

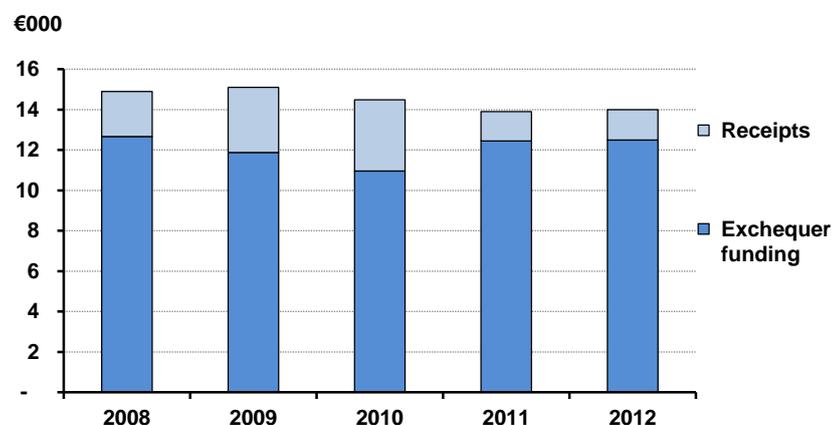
21 Budget Management in the Health Service Executive

- 21.1** Estimates of voted expenditure presented to Dáil Éireann for approval should reasonably accurately represent the amount that it is expected will be spent on each of the related services. In effect, they serve both as budget allocations for the year for individual services, and as cash limits which departments and offices are not permitted to exceed.¹
- 21.2** Spending on healthcare accounts for over one quarter of Government current expenditure. In each of the last five years, the Health Service Executive (HSE) has sought a supplementary estimate as a result of emerging budget overruns. In 2012, an additional €360 million was granted — an increase of 3% on the original voted Exchequer contribution for the year.
- 21.3** The fact that the HSE requires supplementary estimates each year raises concerns about the effectiveness of its budget planning and budget management. This report examines the budget outturn in 2012 by category of expenditure and income, and the main factors that gave rise to the budget overruns.

Trends in Expenditure

- 21.4** Figure 21.1 demonstrates the trends in the level of expenditure by the HSE each year since 2008. Overall, expenditure fell from a peak level of around €15.1 billion in 2009, to around €14 billion in 2012 — a reduction of around 7.3%.
- 21.5** Amounts received from the Exchequer into the HSE vote account in 2012 amounted to just under 90% of the total amount spent. This compares to around three quarters of the total amount spent in 2010. The change reflects the abolition of the 1% health levy (collected through the income tax system) at the beginning of 2011.

Figure 21.1 HSE gross expenditure and funding sources, 2008 to 2012



Source: Health Service Executive Vote 2008—2012

¹ The estimates process is described in more detail in Chapter 5 Vote Budget Management.

21.6 The HSE received a total budget allocation of €13.714 billion for 2012. The outturn for the year was €13.987 billion — around 2% more. However, the percentage variation from budget varied across expenditure categories. Additional expenditure in some areas was offset by under-spending relative to budget in other categories. The net requirement was for an additional €273 million in spending. Combined with a net shortfall on the receipts side of €64 million, there was a requirement for provision of an additional €337 million in Exchequer funds.

Variances by Subhead

21.7 The most significant variances, in terms of cash impacts on the vote, were overruns on medical card services and other community schemes, and in regional expenditure — particularly hospital expenditure — and a shortfall in the planned collection of patient charges for hospital services (see Figure 21.2).

21.8 The appropriation account does not require any explanations of the variances for subheads relative to their original budgeted amounts. In line with the accounting policies set by the Department of Public Expenditure and Reform, explanations are provided for significant variances between the amount appropriated (after supplementary estimate adjustments) and the final outturn.

Figure 21.2 HSE budget outturn analysis, 2012

Expenditure	Budget ^a	Outturn	Variance	
	€m	€m	€m	%
HSE Regions				
Dublin Mid Leinster	1,346.4	1,372.7	26.3	2.0
Dublin North East	1,225.3	1,251.0	25.7	2.1
South	1,912.9	1,946.5	33.6	1.8
West	2,103.4	2,164.5	61.1	2.9
All regions	6,588.0	6,734.7	146.7	2.2
Grants to voluntary hospitals and other health bodies	2,126.7	2,158.9	32.2	1.5
Medical card services and other community schemes	2,518.3	2,756.6	238.3	9.5
Long term residential care payments	994.7	962.6	(32.1)	(3.2)
Children and family services	551.7	569.8	18.1	3.3
Capital programmes for health facilities	341.0	318.7	(22.3)	(6.5)
Pension lump sum payments to HSE staff	207.0	175.5	(31.5)	(15.2)
Other services	184.6	138.3	(46.3)	(25.1)
Administration				
HSE salaries and other administration costs	62.4	64.8	2.4	3.8
ICT systems capital projects	140.0	107.5	(32.5)	(23.2)
Total expenditure	13,714.5	13,987.4	272.9	2.0
Receipts				
Charges for HSE-provided hospital services ^b	455.0	408.8	(46.2)	(10.2)
Recovery of cost of services from EU states	220.0	220.0	—	—
Recoupments from Social Insurance Fund	13.0	—	(13.0)	(100.0)
PCRS rebate receipts	25.0	37.3	12.3	49.2
Tobacco levy receipts	167.6	167.6	—	—
Disposal of mental health and other facilities	8.0	4.5	(3.5)	(43.8)
Pension related deductions from health sector salaries	337.1	352.0	14.9	4.4
Superannuation contributions by HSE staff	200.0	195.6	(4.4)	(2.2)
Miscellaneous receipts	127.8	103.5	(24.3)	(19.0)
Total receipts	1,553.5	1,489.3	(64.2)	(4.1)
Exchequer funding requirement	12,160.9	12,498.1	337.2	2.8

Source: Vote 39 Appropriation Account 2012

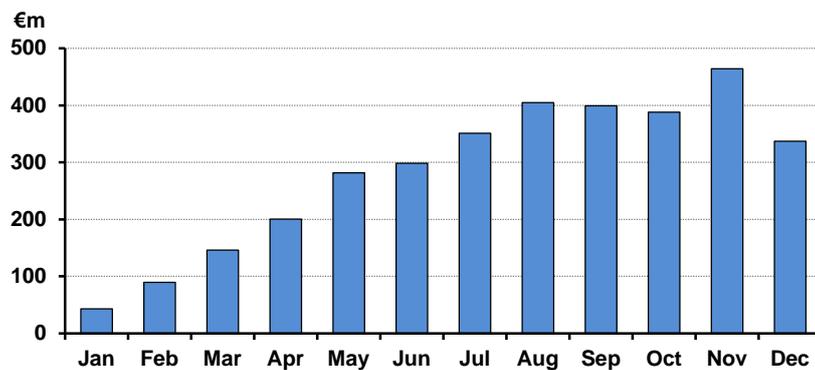
Notes: a The budget relates to the original estimate approved by Dáil Éireann in June 2012.

b Includes charges in respect of maintenance in private and semi-private accommodation in public hospitals, statutory charges in public hospitals and long stay charges.

Budget Monitoring

- 21.9** The HSE monitors its budget position through monthly performance reports. These showed a continuous increase in the 'year to date' budget overrun up to August 2012 (see Figure 21.3).

Figure 21.3 Budget overrun by month, 2012



Source: Health Service Executive Performance Reports January 2012 to December 2012

- 21.10** In July 2012, the HSE implemented a number of measures designed to reduce costs by €130 million in 2012. These included
- cuts to front line services which it expected to result in savings of €57 million — €35 million as a result of a reduction in overtime and in the use of agency staff; €12.8 million due to reduction in expenditure on medical card services; and €9.7 million as a result of reduction in home help hours and home care packages
 - savings of €73 million on non-front line services, as a result of a reduction in expenditure on education and training and travel and subsistence, as well as improvements in procurement and cash and stock management.
- 21.11** The total budget overrun was maintained at about €400 million between August and October 2012 but increased significantly in November to €464 million.
- 21.12** In order to avoid expenditure on the Vote in excess of the amount approved by Dáil Éireann, a supplementary estimate for the amount of €360 million was approved in December 2012. The final outturn for the year was €337 million above the original budget and the balance of €22.8 million became liable for surrender back to the Exchequer at the year end.
- 21.13** The Accounting Officer for the Department of Health has pointed out that the budget overrun in the HSE in 2012 was partly offset by a once-off Exchequer receipt from the Medical Defence Union of €45 million¹ and savings amounting to €70 million which were identified on the Health Vote. These savings comprised approximately €30 million from the National Treatment Purchase Fund, €11.5 million in savings from other agencies funded by the Department, €10 million on legal fees, €7.5 million from the Department's capital vote and various other savings.²

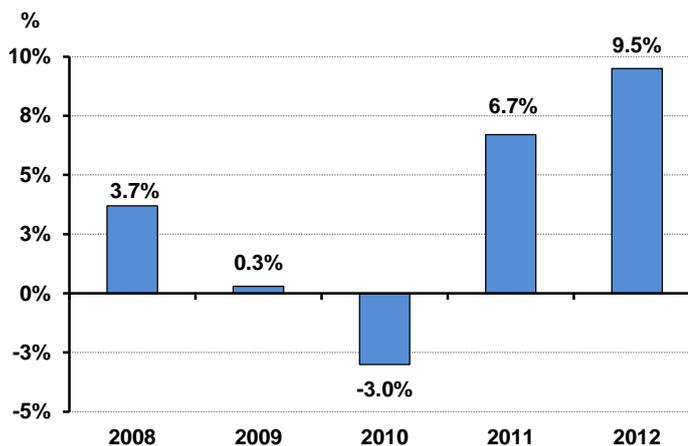
¹ The circumstances around this receipt are explained further in Chapter 29 Clinical Indemnity Scheme.

² See Chapter 5 Vote Budget Management.

Medical Card Services and Community Schemes

- 21.14** Expenditure on medical card and community services — mainly drug re-imbusement schemes — has varied significantly from the budgeted level in four of the past five years (see Figure 21.4). The greatest variances from budget were in 2011 and 2012.

Figure 21.4 Variance of expenditure on primary care reimbursement services



Source: Health Service Executive Vote 2008—2012

- 21.15** The original 2012 estimate in relation to medical card and other community schemes was €2.518 billion. This represented an expected reduction of €65 million (2.5%) on the 2011 outturn of €2.583 billion.
- 21.16** Total expenditure in 2012 was €2.756 billion — a budget overrun of €238 million or 9.5%. A large part of the overrun was due to
- projected savings on drug costs not being achieved
 - a higher number of medical cards issued in 2012 than was projected
 - underestimation of the average cost of medical cards in 2012.

Drug Cost Agreement

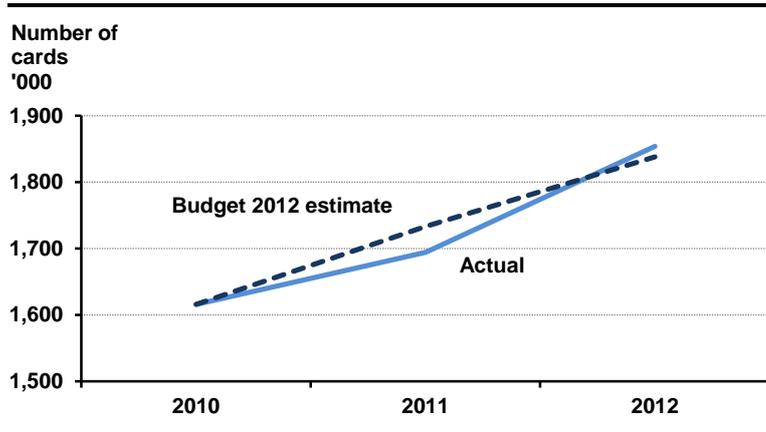
- 21.17** Savings in 2012 due to planned drug pricing changes were projected to be €124 million. Ultimately, savings achieved in 2012 were estimated at just under €15 million.¹ Accordingly, the delay in reaching agreement with pharmaceutical suppliers accounted for about €109 million (46%) of the total budget overrun in medical card services and community schemes.

¹ The full year impact of the savings in 2013 is expected to be greater.

Cost of Medical and GP Visit Cards

21.18 In estimating the expected cost of medical cards, the HSE projected that the number of medical cards in issue at the end of 2012 would be 1,838,000, and that the year on year increase in the number of cards would be 105,000. As Figure 21.5 indicates, this over estimated the number of cards in issue at the end of 2011, and under estimated the number at end 2012. The rapid emergence of a significant backlog in the handling of applications for medical cards in the second half of 2011 — around the time that the 2012 budget was being prepared — was a distorting factor.

Figure 21.5 Projected and actual number of medical cards in issue at end year, 2010 to 2012



Source: Health Service Executive

- 21.19** The HSE has estimated that the average cost of services per eligible cardholder in 2011 was around €1,020. This comprises
- payment of an average of €258 per cardholder to GPs
 - payment to pharmacists of €762 per person who availed of drugs.
- 21.20** In practice, this may overstate the average cost incurred for a cardholder, because it does not take account of those cardholders (around 6% in 2011) who do not avail of pharmacy services in a year.¹ When this is factored in, the average cost of a card in 2011 would be around €973 per person.
- 21.21** The HSE has stated that the cost of a medical card is heavily dependent on the age of the cardholder and can range from €200 for a cardholder aged 16 to 44 as compared to €2,000 for a person aged over 70. The average cost of a medical card in any year is dependent on the mix of cardholders. The HSE is currently developing a more sophisticated costing model which will take account of the different costs of cardholders depending on age.
- 21.22** The HSE's 2012 budget provided for additional expenditure of €15 million for a planned extension of eligibility for GP visit cards. Based on the average payments to GPs in 2011 (€258 per cardholder), this would have allowed for an additional 58,000 GP visit cards. However, the planned extension of eligibility did not occur. In fact, the total number of GP visit cards in issue fell marginally in 2012, to around 131,000. Consequently, the provision in the budget for this extension of scope was not required.

¹ See Chapter 22
Eligibility for Medical
Cards.

Conclusion

- 21.23** Delays in implementing drug savings account for €109 million of the €239 million budget overrun for medical card services and other community schemes. Underestimation of the number of full medical cardholders could account for a further €54 million. These overruns were offset by the saving due to the non-extension of eligibility for medical cards.
- 21.24** The reasons for the remaining cost overrun — around €90 million — are unclear.

Hospitals Budget Overruns

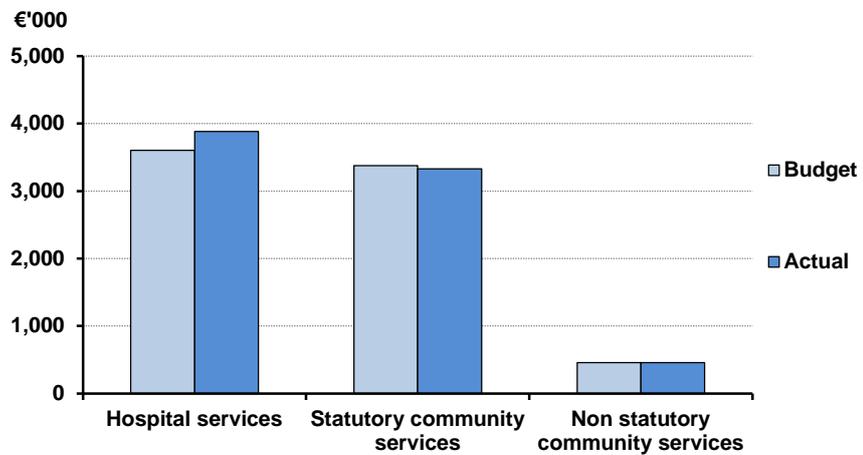
- 21.25** The total budget overrun in the cost of the HSE's regional services — mainly hospital and statutory community services — was €146 million. An additional overrun of €32 million was incurred in relation to grants in respect of health bodies including voluntary and joint board hospitals.
- 21.26** In allocating budgets to individual hospitals and community service providers, the HSE plans and monitors on an accruals (rather than a cash) basis. This should give a more complete picture of income and expenditure for the year's activity.
- 21.27** Monthly performance reports from the hospitals are used to monitor performance against budget. The performance reports for 2012 show a budget overrun in each region amounting to a total of €235 million or 3.2% (see Figure 21.6). The highest percentage overrun was in the services in the Dublin North East Region. The lowest was in Dublin Mid Leinster.

Figure 21.6 Hospital and community service budget variance by region, 2012

	Dublin Mid Leinster	Dublin North East	South	West Region	Total
Budget € million	2,395	1,651	1,634	1,755	7,435
Outturn € million	2,431	1,726	1,681	1,832	7,670
Variance € million	36	75	47	77	235
Percentage overrun	1.5%	4.5%	2.9%	4.4%	3.2%

Source: Health Service Executive Performance Report December 2012.

- 21.28** Most of the overrun occurred in relation to hospital services (see Figure 21.7). Budgets totalling €3.563 billion were allocated to 46 hospitals. The total expenditure incurred by the hospitals was €3.854 billion, representing an average overrun of 8.2%. Five hospitals had budget overruns of 20% or more (see Annex A).

Figure 21.7 Budget overrun in regions by area of service, 2012

Source: Health Service Executive Performance Report December 2012

21.29 The budgets allocated to hospitals in 2012 represented a reduction of 8% in the actual expenditure incurred in 2011. Given the overrun of 8.2% on the 2012 budgets, there was very little change in the overall expenditure.

21.30 During 2012, the HSE made grants of €70 million to nine hospitals to cover budget overruns that had occurred in 2011 (€24 million) and 2012 (€46 million). The HSE noted that the once-off grants were issued with the following conditions.

- Each hospital would be required to sign a service level agreement for 2013 on the understanding that expenditure for 2013 would have to be managed within the available budget.
- Hospitals would be required to manage their cash flow without further recourse to the HSE.

Changes to Hospital Budgeting Process

21.31 The HSE has outlined the following changes to the hospital budgeting process from 2013 onwards.

- Historically, budgets for individual hospitals were derived incrementally with the prior year's budget adjusted for once-off items and new service developments.
- The HSE has adopted a new approach in relation to developing budgets for individual hospitals. Budget allocations are now related to projected spend. Previously, budgets for individual hospitals were developed with only limited reference to past organisational performance or realistic estimates of the potential for cost reductions. As a result, some hospitals were significantly underfunded and budget overruns were inevitable.

- Following a period of consultation, detailed plans outlining the level of services to be provided, the funding and staff available and the quality and access to services were published for individual hospitals in February 2013. The new budgeting process aims to ensure that no hospital plans for a budget overrun in 2013. The process sought to ensure that assistance was provided in respect of those services in greatest need of additional funding while structural deficits were addressed. Hospital managers have now been given tough but achievable budget targets which should allow them to stay within budget while at the same time protecting patient care.
- This rebalancing of budgets is one part of a programme of reform in the hospital sector. The programme includes the establishment of hospital groups by the end of 2013 and the payment to hospitals on the basis of 'money follows the patient' from 2014.

Collecting Patient Charge Income

21.32 The HSE's 2012 service plan provided for an increase of €143 million in hospital receipts in respect of patient charges. This was to be achieved through

- increases in the level of charges
- widening of the scope of the charging regime
- more timely collection of patient income, the majority of which comes from the health insurance companies.

Increases in Patient Charge Rates

21.33 At the direction of the Minister, increases of between 2.7% and 5.3% were applied to in-patient hospital charges from 1 January 2012. It was expected that these increases would generate an additional €18 million in hospital income in 2012 — €9.2 million in relation to HSE hospitals and €8.8 million for voluntary hospitals.

Changes in the Scope of the Charging Regime

21.34 Public hospitals' income from private patients was restricted by the rules around bed designation whereby only private patients occupying a designated private bed could be charged for accommodation costs.

21.35 About 20% of beds in public hospitals are designated for private use and health insurers pay between €200 and €1,000 per day for accommodation depending on the type of hospital. However, if private patients are accommodated in public beds, a standard daily charge of €75 applies.

21.36 It was proposed to introduce legislation in 2012 to allow public hospitals to levy a charge on all private patients regardless of bed designation. It was estimated that this change would result in additional hospital income of around €75 million in 2012. The necessary legislation was enacted in July 2013, with the passage of the Health (Amendment) Act 2013.

21.37 Following discussions with the health insurance companies, the Government decided to defer implementation of the legislation until the beginning of 2014. The deal involves a reduction in the rates charged for overnight inpatient accommodation, but will be due in relation to all private patients treated in public hospitals and not just those in specifically designated beds for fee paying patients.

- 21.38** The HSE expect that the new charging regime will generate additional hospital income in the region of €30 million in 2014.

Timeliness of Collection

- 21.39** In order to improve hospital cash flow in 2012, the HSE planned to improve significantly the timeliness of collection of amounts due from health insurance companies during 2012.

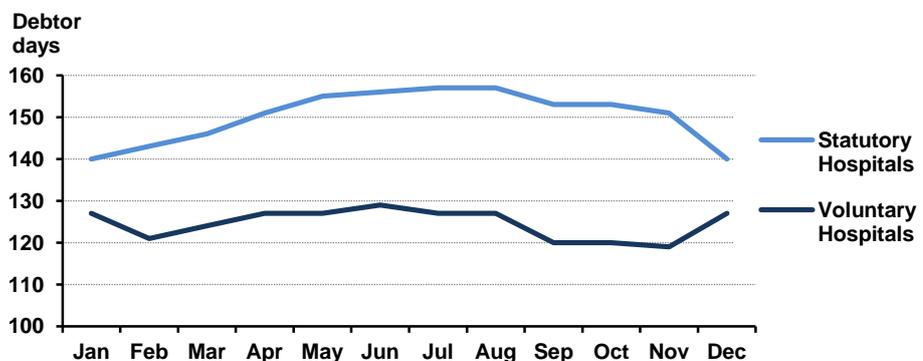
Total Debt Outstanding

- 21.40** At the end of 2012, the total patient charge debt outstanding was €209 million, comprising €128 million in relation to statutory hospitals and €81 million for voluntary hospitals. The HSE stated that about €192 million (92%) of the debt related to amounts owed by private insurers.¹

Measuring Debt Collection Performance

- 21.41** The HSE measures the timeliness of patient charge debt collection in terms of debtor days.² This measure is calculated for all hospitals and reported in the monthly performance reports. However, because only debt less than a year old is included, it does not give a complete picture of the delay in collecting income. It does provide an indication of performance in collecting recent income.
- 21.42** The debtor days at each month end during 2012 for HSE and voluntary hospital sectors are indicated in Figure 21.8. The available data suggests that, on average, HSE statutory hospitals are consistently slower in collecting patient-related debt than are voluntary hospitals. Annex B shows the debtor days at end 2012 for each hospital.
- 21.43** The HSE budgeted for an increase in hospital receipts of €50 million during 2012 as a result of more timely finalisation and payment of amounts due from insurance companies — €28 million for the statutory hospitals and €22 million by the voluntary hospitals. This would have necessitated a reduction of about 45 debtor days during 2012 in both the statutory and voluntary hospitals. In practice, debtor days were little changed in either sector over the year.

Figure 21.8 Age of debt^a for debt that is less than one year old, January to December 2012



¹ The other amounts due in respect of patient charges relates to amounts due from private patients who do not have insurance or tourists who have travel insurance.

² Debtor days is a measure of the age of patient charge debt at a point in time. It is calculated by dividing the debt outstanding by the amount of patient income in the previous 12 months x 365 days.

Source: Health Service Executive Performance Reports January 2012 to December 2012

Note: a The debt analysed above includes maintenance charges only. It includes amounts due from insurance companies and from individual patients who do not have health insurance or a medical card. As a result, the debtor days shown differ from those included in Figure 21.9 which relate to all amounts due from insurance companies.

Stages in the Collection Process

21.44 Amounts of patient income due are recognised when the patient is discharged. Claims to insurance companies are processed in three stages

- hospital administrators prepare the claim once the patient is discharged
- hospital consultants sign off on each claim form
- insurance company validates and processes the claim and pay the hospital or the HSE.

21.45 The HSE provided data in respect of the total amounts due from insurance companies in relation to maintenance and in-patient charges broken down by the stage of the process and showing the average debtor days. This is set out in Figure 21.9.

Figure 21.9 Value and age of debt^a, by stage in process, December 2012

	HSE statutory hospitals		Voluntary hospitals	
	Value of debt €m	Age of debt (debtor days)	Value of debt €m	Age of debt (debtor days)
Administration at hospital level	21.6	30	7.8	11
Awaiting sign off by consultant	38.7	55	25.7	37
With insurance company	55.2	78	43.2	63
Total	115.5	163	76.7	111

Source: Health Service Executive (unaudited)

Note: a Includes maintenance charges and in-patient charges due from insurance companies.

21.46 The HSE set a target that claims would be signed off by consultants within 14 working days of receipt of relevant documentation. At the end of 2012, claims had, on average been with consultants for just under eight weeks in HSE statutory hospitals and just over five weeks in voluntary hospitals.

Advance Payments

21.47 At the end of 2012, claims awaiting payment from insurance companies had on average been submitted for about two months. In late 2012, the health insurance companies provided advances totalling €103 million based on their estimates of private patients who had incurred charges for treatments in acute hospitals but where the claims process had not been finalised. €50 million was allocated to the HSE in respect of its hospitals, and €53 million to voluntary hospitals. While this reduced the amounts owing at the year end, the amounts advanced were deducted from patient charge payments to the HSE and the hospitals in the first six months of 2013.

Initiatives to Improve Collection

- 21.48** The HSE has outlined the following on-going initiatives to improve the timeliness of collection of patient charge income from insurance companies.
- The HSE is rolling out an electronic claims management system. The HSE stated that in August 2013, 17 of the largest acute hospitals (accounting for 65% of total claims in the acute sector) are using the electronic claims system. It is planned to increase this percentage to 80% by the end of 2013. The HSE noted that, even when supported by software, it remains an onerous process with consultants having to enter detailed medical information and sign forms, albeit electronically.
 - The HSE has issued letters to consultants requesting compliance with the commitments set out in Section 5 (vii) (a) of the document "Implementing the Public Service Agreement" issued by the Labour Relations Commission in September 2012. This required a commitment from all consultants to fully complete and sign private insurance forms within 14 working days of receipt of all relevant documentation.
 - The HSE has entered into an agreement with one of the main health insurers to clear up claims in excess of one year old.
 - The HSE, the Department of Health and St James's Hospital have been working with private health insurers to agree an electronic dataset for the submission and payment of claims. By August 2013, a dataset has been developed and is being tested at St James's Hospital. The HSE plans to roll this system out to all hospitals upon successful implementation at the hospital.

Pension Lump Sums

- 21.49** The HSE budgeted to incur about €207 million in relation to pension lump sums for retiring employees in 2012. In 2012, expenditure in relation to lump sum payments was €175.5 million — €31.5 million less than expected. The number of people who retired was almost 2,000 less than anticipated.

Views of the Accounting Officer — HSE

- 21.50** The Accounting Officer noted that the HSE does not set its own Vote allocation and a number of variables affect the final amount allocated. The amount allocated in relation to HSE expenditure is developed against a backdrop of national budgetary objectives. He noted that the final estimate provision, in many cases, is imposed following the conclusion of the budgetary process.
- 21.51** He stated that the service plan for 2012 represented total cost reductions of €750 million comprising
- just under €500 million in savings which were to be delivered through pay and cost reduction measures, reductions in drug prices and a number of other reductions
 - further cost increases of €250 million expected to arise in 2012 which were not provided for in the estimates — these included €130 million relating to expected deficits, mainly in relation to hospital services as well as the additional payroll costs arising from the award of increments and the implementation of an EU Directive in relation to agency staff.

- 21.52** The Accounting Officer noted that the cost reductions set out in the 2012 service plan followed two years in which the HSE had significant budget reductions. He noted that reductions in expenditure in 2010 and 2011 had been achieved through a variety of measures including cuts to pay and staff numbers, reductions in fees paid to GPs and pharmacies, and reductions in drug prices. He stated that the bulk of the cost reductions in 2012 related to reductions in the numbers employed. As a result of the scale of the cost reductions required, and the accumulated reduction in frontline staff, the reductions required in 2012 would impact increasingly on frontline services.
- 21.53** The 2012 service plan noted that the HSE had to deal with the increase in service need associated with demographic changes, disease incidence and other drivers of health and social care needs. The service plan required an expenditure reduction of 7.8% in hospitals but noted that acute hospitals had been under considerable budgetary pressure in recent years and capacity would have to be tailored in line with the available funding to ensure financial sustainability.
- 21.54** He noted that the service plan recognised a number of risks to delivery including the achievement of the large cost reduction targets, risks that services would struggle to meet the targets set and the timing of the legislation to achieve reductions in the cost of community drug schemes and increases in hospital income.

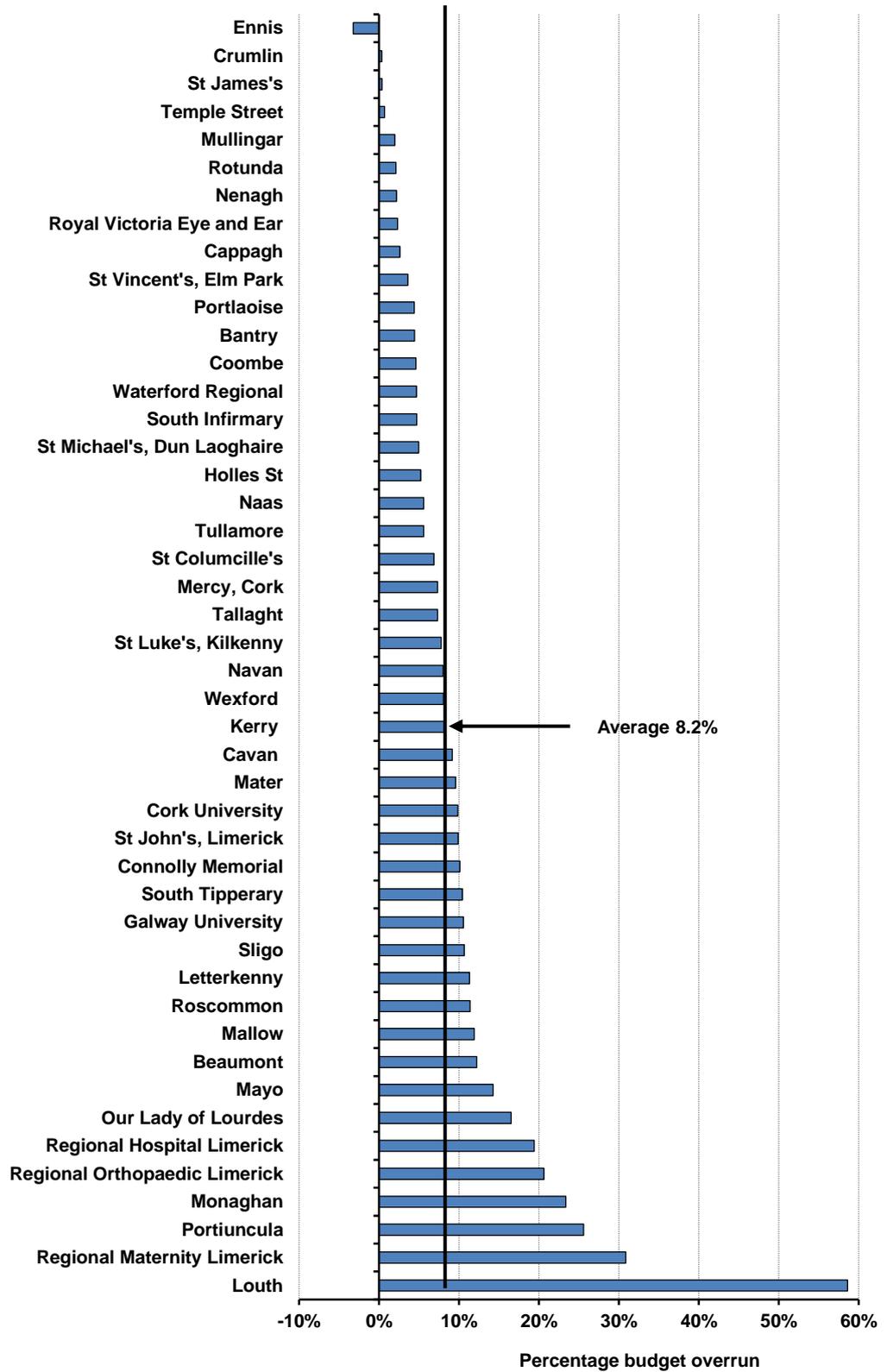
Views of the Accounting Officer — Department of Health

- 21.55** The Accounting Officer acknowledged that there was a significant overrun in the hospital sector in 2012. He noted that the scale of the cost containment measures, coming on top of a number of years of budget reductions proved unachievable. He stated that in developing the budgets for 2013, these issues were taken into account and hospital budgets for 2013 were re-balanced in order to provide hospital managers with more achievable targets.
- 21.56** He noted that following discussions with the health insurers, Government decided to defer the legislation in relation to bed designation with the understanding that the insurers would advance some €100 million to the HSE in 2012 in respect of claims for services incurred where the claim had not been finalised. He acknowledged that this advance had a detrimental effect on receipts from insurance companies in the first half of 2013 but stated that proposals are in place to address this. He noted that the time taken to finalise claims with insurance companies was excessive but the planned roll out of the electronic claims management system would go some way to addressing this delay.

Conclusion

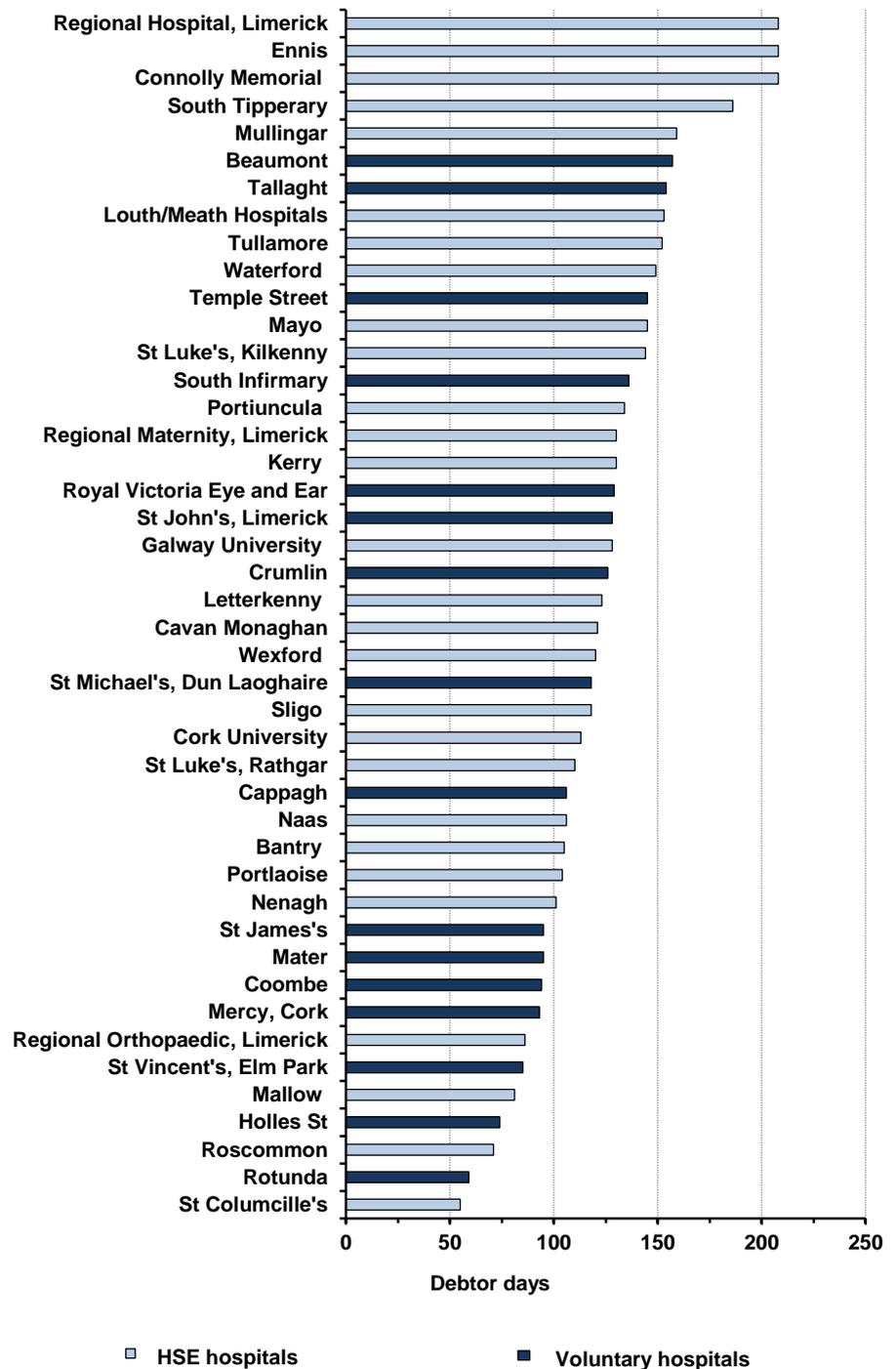
- 21.57** Budgeting for future periods is subject to error because of inherent uncertainty and factors that may be outside the budget holders' control. Nevertheless, as a general rule, estimates presented to Dáil Éireann in respect of voted services should be underpinned by analysis of relevant trends, and realistic assumptions about likely outcomes for the budget period. Key budgeting assumptions should be stated.
- 21.58** The estimates in respect of the HSE for 2012 do not appear to have taken account sufficiently of the underlying cost drivers in some key expenditure areas. There is scope for the HSE to carry out more thorough analysis of the demand for services, and of the associated costs, and of underlying trends.
- 21.59** The HSE has begun to revise its analysis of demand for medical card and other community services, and the associated costs. It has also implemented a revised budget management process in the hospitals sector, where overruns have been an ongoing problem.

Annex A Percentage Budget overrun by Hospital, 2012



Source: Health Service Executive Performance Reports, January 2012 and December 2012

Annex B Age of debt in hospitals for debt that is less than one year old, at December 2012



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