Ireland, North and South*, Institute of Public Administration, 2004.

[44] Government of Ireland, *Report of the Commission on Health Funding*, 1989. Department of Health, *Shaping a Healthier Future*, 1994. Department of Health and Children, *Enhancing the Partnership*, 1996. Department of Health and Children, *Quality and Fairness – A Health System for You*, 2001.

Appendix E Administrative Banding

Payment to voluntary bodies by the HSE can be made under the provisions set out in Appendix A. Within these legislative arrangements there would be merit in distinguishing the payments by type, which would allow for the establishment of an appropriate administrative regime. For practical reasons it may be appropriate to assign suitable financial bands to the categories set out in the table.

Criteria to Select Administrative Regime

Nature of Relationship	**Support Contribution**	**Assistance**	**Procurement of Services**
Basis of Legal Relationship	Grant terms and conditions	Formal letter of understanding	Contract
Evidence of Application of Funds	Confirmation of Application for purpose (self certification)	Independently audited account of the activity	Independently audited account of the activity
Focus of Evaluation	Application of Inputs	Achievement of Outcomes	Achievement of Outcomes and specified outputs
Level of Inspection	Sample basis	Sample basis	Ongoing
Reporting Process	Annual Report and Accounts	▪ Annual Report and Accounts ▪ Formal Report on Activity	▪ Annual Report and Accounts ▪ Formal Report on Activity ▪ Quarterly Meetings

Administrative Prerequisites	Grant Scheme published including terms and conditions	Funding policy with objectives and criteria for specified activities	▪ Integration of purchased service into HSE delivery mechanism ▪ Long term funding framework ▪ Contract document specifying o Populations to be served in each disability band o Intended outcome o Resource provision

Appendix F Principles underlying Agreements

The following principles should govern the content of agreements with nonprofit organisations whether contained in service agreements, provider plans or a combination of both.

Structure for a Service Agreement

Introduction/Preamble

The Introduction/Preamble should identify the parties to the agreement and provide a description of their purposes and responsibilities, giving a context for coming to a service agreement. Legislative arrangements influencing the agreement should be referred to, including those governing the statutory obligations of the HSE.

Principles Underpinning the Agreement

The principles underpinning the agreement e.g. equity, quality, rights of clients etc. should be stated.

Service to be provided

The service to be provided by the nonprofit organisation should detail the number of clients, the range of services involved and the degree or level to which they will be provided and the desired outcome. Locations where services will be delivered as well as the times/periods of delivery should be identified. This section should also specify the role and responsibilities of any partner organisations.

Service providers should meet the essential criteria for recognition as an approved service provider under accepted standards of care.

Profile of those who will be able to avail of the services to be provided

The profile should describe clearly the group or groups of people for whom the service is designed.

Policy in relation to referral, admission and discharge of clients

This information is necessary to ensure total transparency around how each service operates and makes decisions. Clear policies ensure that everyone (clients, families, nonprofit organisations and HSE staff) understand the criteria governing access to the service.

The level of funding to be provided by the HSE

The agreement should specify what funding is to be provided to the nonprofit organisation and how this funding is to be drawn down. Where conditions apply to the provision of funding and/or where accounting criteria must be met, these should be clearly set out.

The manner in which overspends and contingencies will be dealt with should also be addressed in this section. Where more than one HSE region funds a nonprofit organisation, a commitment should be given that any shortfall or funding deficit arising in services provided in one HSE region should not, without agreement, be funded by way of financial transfers or savings in the running of services funded and provided in another HSE region.

Tax Clearance and Insurance

Nonprofit organisations must ensure that they have tax clearance and appropriate levels of insurance cover, details of which should be set out. An indemnification clause should also be included which will indemnify the HSE against all actions and proceedings.

The Number and Category of Staff Employed, or to be Employed by the Nonprofit Organisation

The number and category of staff should be specified clearly, as well as describing the qualifications, experience and skills, which these staff will be required to possess. While it is acknowledged that nonprofit organisations are employers in their own right and will have autonomy concerning their human resource policies, attempts should be made to ensure that these are harmonised with the HSE policies.

Arrangements for Monitoring, Inspection and Evaluation

Clear mechanisms to facilitate monitoring, inspection and evaluation of services being provided should be included.

The agreement should include a commitment on the part of the nonprofit organisation to make regular (at monthly or other intervals) returns of certain information, including financial, human resource and activity data. Decisions about the nature, detail and purpose of data to be returned should be made when the service agreement is being negotiated.

The agreement should provide a right of access to the HSE to undertake inspections and evaluations.

Policy for Dealing with Complaints

A complaints policy to deal with and address complaints made by consumers and the public should be put in place and this complaints policy must be publicised to service users.

Arrangements for Dispute Resolution and Modifications to the Service Agreement

A resolution mechanism including clear steps for notification and investigation of disputes should be agreed at the outset. Arrangements should also be made for occasions when the agreed dispute resolution mechanism fails.

Failure to Comply with the Service Agreement

The agreement should include a section whereby failure to comply with some or all aspects of the agreement can cause the nonprofit organisation to incur a penalty or some such other sanction.