Chapter 47

Management of the HSE Vote

HSE UPDATE JUNE 2012

Foreword

There are three sections in Chapter 47:

1. **Staff Reduction Measures**
2. **Primary Care Reimbursement Service**
3. **Treatment of Private Patients in Public Hospitals**

In updating each of the sections, where extracts from the chapter are cited these are in Black and where we provide an Update we have marked it in Blue.

Management of the HSE Vote

47.1 In addition to producing an accrual based account, the Health Service Executive (HSE), by virtue of the fact that it is voted moneys annually by Dáil Éireann, draws up an Appropriation Account which outlines the amounts provided by Dáil Éireann and its expenditure outturn. It is required to manage its resources in accordance with the rules and procedures applicable to voted funds.

47.2 From an accountability viewpoint, these principally require that

- payments be based on substantiating documentation and
- payees have entitlement to the amounts paid.

47.3 The charge to the HSE Vote comprises two separate elements - expenditure that is administered on an area basis and expenditure on national programmes. The area based expenditure is recorded on legacy accounting systems that predate the establishment of the HSE and which were designed to record transactions on an accruals basis. The Vote outturn for this element of expenditure is derived by eliminating non-cash items and analysing assets and liabilities to identify suspense balances. Ultimately, while this process produces an overall outturn that equates to the Vote outlay, the charge for some subheads is established on the basis of apportionments.

47.4 In 2010, an amount of €14.5 billion was charged to the HSE Vote with €3.5 billion of this outlay being funded through appropriations in aid.

Chapter Focus

The chapter examines a set of issues relating to the management of voted funds by the HSE including

- the manner in which the HSE managed resources in light of staff reduction measures
- information gaps in the records of the Primary Care Reimbursement Service (PCRS) and the financial impact of certain scheme overlaps
- how risks arising from dual eligibility under dental schemes were being managed and how delivery of dental treatment is verified
- the percentage of private patients being charged for their accommodation in public hospitals and the scope for increasing income from that category of patient
- the arrangements for monitoring by the HSE of voluntary hospitals.

Staff Reduction Measures

47.5 Staff resources assigned by the HSE for health and social care activities are based on historic numbers operating in the public health service adjusted annually to take account of service developments set out in the HSE National Service Plan approved by the Minister for Health and Children.

47.6 Employment numbers stood at around 111,000 whole time equivalents (WTE) at the end of 2008. A number of staff reduction measures have been introduced since the beginning of 2009 including

- a general moratorium on recruitment across the public sector – imposed in March 2009
- an incentivised early retirement scheme (ISER) in the public sector – put in place in April 2009
- a targeted voluntary early retirement and voluntary redundancy scheme for the public health service – announced in November 2010.

47.7 The HSE manages employment numbers through an Employment Control Framework (ECF) which was agreed with the Department of Finance. In applying the ECF the HSE sets employment ceilings for all service units including local health offices and hospital networks as well as procedures for the approval and filling of vacancies and the monitoring mechanisms to be used.

47.8 The 2009 ECF set out how Government policy on numbers, including the moratorium, would apply. In line with the ECF, the HSE specified that redeployment, reconfiguration and reassignment of existing post holders and vacancies should be undertaken in order to ensure that the service could be managed within the revised ceilings. It also specified other cost containment measures in respect of the use of agency staff, overtime and on-call expenditure, staff allowances and existing acting-up arrangements.

47.9 At the end of 2010 the number of wholetime equivalent staff employed in the health sector was under 108,000 before taking account of 1,626 WTE staff who availed of the voluntary early retirement and the redundancy scheme. The cost of those staff reduction schemes was approximately €103 million.

47.10 In response to my enquiries the Accounting Officer stated that

- The HSE had seen a reduction in its staffing of 5,615 WTEs between December 2008 and May 2011 resulting in its wholetime equivalent employment level being 105,410 at May 2011.
- The decrease of 5,615 includes the reduction of 1,626 achieved under the 2010 redundancy and early retirement schemes and the 633 WTEs that availed of the ISER in 2009.
- Approximately 1,000 Community Welfare Officers transferred to the Department of Social Protection[375].
- The remaining reduction of 2,356 was achieved while filling approved posts in exempted grades and meeting service developments and demographic pressures.
- The numbers involved in management and administration have reduced by 2,203 WTEs (12%) from their peak in September 2007.

47.11 The First Progress Report on the implementation of the Public Service Agreement[376] also noted that there was a reduction of 4,180 WTE in the health sector between the first quarter in 2010 and the first quarter in 2011 that had generated savings of €289 million.

HSE Update

There have been considerable reductions in staff numbers in the health sector in recent years. Table 1 below shows that from the end of September 2007 to end May 2012 employment has reduced further by 10,438 WTEs, a drop of 9.25%.

The timeframe includes the ending of the "grace period" for retirements, which has resulted in significant reductions in staffing.

The greatest reductions by grade category have been in the General Support, Management/Admin and Nursing grades.

Table 1- Employment reduction September 2007 – end of May 2012

Staff Category/Date/WTEs/% Changes	WTEs	WTEs	WTEs	WTEs	%
	Sep-07	Dec-11	May-12	Change since Sep 2007	
Medical/Dental	**8,100**	**8,331**	**8,244**	**144**	**1.78%**
(Consultants)	***2,285***	***2,474***	***2,445***	***160***	*7.01%*
(NCHDs)	***4,871***	***4,938***	***4,917***	***46***	*0.95%*
Nursing	**38,965**	**35,902**	**35,031**	**-3,935**	**-10.10%**
(nurse managers)	***8,218***	***7,901***	***7,461***	***-757***	*-9.22%*
Health & Social Care Professionals	**15,762**	**16,217**	**15,921**	**159**	**1.01%**
(Occupational Therapists)	***1,014***	***1,197***	***1,187***	***173***	*17.10%*
(Physiotherapists)	***1,433***	***1,534***	***1,538***	***105***	*7.30%*
(Psychologists & Counsellors)	***865***	***1,003***	***960***	***95***	*10.94%*
(Social Workers)	***2,084***	***2,400***	***2,331***	***247***	*11.87%*
(Speech & Language Therapists)	***678***	***835***	***823***	***145***	*21.43%*
Management/Admin	**18,421**	**15,983**	**15,826**	**-2,595**	**-14.09%**
(management)	***1,231***	***1,087***	***1,056***	***-175***	*-14.20%*
General Support Staff	**13,351**	**10,450**	**10,133**	**-3,219**	**-24.11%**
(Catering)	***1,070***	***922***	***899***	***-171***	***-15.97%***
(Household Services)	***6,383***	***4,907***	***4,738***	***-1,646***	***-25.78%***
(Portering)	***2,061***	***1,686***	***1,648***	***-412***	***-20.01%***
Other Patient & Client Care	**18,171**	**17,508**	**17,188**	**-983**	**-5.41%**
(HCA, Nurse Aide, etc)	***13,694***	***12,792***	***12,545***	***-1,150***	***-8.39%***
Total - Health Services	**112,771**	**104,392**	**102,343**	**-10,428**	**-9.25%**

Source: HSPC

The effective management of the overall numbers has ensured that the health sector continues to operate within its employment control ceiling and to meet the employment reductions targets set out in the Employment Control Framework.

Contingency planning for grace period retirements

Validated final numbers in relation to the number of staff, who had their exit from the health services processed through pension services, during the final 6 months of the 'grace period', gave an overall headcount of **4,471** staff, for the period September 2011 to February 2012 inclusive (See Table 2 below). It should be noted that this is the total number of individual staff members who were processed within this timeframe and their Whole time Equivalent Value was determined by their value as recorded in the Health Service Personnel Census at their time of retirement.

Table 2 -The monthly breakdown over the final 6 month period September 2011 to February 2012

Month	Staff Category – Headcount/WTEs						Total Headcount	Total WTE value*
	Medical /Dental	Nursing	Health & Social Care Profs	Mgt/ Admin	Gen Support Staff	Other Patient & Client Care		
September 2011	7	86	19	28	37	77	**254**	***161***
October 2011	9	113	18	16	29	72	**257**	***153***
November 2011	19	177	21	32	45	91	**385**	***289***
December 2011	21	254	45	41	63	118	**542**	***410***
January 2012	15	225	42	37	41	129	**489**	***353***
February 2012	104	1,216	292	248	271	413	**2,544**	***1,812***
Total September 2011 to February 2012	**175** ***(140)***	**2,071** ***(1,575)***	**437** ***(314)***	**402** ***(314)***	**486** ***(361)***	**900** ***(474)***	**4,471**	***3,178***

** Records Home Helps at zero Whole Time Equivalent (WTE) value.*

Reorganisation and Cost Containment

47.12 In relation to staff reorganisation, the Accounting Officer stated that the HSE has been progressing a nationwide reconfiguration of services and reallocation of resources with consequent redeployment of staff. In the course of this, it aimed to prioritise frontline service posts and support new services for the elderly and children including

- the relocation of Orthopaedic services[377] involving the relocation and redeployment of approximately 220 staff of all grades
- the redeployment of 60 staff on the closure of Heatherside Hospital in Cork and its relocation to a new site.

47.13 He stated that the Public Service Agreement facilitates productivity gains through changing work practices and work organisation. Examples of improvements, that he instanced, were

- centralisation of medical card processing
- development of a human resources shared services function with the establishment of three shared services
  - a National Recruitment Service
  - National Pensions Management and
  - National Personnel Administration.

47.14 In relation to other cost containment measures the Accounting Officer stated that

- Savings of €33 million in 2011 are projected in agency staff costs as a result of new contracts with recruitment agencies. Their realisation is dependent on the control of the volume of agency staff recruited.
- In addition, the HSE recently conducted an overseas recruitment campaign to address the shortage of Non-Consultant Hospital Doctors which is expected to significantly reduce the reliance on agency staff in this category.
- Overtime costs reduced by €2.4 million in the period May 2010 to May 2011.
- Agreement had been reached with staff in early 2011 on revised terms for the provision of hospital laboratory services outside normal working hours which means that some 3,000 staff can be rostered between 8am and 8pm from Monday to Friday.
- The filling of all posts is governed by rules that specify that all options, including redeployment of existing staff, reorganisation of work or other alternatives must be exhausted prior to seeking approval to fill vacancies.
- Approval to fill vacancies is subject to compliance with employment ceilings, funding availability and is operated within specified employment categories.
- The recruitment and promotion of staff at regional and local level is proscribed (with an exception for key clinical posts) and all temporary and permanent competitions are run by the HSE National Recruitment Service.

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376 In line with the provisions of the Agreement an Implementation Body was established to monitor its provisions, and verify progress or otherwise on its implementation including the sustainable savings and reforms it was designed to deliver.

377 This involves relocation of orthopaedic services from St Mary's Orthopaedic Hospital in Cork to South Infirmary
Victoria University Hospital

HSE Update Reorganisation and Cost Containment

Staff redeployment, reorganisation and cost containment are key issues being implemented and supported by the Public Service Agreement.

It is estimated that over 4,500 staff redeployments or re-assignments took place during January 2011 and March 2012. The vast majority of these redeployments took place on a voluntary basis. Various major service developments and reconfigurations have necessitated the redeployment of significant numbers of staff. Other redeployments have involved smaller numbers, but were still significant in demonstrating staff flexibility and cooperation.

A range of specific examples are set out below (others can be viewed as appendices to our 2012 Public Service Agreement report on our website (www.hse.ie/go/crokepark) in an effort to demonstrate the scale of redeployment taking place across the health sector:

(a) Acute Hospital Services, Cork City
Between 21st November and 12th December, **over 600 staff** were involved in relocating services in Cork city:

- The medical rehabilitation service moved from the South Infirmary Victoria University Hospital (SIVUH) to St Finbarr's Hospital.
- The cardiology service moved from SIVUH to Cork University Hospital.
- The orthopaedic services, including the pain and plastics services, moved from St Mary's Orthopaedic Hospital to the SIVUH.
- An Urgent Care Centre was developed on the grounds of St Mary's Orthopaedic Hospital.
- The A&E in the SIVUH went from a 24hour to a 12hour service.
- All grades of staff transferred and relocated with the relevant service to ensure that expertise, skills and competence were maintained during the reorganisation process.

(b) Community Welfare Service:
On 1st October 2011, **1,020 Community Welfare Service staff** were officially transferred from the HSE to the Department of Social Protection and became Civil Servants.

(c) Primary Care Reimbursement Service (PCRS):
Between April 2011 and April 2012, a total of **133 staff** have redeployed to the PCRS. Twenty one staff redeployed from the Central Statistics Office. 112 redeployed from within the HSE including voluntary hospitals and Intellectual Disability sector.

(d) Baggot Street Hospital:
Redeployment of approx 41 staff through the transfer of Baggot Street Primary Care Team, Avoca Counselling Service, Alcohol Unit, Addiction Treatment Services and Stroke Unit to Haddington Road.

(e) National Rehabilitation Hospital:
Redeployment of 23 staff in patient services department Processes and services streamlined, less duplication of effort which allowed for the admin associated with a post lost under the VRS to be absorbed. Operational issues addressed and more efficiencies created. Greater flexibility and cross cover arrangements between the staff/programmes/centralised administration.

(f) Wicklow community services: Reconfigure residential care so that the service is delivered from quality facilities, involving closure of Wicklow District hospital and re-designation of service to St Colman's Hospital. **22.9 WTE staff redeployed**.

(g) Laboratory Services, Co Louth: On February 13th, 2012 all laboratory services in Louth County Hospital, Dundalk amalgamated with services for Our Lady of Lourdes Hospital, Drogheda. A range of both clerical and technical grades were redeployed from Dundalk to Drogheda as part of this initiative (e.g. medical scientists, clerical staff and laboratory attendants).

(h) Mental Health Service, North Dublin: The Elderly Mental Health care units at St Ita's, Portrane transferred to St Vincent's, Fairview in April 2011. The acute inpatient admission unit in St Ita's transferred to St Vincent's in September 2011. All grades and staff disciplines redeployed to facilitate this service reconfiguration.

(i) Older Persons Services, Cork: In April 2011, staff and residents of Heatherside Hospital in North Cork re-located to Heather House Community Nursing Unit, on the grounds of St Mary's Orthopedic Hospital, in Cork city. This was the first instance, under the PSA, where a service relocated and staff redeployed further than the 45km as outlined in the Agreement.

Rosters

With the severe reductions in staffing and budgets in 2011 it is even more important to stretch limited resources by adjusting nursing rosters. Effective rostering is a key tool of managers which links with changes in how services are delivered (e.g. changing from inpatient to day treatment or from seven to five day services) in order to achieve greater efficiency.

The complexity of roster types (which links to levels of demand and patient acuity) means that it is difficult to be definitive at a national level concerning the precise changes needed to deploy staff most effectively. However, based on experience to date, it is considered that the local approach/discretion for local managers as set out in the PSA is the best way to proceed. Some specific examples of rostering changes include:

Central Mental Hospital: Significant roster changes, which involve the removal of structured overtime, implemented following the issuing of a Labour Court recommendation in March 2012 under the terms of the Public Service Agreement. Estimated savings of €1million annually from these changes.

Radiography Service: Service-wide roster change implemented on 1st February 2012 with staff now liable to be rostered between 8am and 8pm from Monday to Friday. Review scheduled for June 2012, as recommended by Labour Court.

Laboratory Service: Service-wide roster change which affects some 3000 staff who now have a liability to be rostered between 8am and 8pm from Monday to Friday. The changes for staff under this agreement are considerable and it is worth noting the relatively quick timeframe within which the revised arrangements were agreed by staff and their representative organisations. These revised rosters are in place and operational since February 2011.

Our Lady's Hospice, Harold's Cross: Changes in rosters for support staff with estimated savings of €220,000 per year.

Peamount Hospital: Revised nursing rosters introduced including later finishing times.

Addiction Services Dublin / North-East: Revised roster arrangements introduced which standardised opening hours of clinics and will result in a reduction in overtime and savings of approximately €500,000 per annum.

WestDoc: Revised rosters implemented for drivers resulting in better alignment of available resources with service needs and consequent cost efficiencies.

Clinical Programmes

There have been a number of achievements on the Clinical Programmes to date. Some of these include the following:

- Acute Medicine Programme (AMP)
- 70, 000 bed days saved
- AMP implemented in 12 hospital groups.
- In Beaumont hospital, direct access to the AMP has enabled same day discharge for 80% of patients with approximately 6000 patients annually getting direct access to the AMU from the Emergency Department or directly through their General Practitioner
- National Early Warning Score: 40 sites identified for implementation. In excess of 1,300 staff trained.

Emergency Medicine

- 19 Clinical Tools and guidelines complete and live or in pilot. 15 more progressing.
- Recruitment of 14 additional Consultant posts is being progressed.

Elective Surgery Programme

- 9 hospitals trained and operational in Productive Theatre system, improving theatre improving theatre utilisation to 90%.
- Savings of €2.3m annually from improvement in theatre utilisation in pilot sites.
- Percentage of operations on same day of admission in targeted sites increasing from 48% to 76%.
- Audit programme will reduce deaths in surgical patients from adverse events by 10% over 10 years.

Outpatient Programmes

- **Epilepsy.** Process to establish 6 Regional epilepsy centres commenced. Recruitment process in place.
- **Dermatology.** Target of 30% increase in outpatient attendance has been exceeded to 34.6%.
- Recruitment of 10 new additional Consultant Dermatology posts progressing.
- **Rheumatology.** Increase of 37.7% in new and return rheumatology outpatients seen in 2011 compared to 2009.
- **Neurology.** Activity in outpatient departments increased by 9% (2011 compared to 2009). 13 new additional Consultant Neurologists approved, 7 of which are already in place.
- **Rheumatology and Orthopaedic** 10 musculo-skeletal physiotherapy led clinics established.

Chronic Disease Programmes

- **Stroke.** 6 new dedicated stroke units established. Stroke Register operational in 9 sites.
- **Heart Failure.** 7 heart failure units have been established nationally.
- **COPD.** Outreach services are in place in 5 sites. Approval has been given for appointment of Clinical Nurse Specialist posts.

Cost Containment Measures

- Reductions in overtime, allowances, premium payments, on call allowances, weekends, nights etc saw a reduction of €25m for the period Q1 2011 to Q1 2012.
- The Acute Medicine Programme estimates that €63m costs have been avoided as a result of 70,000 bed days being saved.

Hiring of Retired Staff

47.15 Notwithstanding the staff reductions outlined above, payments to retired staff for services provided to the HSE in 2010 amounted to €14.6 million (€9.7 million: 2009). The categories of staff rehired are set out in Figure 185.

Figure 185 Rehired Staff 2010

Staff Category	Number	Cost €000	Cost Percentage
Medical	49	1,838	13%
Dental	5	159	1%
Nursing	488	8,719	60%
Clerical	49	923	6%
Interviewer	12	60	0%
Health and Social Care Professionals	31	890	6%
General Support Staff	54	1,070	7%
Other Client Patient Services	85	961	7%
Total	**773**	**14,620**	**100%**

Source: Health Service Executive

47.16 The Accounting Officer explained that the HSE rehired pensioners in a number of areas where staff availability, long recruitment timelines and service needs meant that pensioners were the only cohort available to support continued service provision in the short to medium term. These include retired consultant medical staff hired to cover their previous post while a replacement was being recruited and retired psychiatric nurses hired to offset recruitment difficulties in a challenging area of nursing.

47.17 He assured me that the implementation of the restriction on re-engagement of staff who availed of the redundancy and early retirement schemes had been confirmed by Regional Directors of Operations and local service managers in the HSE. The HSE has also confirmed to the Department of Health and Children, based on confirmations supplied by HSE funded agencies[378] that Government policy on this matter is being complied with by those agenicies.

[378] These agencies are funded in accordance with section 38 of the Health Act 2004.

Conclusion – Employment Control

The HSE has reported that staff numbers in the public health service reduced by over 4,600 between the end of December 2008 and the end of May 2011 and a further 1,000 staff were transferred to the Department of Social Protection. Included in the reduction were 1,626 wholetime equivalent staff who availed of the voluntary early retirement and the redundancy scheme at a cost to the State of approximately €103 million.

In 2010, the HSE paid in excess of €14 million to retired staff for services rendered in the year.

In relation to the management of services in the context of this downsizing, the Accounting Officer has stated that risks involved are being managed through a risk management process and that the operation of the general moratorium on recruitment and promotion has been devolved so that local clinicians and managers can balance resource needs with required reductions in numbers employed.

HSE Update

Hiring of Retired Staff

Payments to retired staff for services provided to the HSE in 2011 amounted to €11.6 million (€14.6 million: 2010). The categories of staff rehired are set out below.

Table 3 – Rehired staff 2011

	Payments to Retired Employees			
2011	**Grade**	**Number**	**Whole Time Equivalent**	**Amount**
	Medical	45	15	1,762,432
	Dental	4	1	154,203
	Nursing	462	154	7,064,614
	Clerical/Interviewer	48	16	717,353
	Health & Social Care Professionals	30	10	556,770
	General Support Staff	30	10	361,228
	Other Client Patient Services	67	22	962,270
	Total	**686**	**228**	**11,578,870**

The policy of the HSE is not to rehire staff who have retired except in the most exceptional of circumstances, for a specified period of time, and only if signed off at Regional Director of Operations level. In circumstances where this happens it is after having exhausted every other option available to address a critical staff or service need. If a retired member of staff fills a post on a fulltime basis there is no financial gain for them in this because for the period that they are rehired their pension is abated. This process is carefully monitored and we now have in place robust arrangements to manage compliance.

Some of the reasons for the recruitment of retired staff would include:

- To cover clinical risk in key frontline posts while the recruitment process is underway or while services are being reconfigured. An example here would be in Waterford General Hospital a Consultant Haematologist WRH Retired 30/11/2010 and provided locum from 17/01/2011 to 31/05/2011.
- Vaccination procedures: The various vaccination programmes are delivered during school terms. Teams comprising medical officers and nurses are utilised for programmes such as HPV. Given the tight periods available for this work some teams would be supplemented with retired medical officers and public health nurses. These would mainly be employed for a day or two a week and mainly for a four week period.
- Mental Health: Over the last few years there has been high levels of retirements in the Psychiatric Nurses with a result that we have had shortages of staff pending recruitment and reconfiguration of services. Indeed the HSE South reports that since 2009, 437 have left the service and this was equivalent to 401 WTE's. Over 86 psychiatric nurses which is equivalent to 31 WTE's were employed pending the reorganisation of this service in line with the strategy of Vision for Change.
- Community homes. Dublin Mid Leinster have indicated that they would hire retired nurses on short term contracts to cover rosters in community nursing homes pending the reorganisation or transfer of patients to new facilities.
- Clerical/Mgt Administration: The use of these former staff in this category is mainly to participate on interviews boards.

We have over the last year reduced our need for such staff as the figures for 2011 above show when compared to the 2010 figures in the C and AG's report.

Retirement under the" Grace Period" up to end February 2012

Table 4

Region	No. Persons Rehired		*Total*	No. posts ceased as @ 20th June	Total Still in place as @ 20th June	No. due to cease at end June	Remaining posts
	Hospitals	Community					
South	3	7	***10***	2	8	3	5
DNE	5	13	***18***	8	10	4	6
DML	6	2	***8***	1	7	2	5
WEST	6	6	***12***	3	9	1	8
TOTAL	***20***	***28***	***48***	***14***	***34***	***10***	***24***

Since September 2011, 48 staff have been rehired to provide critical and urgent service following the Government decision to allow such staff retire under the 'grace period' 28th February 2012. This is equivalent to 34 WTE's and of these 42.2 (29.9 WTE) are still in place with 8.8 finishing at the end of June. The majority are Medical Consultants.
The HSE are working to phase out reliance on retired staff and we intend to achieve this by the end of 2012.

Any request to employ retired staff needs the approval of the relevant Regional Director of Operations and will only be approved in very exceptional circumstances.

Primary Care Reimbursement Service (PCRS) –

Chapter 47 – sections 47.18 – 47.46 pp 633 – 638

Introduction

In the sections that follow where we have updated or commented on the chapter findings we have marked the chapter extracts and enclosed with borders and our updates follow each extract.

In addition at Appendix 1 and Appendix 1(a) please find attached PCRS Update Briefing Information

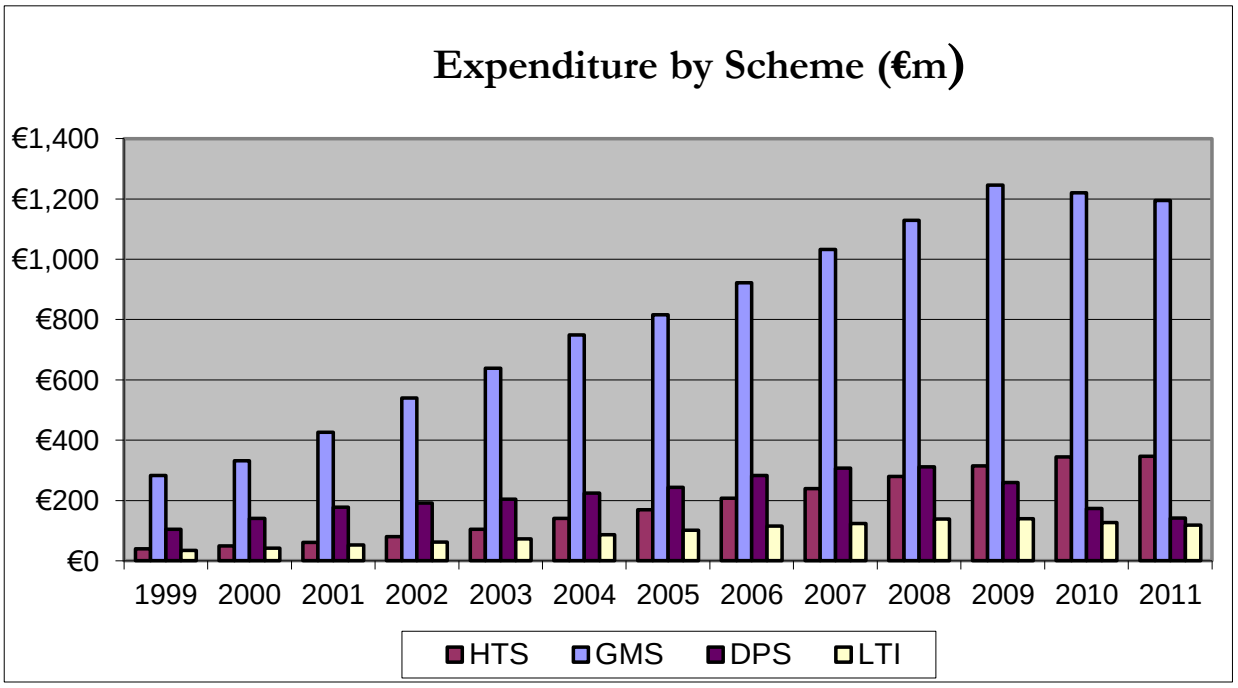
The PCRS manages a wide range of primary care services across 12 community health schemes, including the Medical Card Scheme, to a population of over 3.6 million people. These services are provided by more than 6,660 primary care contractors and involve 77.9 million transactions annually.

The expenditure outturn for 2011 was €2,517m delivering an overall reduction in expenditure in 2011 of €360m. The total budget for 2012 of €2.442bn is allocated to fund the estimated cost of community schemes this year, including the cost of additional Medical Cards and GP visit cards and the extension of GP visit cards to claimants under the long term illness (LTI) scheme as provided for in the *Programme for Government*.

In 2007, Eurostat reported that Irish pharmaceutical prices in 2005 were 19% in excess of the average of OECD EU25 countries. Between 2000 and 2009 average annual real growth in pharmaceutical expenditure in Ireland was 8.7%, (only exceeded by Greece - 11.1%), among OECD countries and significantly above the EU average. By 2009, the annual cost to the State of supplying medicines (including hospital medicines) exceeded €2.24 billion – a greater than six-fold increase had occurred over a decade. During the period (2000 – 2010), this was one of the fastest growing components of public expenditure. It increased by 158% in real terms and accounted for 12.9% of total public health expenditure.

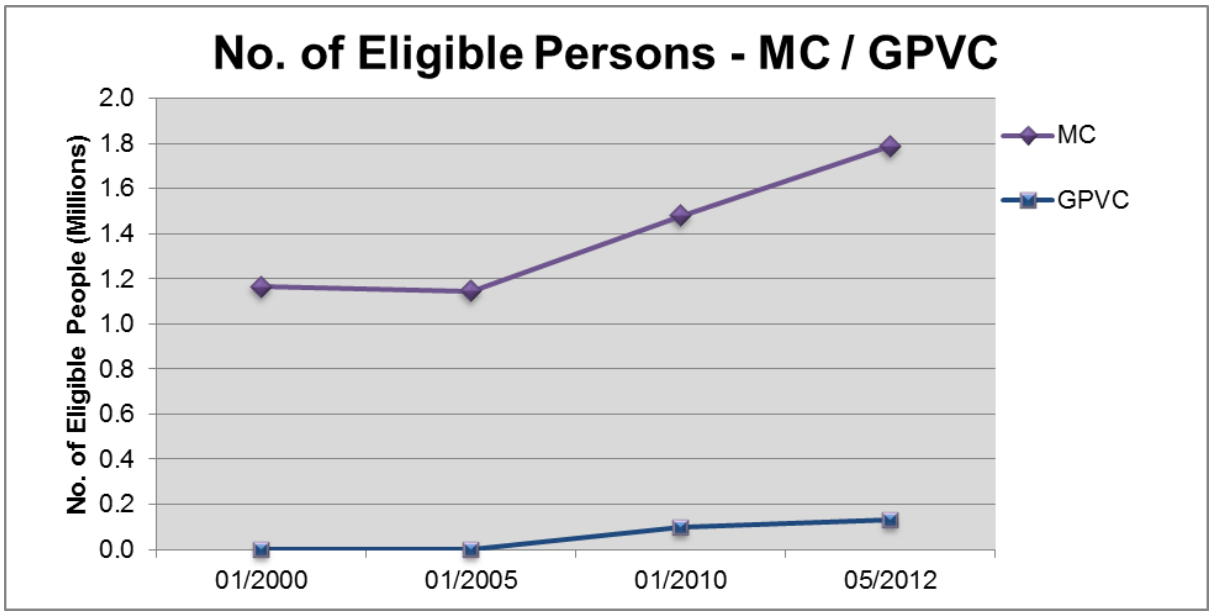
In recent years, a number of changes to the pricing and reimbursement regimes have been successfully introduced and a reversal of the upward trend was seen from 2009.

Graph 1 – Expenditure by Scheme 1999 – 2011



As of the 1 May 2012 there were 1,787,839 Medical Cards and 128,929 GP Visit Cards in circulation, an increase of 183,536 on the 1 January 2011 figure. When compared to 1 January 2005 there has been an increase of 771,685 cards in circulation, which is 67% more than the 2005 level.

Graph 2 – No of Eligible Persons – MC/GPVC



	Medical Cards	GP Visit Cards	Total
1/01/2005	1,145,083		1,145,083
1/01/2006	1,155,727	5,080	1,160,807
1/01/2007	1,221,695	51,760	1,273,455
1/01/2008	1,276,178	75,589	1,351,767
1/01/2009	1,352,120	85,546	1,437,666
1/01/2010	1,478,560	98,325	1,576,885
1/01/2011	1,615,809	117,423	1,733,232
1/01/2012	1,694,063	125,657	1,819,720
1/05/2012	1,787,839	128,929	1,916,768

Conclusion – Payments to Doctors and Pharmacists p636

Entitlement was not evidenced at the point that payments were made in 2010, in respect of

- €16 million in payments to pharmacists in cases where the patient's medical card had expired.
- €9.8 million paid in respect of prescriptions in instances where a medical card number was either missing or incorrectly recorded.

The HSE has recently agreed a protocol with the Irish Pharmacy Union for managing incomplete claims. The process involves paying the pharmacist but seeking to have the person subsequently regularise the medical card position. More refined information is desirable to pinpoint the categories of cases that give rise to these types of claims in order to address the matter in a systematic way.

The HSE made excess payments to GPs estimated at €1.48 million which were not recovered. Adjustments for deceased persons are not made from the date of death. The HSE stated that it foregoes this sum taking account of the fact that doctors do not claim for newborn children from birth. From a practical viewpoint, it should be possible for the doctor to notify the date a child is first attended so that the State is paying for a measured service that is actually delivered.

Information is not available on the number of persons on the Long Term Illness Scheme who also have medical cards. This hampers any monitoring of instructions to pharmacists to use the least costly scheme. The HSE has estimated that moving all Long Term Illness clients to the GMS scheme could result in savings. Again, more refined information would be necessary to position the State to evaluate this option.

The capture of PPSNs for all schemes would greatly increase the capacity to make evidence-based decisions and ensure that the services are operated in the most economic way

HSE Update

Pharmacy Claim Processing

The PCRS manages a wide range of primary care services across 12 community health schemes, including the Medical Card Scheme, to a population of over 3.6 million people. These services are provided by more than 6,660 primary care contractors and involve more that 77 million items/transactions annually.

In line with the administrative processes agreed in contractual discussions, Doctors and Pharmacists can submit claims for payment, in circumstances where a patient number is not available. This is a part of the original design of the supporting administrative systems. However, there are complementary controls in place, which provide assurance in relation to the substantiating documentation. Reference is made to one of the complementary controls in the Comptrollers report i.e. these claims are made on securely controlled GMS prescriptions.

In relation to the procedures to securely control GMS prescription forms; GMS prescription form base stock is maintained in a secure locked caged area, with security cameras and controlled access, and is maintained to ISO and PS9000 standards. When base stock is ordered for a named contracted GP each prescription form is printed with the name and identification details of the named GP and a unique reference number, which can be traced back to the batch of forms issued and the GP to which the forms are issued, is printed on each prescription form and recorded. A log is kept of every prescription produced for every GP in every batch. These are delivered by courier directly to the GP surgery, and signed for.

Each and every claim submitted for reimbursement is supported by a GMS prescription signed and stamped by the contracted General Practitioner (GP). There is no evidence that GP's are providing free consultations to every patient rather than collecting private fees in each case. In addition, Patients complain if charged inappropriately and, for example, have recently and publicly raised concerns where GP's have sought to charge for services such as Phlebotomy.

The HSE has implemented more advanced systems, which manage this issue and lend assurance that payees have entitlements to the amounts paid. Pharmacy systems are directly integrated into the PCRS systems such that eligibility is confirmed at the point of service. PCRS receive over 220,000 of these eligibility confirmations per day from pharmacies and other health service providers. If the patient is not eligible then the pharmacy system receives that information directly from PCRS in real time and relays the message to the pharmacist who in turn engages with the patient alerting him/her to the situation. This approach is akin to the payment card authorisation process whereby any retailer or service provider is assured of payment if they accept the card presented once authorised as opposed to a cash payment. This modern approach was not available at the time the Scheme was introduced and it serves to focus all stakeholders on the importance of holding and presenting a valid card number. This legacy issue is now resolved in agreement with the principal stakeholders i.e. General Practitioners and Pharmacists.

With the centralisation of Schemes into the PCRS the HSE has also put in place an Inspectorate Function. The inspection process is based on both risk analysis and an element of random selection targeted through PCRS generated 'outlier' reports i.e. those pharmacies who's claiming patterns appear to be outside the norms for the population it serves.

In addition, over the past two years the HSE have in a conjoint approach participated in more than 170 iinteragency inspections with the Pharmaceutical Society of Ireland and the Irish Medicines Board. These inspections have the potential to exert a significant deterrent effect on contractor behaviour. They reach a large number of contractors over a short period of time with significant impact from limited resources. To maximize effect on contractor behaviour, Inspections are a mix of 'two/three day' operations swamping an area and inspecting the majority of pharmacies in the county and 'one day' lightning strikes.

In relation to the expiry date on a card, it is important to note that the expiry date does not imply loss of eligibility; rather it is used to manage reviews of eligibility. For example, a Medical Card remains valid, irrespective of the expiry date shown on the card, once the Medical Card holder is genuinely engaging with the HSE review process. Eligibility can be confirmed by any Doctor or Pharmacist, or by the Medical Card holder online at www.medicalcard.ie or through the GP practice systems. This means that a person can continue to claim free drugs and GP services while they await a decision on their medical card renewal application, by simply using the medical card number.

The purpose of this approach is to recognise that there can be some vulnerable clients who are incapacitated or who cannot immediately appreciate the need to liaise with the HSE in relation to their eligibility and will require to continue to require access to their GP and medication while they are supported through the eligibility renewal process.

Our experience is that when medical cards expire, particularly in the current economic circumstances, the means of the eligible person have not changed to the extent that eligibility is not retained. It has also happened that when eligibility was confirmed the client received a new medical card number, however the contractor continues to quote the old medical card number. The HSE has now centralised the processing of medical cards to make the process of review more efficient and effective and to deal with legacy issues such as issuing new numbers to eligible persons following a review of their means and confirming their eligibility. The process of centralising medical cards was completed in July 2011.

In agreement with the Department of Health, and taking cognisance of the genesis of the arrangements in place, the HSE has successfully pursued an approach of working with the representative organisations of the Primary Care Contractors to put systems in place which would strengthen and enhance the existing controls. We now have comprehensive agreements with both the Irish Medical Organisation (IMO) and the Irish Pharmacy Union (IPU) to strengthen the controls in place in relation to these issues. The clear evidence is that these controls are operating satisfactorily.

General Practitioner Payments p635

47.27 Unrecovered overpayments of €1.48 million were made to General Practitioners (GPs) due to a time delay between the death of an individual and the amendment of the monthly capitation payment to the GP. These payments are not retrospectively adjusted.

47.28 In response to my enquiries the Accounting Officer stated that GPs maintain that the

underpayment due to them in respect of delays in adding newborn babies to the register, clients who lose eligibility for a period and delays in client registration at local office level, would account for a greater amount annually.

47.29 He stated that automatically recouping capitation payments from the date of death is problematic given the arguments advanced by GPs and that this issue can only be resolved in the context of an equally robust solution for underpayments associated with births.

47.30 He stated that the list of eligible medical cardholders can only be maintained with the assistance of all stakeholders and users of the list and that for the first time ever in 2011, following agreement in that regard, GPs will be directly involved and committed to list maintenance with the HSE.

47.31 He outlined the recent changes implemented by the HSE, in particular, centralisation of medical processing in a single location. Since centralisation, PCRS has put in place, for the first time, systematic processing of death information based on the Death Event Publication Service (DEPS) which is received on a weekly basis by PCRS from the Department of Social Protection. Where the notification is complete, eligibility is removed immediately upon receipt. Prior to the monthly pay run of GP capitation all DEPS data are compared against the HSE records of clients with existing eligibility.

47.32 He stated that in 2010 PCRS received 21,415 DEPS notifications which matched to clients with existing eligibility and all were removed immediately. However, due to the lag between actual death and the DEPS publication, he stated that capitation was paid in respect of 62,221 capitation months in total and based on an average monthly capitation rate of approximately €23.26 the total payment concerned is approximately €1.48 million.

HSE Update

General Practitioner Payments

Following concerns, over many years, HSE and the Department of Health decided, that fundamental change in the administration of the Medical Card Scheme was required. Therefore, it was decided to centralise the processing of medical card applications in a single office as opposed to administration across 100 locations.

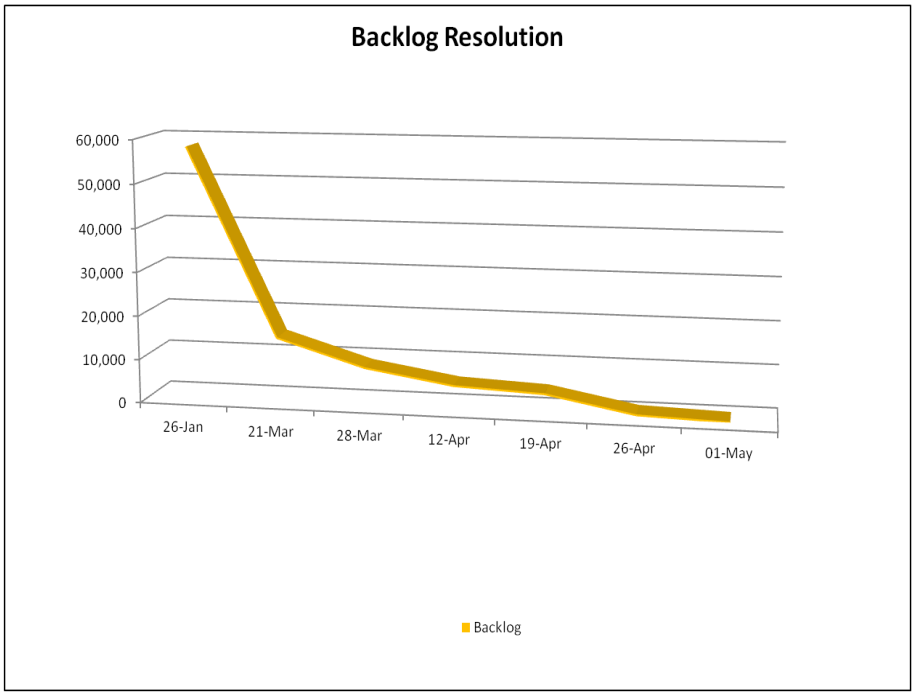
A major change programme was initiated, planned and developed by the HSE to centralise medical card processing in PCRS. The purpose of the centralisation project was to;

- Provide for a single uniform system of medical card application processing
- Streamline work processes and the staffing involved in medical card processing.
- Ensure a far more accountable and better managed medical card processing system.

During the first 6 months after centralisation, a considerable backlog in processing applications accumulated. This caused regrettable difficulties for applicants and resulted in public criticism of the HSE. Since that time, a planned review, supported by Price Waterhouse Coopers (PWC) of the first six months of the centralised operation has been carried out. One of first actions of the Review was to address this backlog.

This work has now been completed and the backlog cleared which was 57,000 in January 2012 is not cleared at zero on 30 April 2012.

Graph 3



The completion of centralisation of the medical card scheme on 1 July 2011 brought control and management of the register of patients into a single place and allowed for the cessation of the multiple data flows from health regions by which medical card data had been maintained for some decades.

These changes in administration facilitated implementation for the first time of the systematic processing of death information received from the Death Event Publication Service (DEPS).

Death events notifications (DEPS) are received by PCRS from the Department of Finance CMOD section on a weekly basis and loaded to the PCRS payment systems. Where the notification is complete, medical card eligibility is removed immediately. Prior to the execution of GP capitation payments on a monthly basis all DEPS are matched to clients where there is existing eligibility. Existing eligibility is removed immediately such that there is no overpayment following notification in these cases.

The matter of collecting any excess payment to GP's due to the time delay between the death of an individual and the amendment of the monthly capitation payment to the GP has been successfully resolved to the benefit of the taxpayer. In fact, since the processing of medical card was centralised from July 2011 the HSE has recouped €344,791.50 automatically as part of each end of month process in respect of death events.

DEPS notifications are not issued by the Department of Finance on the date of death but rather when best efforts have been made by them to complete the data set for publication. In 2010 PCRS received 21,415 DEPS notifications which matched to clients with existing eligibility. All of these notifications were removed immediately with zero overpayment between receipt of notification and cessation of the payment of capitation.

The automatic processing of death events which includes the removal of eligibility, calculation and recoupment of any capitation fees and the reporting of these financial transactions to the necessary level of transparency with the minimum of human intervention involved a significant level of complexity.

The Comptroller raised the issue of the outstanding legacy issue associated with the pre-centralised manual methods of death processing. The GP Capitation Contract provides that capitation fees shall be paid not later than 15th day of each month, in respect of each eligible person on the medical practitioner's panel on the first of each month. The capitation system required an understanding that deaths which occur on the second and subsequent days in the month would be offset by births which occur on the second and subsequent days in the month.

The list of eligible cardholders can only be maintained with the assistance of all stakeholders and users of the list. Centralisation of the medical card scheme facilitated an agreement for GP involvement in direct maintenance of the register to add babies at birth and to remove eligibility upon death. For the first time ever, GPs are actively, transparently and directly involved and committed to list maintenance with the HSE.

This development and the body of work building a foundation of single systems, single systematic reporting and full transparency for GPs which was required to get to a place where their direct assistance with management of the register could be agreed should not be underestimated. Centralisation has facilitated the resolution of this problem, which has existed for longer than a decade. Systematic processing of births and deaths is now in place in a robust, transparent way. PCRS have also been actively working with the Department of Health who have taken a lead role to facilitate the exchange of data between the Departments and Agencies. The development of an agreed interface between the PCRS and the Department of Social Protection (DSP) and Revenue as an additional validation is progressing.

In relation to the outstanding legacy issued raised by the Comptroller, the HSE has completed an analysis in respect of all old cases of a time delay between the death of an individual and the DEPS notification. Table A below, records the results of this analysis and the amounts to be recouped following consultation with GPs.

The data produced as part of this analysis work lends itself to the production of detailed statements per GP indicating the amounts to be recouped. These statements will be required to provide sufficient transparency to GPs as the issue is closed. This detailed work involves analysis over tens of millions of rows of data and therefore the rigorous testing required prior to issuing detailed statements to GPs is underway.

Table A.

Year	Deaths € Amount to be Recouped
2005	18,460.38
2006	43,932.31
2007	98,725.97
2008	504,319.25
2009	670,141.56
2010	1,074,229.87
2011	685,370.96
2012	0.00
Total	€3,095,180.30

The amount of €3,095,180.30 to be recouped is based on eligibility existing after the date of death until the death was notified to PCRS and the eligibility was removed. PCRS first received DEPS files Mid-2008 but these files contained dates of death prior to that time.

As outlined, the capitation system required an understanding that deaths which occur on the second and subsequent days in the month would be offset by births which occur on the second and subsequent days in the month. GP's provide a service to these babies and they maintain that the underpayment of €2,807,576.04 in respect of delays in adding new born babies to the register are also due. Table B below records the amounts to be reimbursed to GP's.

Table B.

Year	Birth € Amounts to be Reimbursed
2005	233,004.80
2006	269,756.70
2007	356,197.47
2008	418,943.24
2009	472,889.81
2010	500,202.94
2011	433,468.40
2012	123,112.68
Total	€2,807,576.04

Arrangements will be put in place to give effect to the reimbursements and recoupments

Scheme Overlaps p 636

47.33 There are overlaps in the populations entitled to free pharmacy services under the GMS and the Long Term Illness (LTI) schemes. The cost of medicine from the LTI is dearer 380.

47.34 The HSE issued an instruction to pharmacists in mid-2010 reminding them that it was not appropriate to submit claims under the LTI scheme where a patient holds a medical card.

47.35 However, the HSE's capacity to track the implementation of this instruction is limited due to data deficiencies. In relation to the number of persons on the Long Term Illness Scheme that also had medical cards, the Accounting Officer stated that the information could not be provided as PPSNs are not recorded for all LTI clients and cannot be cross referenced against the Medical Card register 381.

47.36 With regard to the steps being taken to populate the HSE data records with PPSN information for all medical card holders he stated that the HSE is addressing what is a relatively small number of legacy medical cards still not associated with a PPSN.

380 The Accounting Officer stated that moving all LTI clients to the GMS Scheme could result in annual savings of approximately €6 million, i.e. €21 million savings of retail mark up that is not applicable on the GMS scheme would be saved which would be offset by €15 million of the GP element of the Medical Card. However, in such a case, the issue of the reimbursable list of products would also need to be addressed since certain items approved for LTI patients are not on the GMS list.

381 *The Medical Card register is itself missing approximately 6,700 PPSNs at April 2011.*

HSE Update

Long Term Illness Scheme

There are overlaps in the populations entitled to free pharmacy services under the GMS and the Long Term Illness (LTI) schemes and the Comptroller & Auditor General has identified a feature of the design of the Schemes. There are currently approximately 60,000 active long term Illness cards. The Government has committed to reforming the current public health system by introducing Universal Health Insurance with equal access to care for all. In line with this programme, the Government has given its approval to the preparation of Heads of a Bill to progress the phased introduction of free GP care. This Bill will give enabling powers to the Minister to extend GP Visit Card eligibility. Initially it is intended to extend GP cover without fees to persons with defined long-term illnesses who are in receipt of drugs and medicines under the Long Term Illness Scheme and the Government has allocated €15m to this programme in 2012. This new arrangement will provide full visibility to allow all dispensing to be tracked. It is intended that LTI cards will be replaced with a GP visit cards.

Pharmacists were reminded in a circular (16/10) in July 2010 that notwithstanding any request that may be made by the patient, where a patient holds GMS eligibility, this eligibility must be used when dispensing a product which is on the List of GMS Reimbursable Items for an LTI patient.

Conclusion – Dental Schemes p638

Given the potential for dual reimbursement by the HSE and Department of Social Protection for dental treatment to patients under the Dental Treatment Services Scheme and the Dental Treatment Benefit Scheme, if two separate schemes are to continue, there would be merit in more regular data-matching of the records of the two bodies and greater use of computer assisted checks in mitigating the risk.

A 2009 report concluded that probity levels had decreased since 2007 which infers a greater risk of overpayment.

The HSE circularises a small sample of patients each month in order to verify that the treatment, which the State has paid for, has been received.

In view of the small sample, and the inherent risk noted in probity reviews it would be prudent to increase the sample size and review a greater number of claims and introduce a procedure to independently validate the treatment in the cases sampled.

HSE Update

Dental Treatment Services Scheme (DTSS)

It is estimated that approximately 40% of adult medical card holders have dual eligibility for dental treatment as they are also covered under the Social Protection Dental Treatment Benefits Scheme (DTBS).

This cohort of patients can therefore gain access to treatment under the DTSS which offers certain free treatments to patients in emergency/high risk cases. They can also gain access to the DTBS.

The possibility existed for duplicate claims to be made for the same item of treatment, where reimbursed by both schemes. However the DTBS has been restricted to a free dental examination only.

In Budget 2010 the Government decided to limit expenditure under the Dental Treatment Services Scheme (DTSS). The HSE implemented this government decision and prioritised the range of treatments available under the Scheme to provide emergency dental care.

These measures were introduced to protect access to emergency dental care for medical card holders and to safeguard services for children and special needs groups. Services for high-risk patients and those requiring exceptional care continue to be available. The remaining care provision is subject to prior approval, which will be required from a clinician in the HSE, who prioritises for:

- High risk and exceptional patients,
- Those requiring emergency care, and
- Patients who are considered to have greater clinical urgency and/or necessity in receiving care.

The treatment of disease and infection are determined primarily by clinicians. Where prior approval is required for the treatment, the HSE Principal Dental Surgeons apply their clinical judgment to determine, in the circumstances, whether or not there is a clinical emergency, and whether or not treatment should therefore be approved.

These changes limit the services that can be provided under to DTSS without prior clinical approval. Apart from these changes being an exercise of financial control, the effect of the implementation of the Circular introduced a much tighter regime in relation to approvals and strengthened the controls around the Scheme.

In relation to the Dental Treatment Benefits Scheme (DTBS), following budget 2010, the services available under this Scheme have been so altered as to significantly reduce the risk of any duplicate payments being made by the Department of Social Protection.

The DTSS operates mainly on a transactional basis in line with a national contract and what it permits. PCRS has financial controls in place and validates that the scheme is being implemented as agreed. Prior to each monthly payment the records are verified to ensure there are no duplicate claims for the same patient with the same form number and claim date.

The HSE has also appointed a National Oral Health Lead to progress the planning and delivery of quality Oral Health services driven by national standards. One of the Oral health Lead's roles is the implementation of the recommendations contained within the 'Strategic Review of the Delivery and Management of HSE Dental Services' which includes development of an Inspectorate. This Inspectorate is now in place and 4 Inspectors have been appointed.

Treatment of Private Patients in Public Hospitals Chapter 47 - section 47.47 – 47.67

47.47 Public hospitals accommodate a quota of private patients. In the case of private patients, fees are payable to their medical consultant in respect of their treatment while, in certain cases, maintenance

charges are payable in respect of their accommodation.

47.48 The capacity of a public hospital to bill a private patient that is accommodated by it while being treated on a private basis is restricted in a number of ways

- the hospitals can only charge for private patients who are accommodated in a designated private bed – patients in public or non-designated beds are not chargeable

- where a patient with private health insurance is admitted to hospital by a Category A consultant, notwithstanding the fact that the patient is accommodated in a designated private bed, the patient is treated as a public patient even if care is subsequently provided in whole or in part by non-Category A consultants[1].

47.49 Information relating to in-patient private and public bed usage in 23 hospitals for 2010 was

examined and compared to 2008 which was the last time the matter was reviewed[2]. Data is not available for some of the larger hospitals and certain smaller hospitals because they do not as yet have systems in place to capture bed occupancy by type of patient. The results are set out in Figure 186.

Figure 1 Comparison of Bed Occupancy in 2008 and 2010[a]

	Public Patients			Private Patients		
	2008	2010	2011	2008	2010	2011
Patient Designation	1,299,509	1,322,022	1,302,919	405,076	368,261	346,366
Patient Accommodation						
Public Beds	1,136,657	1,146,753	1,127,662	181,960	143,392	121,813
Private Beds	81,283	85,720	86,565	201,951	201,742	204,018
Non-designated Beds	81,569	89,549	88,692	21,165	23,127	20,535

Source: Health Service Executive

Notes: a The figures represent the number of bed days in each category

b The results excludes Monaghan, Tallaght and Portiuncula Hospitals as data in respect of both periods was not available for those hospitals. Portiuncula and Tallaght generated 84% and 66% respectively in income from private patients treated in private beds in 2010.

47.50 Around 30% of designated private beds were not used to accommodate chargeable private patients in 2008 and 2010. Within the funding arrangements agreed with health insurers, if this pattern was replicated across the system, it would represent a foregoing of a potential income of around €137 million

[1] The introduction of the new consultant contract provided that certain consultants do not have any private practice in public hospitals (Category A consultants).

[2] See Chapter 37 of the 2008 Report of the Comptroller and Auditor General on the Accounts of the Public Services.

HSE update

The 2011 number is estimated at €167m. This higher value is due to the increase in bed charges of 21% that were introduced on the 1st January 2011.

47.51 Overall, 45% (41% in 2011) of private in-patients who are accommodated in the 23 public hospitals reviewed and who are treated privately by their consultants are not charged for their maintenance.

47.52 In response to my enquiries in relation to the management of beds, the Accounting Officer stated that during 2011 there has been a significant focus on bed utilisation across hospitals and on the increased necessity to generate and collect income. The HSE is currently gathering more detailed data on private bed utilisation and the potential for transfer of existing bed designations between hospitals and expects to have this information available by Autumn 2011. This will supplement information on bed days that has already been gathered by it.

47.53 He stated that the HSE has been in discussion with the Department of Health as it is acknowledged that it is a function of the Minister to determine policy in relation to the overall level of private patient capacity in public hospitals. The HSE has made proposals that would lead to a significant improvement in the practical management of hospitals and support the provision of public care by the HSE. These would entail

- agreeing a process for the review and amendment of bed designations on a six monthly basis – this is particularly relevant in the context of hospital reconfiguration
- changing the regulations to allow a move away from specific bed designation to general designation[3]
- updating private bed designations to reflect the shift from in-patient to day case work.

47.54 The re-designation of beds within and between hospitals in Dublin North East was approved by the Minister for Health in July 2011 and further approvals have since been given in respect of the Dublin Mid Leinster region. Similar proposals for HSE South and HSE West are being prepared for submission to the Minister. The HSE has met with the Heads of Finance and the Clinical Directors of all HSE-funded acute hospitals and has stressed the importance of improving bed management.

HSE Update

A proposal for HSE South has been submitted to the Department of Health for consideration and with the proposed d evelopment of Hospital Trusts in Galway and Limerick proposals will be made for the optimum designation in the region.

47.55 In regard to a process for the timely management of maintenance claims, the HSE intends to

submit a business case to the Department of Health seeking approval for a Health Insurance Claims andInformation System. This system will assist hospitals to manage their private income by providing real

time bed occupancy information.

[3] For example where a hospital has 100 beds – permitting any 20 beds to be utilised as private. Such a change would reduce the need to re-locate patients after admission simply for the purposes of managing private throughput.

HSE Update

The HSE has concluded the tender process for the implementation of a Health Insurance Management System and work has commenced on the initial tranche of sites which are expected to go live in July 2012. This system will assist hospitals to manage the accommodation of patients in the appropriately designated bed.

47.56 He also stated that the recent establishment of a Special Delivery Unit in the Department and the focus on bed management will also contribute to this work in the short-term.

Conclusion – Treatment of Private Patients in Public Hospitals

Overall, 45% (41% in 2011) of inpatients treated privately by their consultants (in the 23 hospitals reviewed) were not charged for their maintenance costs.

Based on information available from those hospitals up to €137 million (€167m in 2011) in income is foregone in respect of designated private beds not used to accommodate this category of patient. While the practical management of hospitals necessarily requires that beds designated as private be available to address infection control and other medical issues there appears to be scope to improve revenue generation through improved bed management.

The HSE has recently received the approval of the Minister for Health for the re-designation of beds

within and between hospitals in a number of regions in order to maximise the utilisation of facilities

designated for private use and thereby optimise hospital income. Proposals for other regions are currently being prepared for approval.

There are information gaps in that in-patient private and public bed usage was only available for 23 hospitals since some do not as yet have systems in place to capture bed occupancy by type of patient.

HSE Update

The twin objectives of ensuring equitable access for patients and optimising the recovery of the cost of maintenance of all privately treated patients are difficult to achieve simultaneously within the present system. The Health Service (Inpatient) Regulations which were introduced pursuant to the Health (Amendment) Act, 1991 state that a hospital providing services under Sections 52 and 55 of the Health Act, 1970 shall designate every bed as a designated public or a designated private bed, subject to the direction and approval of the Minister. While hospitals make every effort to ensure that private patients are accommodated in designated private and semi private accommodation, a range of issues can affect the hospitals ability to do so on a daily basis. Examples include:-

- **Isolation Policies** – The overriding consideration in the treatment of any patient is the appropriate clinical care and, in some instances, whatever the patient's designation, the appropriate clinical care demands isolation in a single room, particularly in the case of Infection Control patients. Please see detailed rationale in specific section hereunder.
- **Medical Reasons** - patients may be placed in particular beds for medical or observation reasons.
- **Bed Availability** - The relationship between the number of private beds available and the flow of private patients in not linear. There is no control as to when private patients will present for emergency admission. There will be times when there is an excess of private patients available to be moved into a private or semi private bed but equally there will be times when no private patient is available to be moved into a private or semi private room.
- **Emergency Admissions** – sometimes a patient is placed in whatever bed is available, regardless of their public/private status. The frequent outcome of this is that patients will refuse to move if they have been in a particular bed and have settled there.

- **Historical / Socio Economic Issues** – The ratio of private beds to public beds is not uniform across hospitals and the percentage of private beds can range from a low of 10% (e.g. The Mater) to a high of 40% (e.g. Portiuncula). Flexibility in the management of bed designation would allow the HSE to manage the mix so as to improve income generation whilst maintaining equitable access.
- **Gender Issues** - it may be necessary to accommodate a male patient on a female ward in which case every effort is made to accommodate the patient in a private room.
- **Non Designated Beds** – Intensive Care Units, Coronary Care Units and other specialised beds are non designated which means that the HSE are not allowed to charge private fees to private patients accommodated in these beds.
- **End of Life** - Privacy issue.

The HSE are awaiting the proposed change to the legislation as outlined in Budget 2012 that will ultimately abolish the existing system of designated private/public beds and to allow hospitals to raise charges in respect of all private patients.

Infection Control – Detailed Rationale behind the necessity to prioritise these beds for infection prevention and control purposes

Two sets of standards are used to care for patients:

A) All patients are cared for using a set of standards called 'Standard Precautions'. These assume that any patient may have a transmissible infection that may not have been diagnosed and this approach provides a basic set of measures for all patients at all times. Standard Precautions include hand hygiene, cleaning and decontamination of patient care equipment and environmental cleaning. All HSE staff use Standard Precautions when caring for patients irrespective of the healthcare setting.

B) An additional set of standards called 'Transmission-based Precautions' is required from time to time. This occurs if a patient has a suspected or confirmed infection, such as TB or *Clostridium difficile* or is carrying a multi-drug resistant microbe, such as MRSA. A key component of transmission-based precautions is the need to care for the patient in a single room (isolation room) to protect other patients and staff from acquiring that infection or multi-drug resistant microbe. National guidelines [1-3] recommend when single rooms should be used to care for patients. National building guidelines[4] recommend 100% single rooms when designing and constructing any new acute hospital even if our current hospital infrastructure in terms of availability of single rooms is currently well below this standard. From time to time the demand for single rooms for isolation purposes outnumbers availability. While for some patients (e.g., patients colonized with MRSA) options such as cohorting, i.e. grouping similar patients together for infection control purposes, are available and acceptable, for others (e.g., patients with TB or *C. difficile)* cohorting is not a safe option and patients must be cared for in single rooms for the reasons outlined above. In these instances, if single (private) rooms are available and the number of patients requiring them outweighs the number of public single rooms, the HSE must prioritise these for isolation purposes to provide safe patient care.

1. Strategy for the Control of Antimicrobial Resistance in Ireland (SARI). The Control and Prevention of MRSA in Hospitals and the Community. September 2005. HSE-Health Protection Surveillance Centre. ISBN: 0-9540177-7-3

2. HSE-Health Protection Surveillance Centre. Surveillance, Diagnosis and Management of *Clostridium difficile* – associated disease in Ireland. May 2008. ISBN 978-0-9551236-3-4

3. HSE-Health Protection Surveillance Centre. Guidelines on the Prevention of Tuberculosis in Ireland. ISBN: 978-0-9551236-5-8

4. Strategy for the Control of Antimicrobial Resistance in Ireland (SARI). Infection Prevention and Control Building guidelines for Acute Hospitals in Ireland. HSE-Health Protection Surveillance Centre. December 2008.

Performance Information

47.60 In respect of 2010 the audit found that

- The activity levels for the defined categories of work are being achieved in the cases examined. However, because funding is not definitively linked to activity due to the incremental development of budget allocations over the years it is not readily possible to determine whether resources and output are properly aligned.
- From a performance reporting viewpoint, a drawback is that only seven of the 16 voluntary hospitals report on the HealthStat system. In respect of those that report using the dashboard[392] system three of the seven were classified in March 2011 as being in the red zone from a resource utilisation viewpoint and four were categorised as amber[393]. Results for resource utilisation were not compiled in respect of the remaining nine hospitals[394].
- Overall, the 16 voluntary hospitals were exceeding their employment ceilings by 1.6% at March 2011. Three hospitals were more than 5% in excess of their ceilings. The reported employment figures do not include nursebank resources[395].

HSE Update

HealthStat

1. In March 2012, within the voluntary hospitals sector, 3 hospitals were classified in the red zone and 4 as amber on the HealthStat dashboards. This is the same number as in 2012, although a different mix of hospitals. The C&AG report suggested that all 16 of the voluntary hospitals should be included in HealthStat. The HSE management comment is that the 33 hospitals (increased from 29), for which dashboards have been developed, are the largest hospitals. The remaining small number of hospitals not covered by HealthStat dashboards, which includes a number of the voluntary hospitals referred to by the C&AG, are much smaller services which in time will link to the larger hospitals as part of the evolving hospital groups. Their performance then will be monitored as part of the whole hospital group performance. In the interim their performance continues to be monitored using traditional data but not using HealthStat dashboards. The HSE is currently working on the next iteration of our performance improvement tool.

2. Overall the 16 voluntary hospitals were exceeding their employment ceilings by 3.3% at March 2012. Four hospitals were more than 5% in excess of their ceilings. The March 2012 figures include nurse bank figures for which a ceiling uplift has not been provided. Hospitals will have to continue to reduce their employment levels in line with the Employment Control Framework.

Performance Information relating to Nurse Bank

Nurse Bank figures are now integrated into and returned in the main Health Service Personnel Census (HSPC) since the end of 2011. The DATHs Nurse Banks have been in place since 2006 and even though these staff were on pay roll prior to the end of 2011, there was no corresponding adjustment made to the overall approved employment ceiling of the health services or to the targeted reductions set for it.

Accordingly their inclusion in the HSPC at the end of 2011 absorbed a significant portion of the under ceiling variance at that time. This matter is still the subject of engagement with both the Department of Health and Department of Public Expenditure and Reform.

We have maintained a reporting capability to show Nurse Bank WTEs across the five Dublin Academic Teaching Hospitals that continue to operate a Nurse Bank.
Please see Table 5 below showing the situation since the end of 2011 with commentary, as at the end of May:

Table 5

Hospital	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12
Beaumont Hospital	91.76	85.32	93.76	87.83	78.31	75.3
Mater Hospital	116.79	118.58	114.19	107.38	102.17	110.5
AMNCH	87.93	73.74	67.06	54.19	49.21	49.43
St James's Hospital	65.21	62.53	57.79	60.77	57.76	51.38
St Vincent's Hospital	8.4	10.78	13.73	8.4	8.61	6.53
Total	**370.09**	**350.95**	**346.53**	**318.57**	**296.06**	**293.14**

The DATHs have indicated that the operation of the Nurse Banks has resulted in net savings of the order of €8.5 million over the period 2008/2010 and ongoing annual savings of the order of €4.5 million. The proven benefits of establishing nursing banks within the DATHs include:

- Organisations have control over the quality and competency of staff that they employ,
- Provision of a centralised process thereby relieving senior nurse managers of the need to spend valuable time liaising with the Nursing Agencies,
- Use of a consistent operational policy and principles have been agreed and is used by the organisations,
- The costs are cheaper than paying overtime or agency staffing to cover critical service needs

In patient Discharges

In 2012, Patient Discharges were 3% above the planned activity level in the case of inpatients and day case activity 1% above planned levels. This compares to figures of 13% and 5% for the year reviewed by the C%AG and demonstrates much tighter control on activity exercised at individual hospitals level in order to deliver within available budgets in 2011. The updated figures for 2011 are contained in *Table 6* below. Outpatient information is not available for 2011 as the collection of the data was suspended as a new system was introduced however this recommenced in 2012 and the information for Q1 2012 is provided in *Table 7* on page 37.

Table 6 - Activity for Voluntary Hospitals in 2011

Voluntary Hospital	Inpatient Discharges		Day Cases		Outpatient attendances*		Emergency Departments	
	Planned	Actual	Planned	Actual			Attendances	Admissions
Tallaght Hospital	23,682	25,074	33,958	33,472			72,995	17,764
Coombe Women and Infants University Hospital	18,583	19,453	18,058	20,354			-	-
National Maternity Hospital Holles Street	19,342	17,779	3,240	4,098			-	-
Royal Victoria Eye and Ear Hospital Dublin	2,292	2,415	5,745	7,251			34,119	675
St. James's Hospital	24,056	25,153	96,075	93,552			45,760	14,723
St. Michael's Hospital Dun Laoghaire	2,350	2,579	5,412	5,803			13,704	1,385
St. Vincent's University Hospital Elm Park	14,449	14,631	53,247	52,395			40,106	8,287
Our Lady's Hospital for Sick Children Crumlin	10,258	9,841	16,685	18,287			33,980	4,114
Children's University Hospital Temple Street	7,447	8,103	5,069	7,081			46,309	4,415
Beaumont Hospital	21,004	21,890	47,519	46,121			49,337	11,552
Cappagh National Orthopaedic Hospital	2,333	2,195	8,839	9,041			-	-
Mater Misericordiae University Hospital	15,230	16,802	39,470	39,006			48,348	10,163
Rotunda Hospital	15,803	17,030	3,395	3,645			-	-
Mercy University Hospital Cork	8,851	9,541	19,264	18,875			26,639	5,429
South Infirmary University Hospital Cork	8,370	8,138	16,214	16,576			18,724	3,206
St. John's Hospital Limerick	3,903	3,892	6,619	7,754			15,492	2,049
Total	**197,953**	**204,516**	**378,809**	**383,311**			**445,513**	**83,762**

* the outpatient data system was updated in 2011 and is not comparable to 2010 figures. A separate table is presented with attendances for Q1 1012.

Table 7 - Outpatient attendances first Quarter 2012*

Hospital	Actual
Tallaght	47,588
Royal Victoria Eye and Ear	10,315
St James's	50,138
St Michael's	5,367
St Vincent's	30,830
Crumlin	16,069
Temple St	13,818
Beaumont*	37,173
Cappagh	1,573
Mater*	31,267
Mercy	8,271
South Infirmary	14,352
St John's	2,452

***Outpatients Note**

The Outpatient Data Quality Programme was introduced in hospitals on 1st January 2011. This Programme has fundamentally altered and improved the capture and reporting of all activity relating to Outpatients services. Significant business process and IT changes were required in all hospitals to implement the roll-out of the reformed minimum data set and metrics. For the first time, GP Referral data is now collected and reported by specialty along with the time taken by Consultants to triage Referrals.

Attendance data has been more carefully defined to ensure correct reporting of activity across all sites. Waiting lists and waiting times are now reported in standardised time bands.

Conclusion: Management Comment

Management welcomes the C&AG comment that reasonable systems are in place to monitor the financial and operational performance of the voluntary hospitals system. The hospitals continue to work with the HSE on the provision of activity, waiting list, HR and finance data and take part in regular performance monitoring sessions with the Regional Directors of Operations and HealthStat which reviews all aspects of performance: quality, budget, employment controls and activity.

The HSE treasury unit monitors cash balances in the major voluntary agencies funded by it and factors this into the cash provision to voluntary agencies.