Chapter 47

Management of the HSE Vote

Vote 40 Health Service Executive

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.

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[375] The formal transfer will be completed at 1 October 2011.

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.

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.

Primary Care Reimbursement Service

47.18 The HSE's Primary Care Reimbursement Service (PCRS) administers a number of schemes providing free or reduced cost health services to the public at a cost of over €2.5 billion in 2010 including €1.9 billion paid for pharmaceutical services and fees and allowances of €572 million paid to doctors and dentists.

47.19 Health providers are reimbursed from PCRS in respect of a number of schemes which include

- the General Medical Services (GMS) scheme where persons with lower income or aged over 70 can obtain without charge general practitioner medical and surgical services together with prescribed medicines and appliances dispensed through retail pharmacies[379]
- the Drugs Payment Scheme (DPS) where persons without medical cards pay no more than a specified monthly threshold for approved medicines and appliances
- the Long Term Illness Scheme (LTI) where persons suffering from one or more specified illnesses obtain necessary medicines and appliances without charge and irrespective of their income
- the Dental Treatment Service Scheme (DTSS) for GMS eligible adults who can access certain dental treatments, clinical procedures and a range of prescribed medicines
- High Tech Drugs supplied by the HSE and dispensed through community pharmacies to patients usually for hospital prescribed or initiated medicines such as anti-rejection drugs for transplant patients or medicines used in conjunction with chemotherapy
- the HSE Community Ophthalmic Services Scheme which provides spectacles and appliances for adult medical cardholders and their dependents.

[379] Where a pharmacy has an agreement with the Health Service Executive to dispense GMS prescriptions.

Pharmacy Claim Processing

47.20 A review of the medical card and GMS database records for 2010 noted instances where the HSE does not hold complete and up to date information in relation to persons on behalf of whom payments were made, in particular

- €9.8 million had been paid in 2010 in respect of medical prescriptions where the medical card number was not recorded or was incorrectly recorded on the claim
- a further €16 million was paid in cases where the medical card had expired.

47.21 In relation to how the HSE validated the chargeability of payments to the Vote in respect of prescriptions in circumstances where a medical card number was invalid or incomplete, the Accounting Officer stated that prescription claims are issued on securely controlled GMS prescriptions and that every claim is supported by a GMS prescription signed and stamped by the contracted GP.

47.22 He stated that the following procedures are in place to securely control blank prescription forms in their printing, safekeeping and distribution

- Each GMS prescription form is printed with the name and identification details of the contracted GP and a unique reference number, which can be traced back to the batch of forms issued to the GP.
- The base stock of GMS prescription forms is securely maintained with security cameras and controlled access.
- A log is kept of every batch of forms and stocks of forms are delivered by courier directly to the GP surgery and signed for.

47.23 He stated that to reduce the level of incomplete claims to the minimum consistent with immediate patient need the HSE reached agreement in November 2010 with the Irish Pharmacy Union on a protocol for managing incomplete claims. This provided for the following

- The HSE will work with other healthcare professionals to ensure that the majority of prescriptions being presented at pharmacies contain accurate patient and other details.
- While the HSE has responsibility for determining the eligibility of all patients, the pharmacy contract provides that the pharmacy contractor shall supply, with reasonable promptness, to any GMS eligible person, or other person authorised to act on his or her behalf, who presents a properly completed prescription form signed by a practitioner.
- Notwithstanding this, where a prescription claim is presented to the HSE and it is not satisfied as to the accuracy of the details on the form, the HSE will pay the claim and notify the pharmacist that the eligibility or identity of the patient is not clear.
- The claim in question will be reported on the Pharmacy's Detailed Payment Listing to alert the pharmacist to the fact that the eligibility or identity of the patient is not clear.
- The HSE will also provide a letter for the pharmacist to hand to each individual patient or their carer at the next visit to the pharmacy advising them of the position.
- The pharmacist will then inform the patient of the need to regularise their medical card registration in order to continue to access the item(s) under the Medical Card Scheme and advise the patient to contact the local HSE office to resolve the matter when the patient or their agent next visits the pharmacy.
- The patient will be assisted to do this by the HSE Local Health Office and the PCRS and, where necessary, the HSE will write directly to the patient.

- The PCRS will also alert the GP to the need to regularise the patient's medical card registration and also ask the GP to advise the patient on the next visit to the surgery to contact the local HSE office or HSE.
- The HSE will ensure that its administration and records are kept up to date on a timely basis and that there is consistency of administration, records and procedures across all parts of the HSE.

47.24 The Accounting Officer stated that the HSE has been implementing the protocol for claims made with effect from January 2011 and has been reporting to pharmacies on a monthly basis alerting them to incomplete cases defined under the protocol. In line with the protocol, all incomplete claims submitted by a pharmacy will be paid as long as the level of incomplete claims continues to decrease.

47.25 In relation to payments continuing to be made in cases where the medical card expiry date has passed the Accounting Officer stated that the expiry date on the card does not imply loss of eligibility – rather it is used to manage reviews of eligibility.

47.26 He stated that in the HSE's experience, 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.

General Practitioner Payments

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.

Scheme Overlaps

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.

Conclusion – Payments to Doctors and Pharmacists

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 type 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.

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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.

Payments to Dentists

47.37 A Dental Treatment Service Scheme is administered by the HSE which cost €76.2 million in 2010 (€86.6 million in 2009). The scheme pays private dentists in respect of dental examinations and treatments provided to medical card holders up to April 2010. Since April 2010 the HSE has limited the range of services that can be provided under its scheme without prior clinical approval. Separately, a further scheme, administered by the Department of Social Protection (DSP) – the Dental Treatment Benefit Scheme, is accessible to those that have made a certain number of eligible PRSI contributions. Historically, the DSP scheme covered free dental examinations and provided for the carrying out of other routine dental work at discounted prices. Since the beginning of 2010, only oral examinations are available under the DSP scheme.

47.38 Dual eligibility exists in situations where an individual can access treatment under a medical card and by virtue of PRSI contributions paid. The HSE currently estimates that approximately 40% of adult medical card holders have dual eligibility for dental treatment.

47.39 The DSP has made reimbursements to the HSE to compensate for the fact that the HSE had borne the cost in instances where the patient concerned could have claimed under DSP's Dental Treatment Benefit Scheme. These amounts ranged between €8.3 million and €9.3 million between 2006 and 2010.

47.40 Dual eligibility gives rise to a risk that dentists may claim for the provision of treatments from both the HSE and the DSP. Two separate exercises were conducted in the course of audit. These sought to compare HSE and DSP payment records and isolate instances where both organisations had apparently paid for similar treatments in respect of the same individuals.

- An examination of HSE and DSP payment files in respect of treatments, paid for in 2009, identified 10,205 individual patients with records on both files. The audit examined a sample of 185 individuals who had received 588 treatments (excluding oral examinations). In relation to 34 treatments (6% of the sample examined) both the HSE and DSP appeared to have paid dentists in relation to the same individual who received a similar treatment within 60 days[382].
- An examination of HSE and DSP payment records in respect of oral examinations for 2009 identified 7,995 instances where oral examinations had been claimed for by dentists under both the HSE and DSP schemes. The audit examined a sample of 100 of these cases. In 24 cases, the claims had been made in respect of the same individual under the HSE scheme and the DSP scheme and the dates of the oral examination occurred within two months[383].

47.41 The HSE accepts that the possibility of duplicate claims for the same treatment under both schemes exists[384]. The only effective method of detecting duplicate claims is through data sharing between the HSE and the DSP. A data matching exercise was completed in 2008 in respect of the 2005/2006 year. At that time, duplicate payments totalling just under €10,000 were identified in relation to 29 dentists. Most of the overpayments were recouped by DSP from the dentists concerned[385].

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382 The HSE has time limits on treatments allowed under the Dental Scheme. Most of the time limits significantly exceed the 60-day time window adopted for this analysis. For example, restoration (filling) can only be claimed once in a five-year period unless a clinical necessity is proved.

383 The HSE allows for one oral examination per patient in a twelve month period, unless a clinical necessity is proved.

384 HSE report, Dental Treatment Services Scheme, p5, 22 January 2010.

385 In a small number of cases the dentists were no longer practicing or were not on the HSE's panel of dentists and the monies were not recovered.

47.42 In relation to payments to dentists, an effective probity system would

- cover compliance with contractual terms, the quality of the care provided and financial controls
- include risk management systems and elements designed to prevent, detect and deter non-compliance by dentists.

47.43 In 2009, the Department of Health and Children engaged a consultant to report on probity within the dental care sector[386]. The same consultants had previously completed two probity reports on the dental care sector, the first in 2002 and the second in 2007.

47.44 The 2009 report concluded that probity assurance had decreased since 2007, as an examining dentist scheme in place when the 2007 report was completed had been discontinued. Under that scheme, independent dentists reviewed a sample of patients to validate that treatments had been provided and to assess the quality of care. As a result, the report concluded that assurance had been substantially weakened as the perceived deterrent was weaker and contract holders (dentists) were likely to perceive that the authorities did not place any value on probity arrangements. The report also drew attention to the lack of development in the HSE aimed at identifying the risk exposure of the DSP scheme.

47.45 The Accounting Officer stated that during 2010 the HSE undertook a review of the management and organisational arrangements in the National Oral Health Service that found that probity arrangements need to be further developed and strengthened.

47.46 Between March 2010 and December 2010 the HSE circularised 99 patients who had received treatment under its Dental Treatment Service Scheme[387]. Ten patients reported that the full treatment as billed had not been delivered. The HSE has reported that following engagement with eight dentists, the dentists confirmed that treatment had been provided in all but one case where the payment was recouped. In the two remaining cases, the HSE had sought further clarification from the patients and, in the absence of response, will seek confirmation from the dentists concerned.

Conclusion – Dental Schemes

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.

386 A Report on Probity Assurance within the Dental Sector, Oral Care Consulting.

387 The questionnaire was not replied to in 20 cases.

Treatment of Private Patients in Public Hospitals

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[388].

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[389]. 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 186 Comparison of Bed Occupancy in 2008 and 2010[a]

	Public Patients		Private Patients	
	2008	**2010**	**2008**	**2010**
Patient Designation[b]	1,299,509	1,322,022	405,076	368,261
Patient Accommodation				
Public Beds	1,136,657	1,146,753	181,960	143,392
Private Beds	81,283	85,720	201,951	201,742
Non-designated Beds	81,569	89,549	21,165	23,127

Source: Health Service Executive

Notes: a The results exclude Monaghan, Tallaght and Portiuncula Hospitals as data in respect of both periods was not available for those hospitals. Portiuncula and Tallaght generated 87% and 66% respectively in income from private patients treated in private beds in 2010.

b The figures represent the number of bed days in each category.

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.

47.51 Overall, 45% 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.

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

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

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[390]
- 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.

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 and Information System. This system will assist hospitals to manage their private income by providing real time bed occupancy information.

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.

[390] 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.

Conclusion – Treatment of Private Patients in Public Hospitals

Overall, 45% 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 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.

Monitoring of Voluntary Hospital Performance

47.57 Voluntary hospitals are arms length bodies that are integrated into the delivery of the public health system. In 2010, the HSE provided around €1.9 billion to fund the 17 voluntary hospitals[391]. These funds are made available under arrangements for the provision of health services entered into under the Health Act 2004. The procurement is governed by a three-year service arrangement that incorporates a service level agreement and a business plan.

47.58 The basis for control and monitoring of the operations of voluntary hospitals is founded on

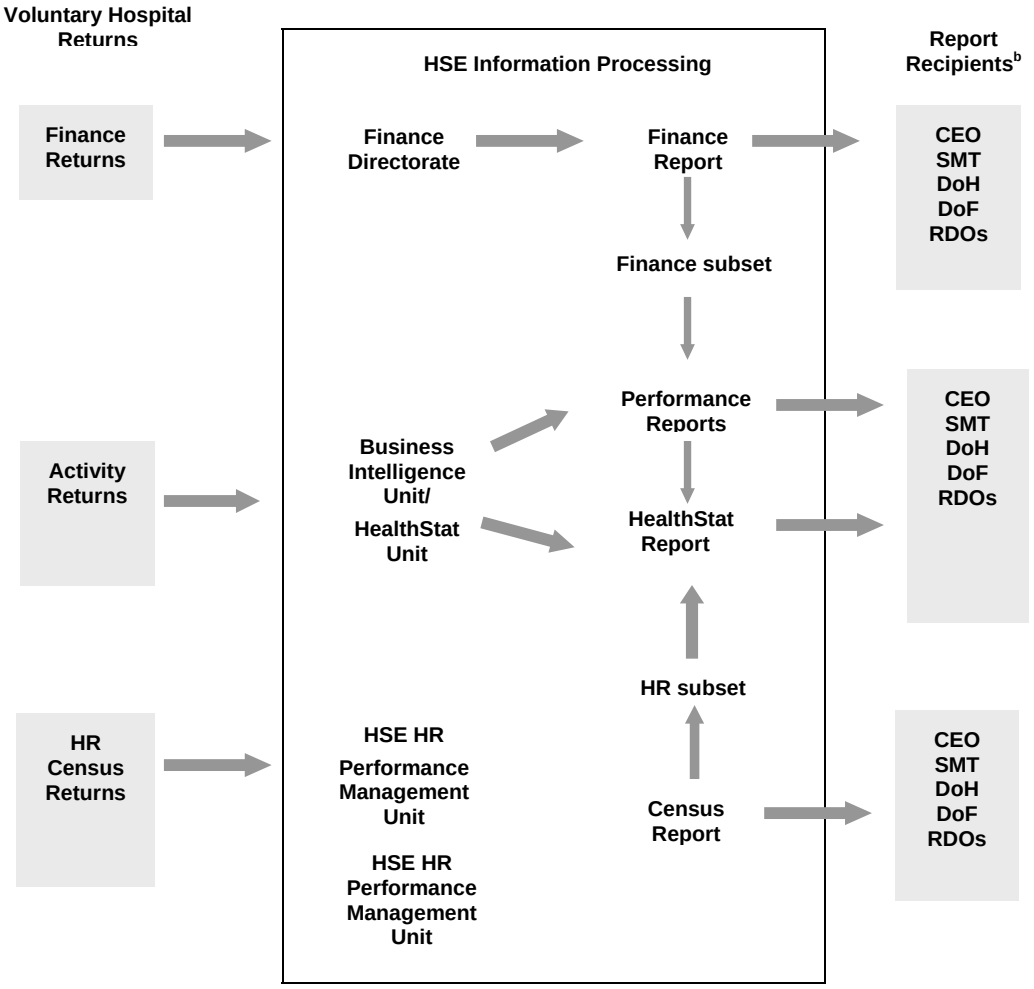
- an annual business plan that specifies the allocation
- activity levels specified for defined categories of work (inpatient discharge numbers, day cases, outpatient attendances and in the case of hospitals with Emergency Departments, emergency presentations and admissions)
- an approved employment ceiling.

[391] The number of voluntary hospitals reduced to 16 during 2010 as St. Lukes Hospital Board was dissolved and its functions merged into the HSE on 31 July 2010.

Management Information

47.59 Each month, voluntary hospitals compile information on financial and operational performance as well as employment levels. The use to which this information is put is outlined at Figure 187.

Figure 187 Voluntary Hospital Reporting[a]



Notes: a References to subsets are to the elements of reports that are used in the course of further processing.

b All report output is published on the HSE website.

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].

47.61 Figure 188 outlines the activity levels for Voluntary Hospitals in 2010.

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392 HealthStat presents detailed monthly performance information from hospitals as a series of graphs on a performance dashboard.

393 Red denotes unsatisfactory performance and requiring attention. Amber denotes average performance with room for improvement.

394 These comprise three maternity hospitals, two paediatric hospitals, two with single specialty functions and two small hospitals.

395 Nursebank arrangements involve creating a resource unit within a hospital where a register of nurses is maintained that will provide nursing services, either on a specific contract or by providing additional hours.

Figure 188 Activity Levels for Voluntary Hospitals in 2010

Voluntary Hospital	Inpatient Discharges		Day Cases		Outpatient Attendances		Emergency Departments[a]	
	Planned	Actual	Planned	Actual	Planned	Actual	Attendances	Admissions
Tallaght	20,643	24,634	31,044	32,406	240,642	249,395	73,963	18,029
Coombe[b]	18,606	19,217	6,803	16,469	95,520	105,575	—	—
National Maternity	18,205	19,557	3,162	3,190	82,211	91,569	—	—
Royal Victoria Eye and Ear	2,285	2,391	4,235	5,582	40,083	39,695	33,867	681
St James's	19,664	24,537	92,769	92,695	205,566	218,039	44,911	13,912
St Luke's	1,613	1,772	2,861	3,105	53,112	66,835	—	—
St Michael's	2,315	2,582	4,576	5,193	20,223	21,297	12,278	1,285
St Vincent's	13,455	15,028	48,465	50,723	127,494	134,249	42,139	8,545
Crumlin	9,813	10,245	15,221	16,274	81,959	77,398	31,642	3,795
Temple St	6,110	7,617	4,733	5,260	54,908	59,394	38,970	3,470
Beaumont	19,031	21,685	46,645	45,948	153,500	167,509	47,177	11,859
Cappagh	1,970	2,474	8,190	8,779	8,100	8,129	—	—
Mater	14,260	15,925	36,294	37,485	194,000	202,047	46,876	9,613
Rotunda	15,355	15,921	3,064	3,306	85,129	90,212	—	—
Mercy	8,027	9,169	17,862	18,966	40,972	45,682	25,723	5,251
South Infirmary	7,733	8,499	17,609	15,528	54,087	52,389	19,727	3,577
St John's	3,408	4,258	6,840	6,927	13,756	13,206	17,261	2,204
Total	**182,493**	**205,511**	**350,373**	**367,836**	**1,551,262**	**1,642,620**	**434,534**	**82,221**

Notes: a Figures for the three maternity hospitals and the two specialty hospitals are not available.

b Certain procedures, including colposcopy, were done as day cases in the year.

47.62 Patient discharges were 13% above the planned activity level in the case of inpatients and day case activity was nearly 5% above the planned level. There was a 6% increase in outpatient attendances compared with the level planned.

Monitoring Process

47.63 Voluntary hospitals are held to account based on a monthly Performance Report which is the basis for discussions with the HSE Board and the Department of Health and is prepared in response to the HSE's responsibilities under the Health Act 2004. This report is submitted to the HSE Board and then onward to the Department. Its focus is on each hospital's performance in terms of the annual activity commitment, its financial outturn (including value for money) and HR performance.

47.64 In regard to the classification of hospital performance by HealthStat the Accounting Officer stated that HealthStat is a performance improvement tool, and whilst it is useful in terms of bringing accountability for service delivery, its major function is to support service improvements through the use of data.

47.65 The Accounting Officer stated that the HSE does not have an integrated payroll and personnel administration system covering all employees nationally and this is an underlying system deficiency. He stated that the HSE has sought to compensate for this by putting a database in place which attempts to integrate the payroll and employment data sets for the statutory system only.

47.66 He stated that governance arrangements in relation to voluntary hospitals are separate to those for statutory hospitals. The HSE monitors employment numbers for the voluntary hospitals but does not have an audit role for voluntary hospital payroll systems. Voluntary hospitals have their own internal and external audit arrangements in place. In 2011, the HSE's Internal Audit Directorate will be undertaking a series of audits of compliance with the provisions of the Service Arrangement with a number of HSE funded agencies.

47.67 In relation to the arrangements in place to ensure that overall cash balances within the public health system are managed with the maximum economy he stated that bank balances, of voluntary hospitals as disclosed by them are monitored on a monthly basis. The HSE treasury function investigates any large balances and seeks to minimise them by reducing cash disbursement accordingly.

Conclusion – Voluntary Hospital Monitoring

The HSE has reasonable systems in place to monitor the financial and operational performance of voluntary hospitals. Areas which might merit a review include a closer monitoring of compliance with employment ceilings, their alignment with the budget and the scope for more refined treasury management. For example, in this connection, St James's Hospital had cash balances of €21 million at end 2010 partly due to the level of cash advances made to it by the HSE in December 2010.