

Chapter 36 Department of Health and Children

National Treatment Purchase Fund

National Treatment Purchase Fund

36.1 The National Treatment Purchase Fund (NTPF) was set up on an administrative basis in 2002 and established on a statutory basis in 2004. The principal aims of the NTPF are

- to arrange and fund treatment for public patients who have been waiting longest for elective i.e. non-emergency treatment in a public hospital
- to collect and make available reliable lists of persons waiting for such treatment.

Since 2005, the NTPF has also engaged on a pilot basis in the provision of out-patient consultations and resultant surgery where required.

36.2 The NTPF had a staffing level of 47 in 2008 and a budget of €104 million. A total of 20,829 public in-patients were treated during the year, and 12,342 out-patient consultations and 3,098 MRIs were arranged. At year-end, the National Patient Treatment Register (PTR) held details of a total of 18,221 persons¹¹⁰ awaiting treatment for a period longer than 3 months. Details of operational data in respect of the period 2005- 2008 are included in Figure 118.

Figure 118 NTPF Resources and Patients Assisted 2005-2008

	2005	2006	2007	2008
Annual Budget	€64m	€78m	€92m	€104m
Staff Complement	28	35	41	47
In-Patients Treated	14,580	15,003	19,769	20,829
Out-Patient Consultations	4,414	7,480	10,569	12,342
MRIs Provided	—	1,928	2,300	3,098

36.3 The NTPF interacts with each of 44 public hospitals, both in terms of compilation and validation of waiting list data and of the identification of patients for NTPF intervention. While the NTPF arranged 20,829 in-patient treatments for public patients in 2008, the total elective in-patient treatments in public hospitals amounted to 658,000 in that year. The NTPF service, therefore, complements mainstream public hospital elective treatments.

36.4 The relative impacts can be seen from Figure 119 which shows the total number of elective in-patient¹¹¹ treatments provided in public hospitals in the years 2005-2008 and the additional treatments arranged and funded by the NTPF.

¹¹⁰ Comprising 13,863 Surgical Cases and 4,358 Medical (i.e. non-surgical) Cases.

¹¹¹ The term 'in-patient' includes a person receiving treatment as either an overnight or a day case and is distinguished from the term out-patient which refers to a person waiting for an appointment with a consultant.

Figure 119 Elective Treatments 2005-2008

Year	Public Hospital Treatments	NTPF Treatments	Percentage of Patients Treated %
2005	450,953	14,580	3.23
2006	511,924	16,931	3.31
2007	631,987	19,769	3.13
2008	657,806	20,829	3.17

Audit Focus

The audit examined

- the procedures in place to validate the waiting list
- the arrangements for the cost-effective procurement of treatments by the NTPF.

Waiting Lists

36.5 In each public hospital, patients are placed on the treatment waiting list of that hospital on the direction of a consultant doctor. Hospitals are required to keep the waiting lists up to date, and to suspend or remove patients from the list where appropriate in accordance with the National Guidelines for the Management of Waiting List Data.

National Guidelines for the Management of Waiting List Data

National Guidelines for the management of in-patient and day case waiting list data were developed by public hospitals and the NTPF and introduced in July 2007. They apply to all hospitals with public in-patient and day-case surgical and medical waiting lists. The guidelines set out

- general principles for the administration of waiting lists including notification of data to the NTPF
- a requirement on hospital management to validate the waiting list at least quarterly
- the basis for addition to, and removal or suspension of patients from, the waiting list.

Patients on waiting lists should be medically fit for treatment and available for admission. Patients unavailable for social or medical reasons are placed instead on a suspension list until they are available for treatment. Patients who decline treatment, or do not attend on two occasions following receipt of admission dates, should be removed from the hospital waiting list.

Collection of Waiting Data by NTPF

36.6 Each of 44 public hospitals, excluding maternity and psychiatric hospitals, provide the NTPF with details of patients on its waiting list. The information, including contact details, medical or surgical procedure required and date of medical consultation, is sent weekly to the NTPF by electronic transfer. The information is collated by the NTPF to form the PTR. The PTR is available online and may be consulted at varying levels of detail by the general public, hospital staff or General Practitioners subject to password protection.

36.7 While details of all patients on waiting lists are provided to the NTPF, only patients who are on a hospital waiting list for longer than three months are available for an offer of NTPF intervention. When that requirement is taken into account together with the provisions of the National Guidelines for the Management of Waiting List Data, the 'active' PTR comprises patients who

- are waiting longer than three months
- have not been suspended¹¹² as unfit for treatment, or temporarily unavailable for social reasons
- have not been removed under request or due to failure to attend
- have not been scheduled for treatment by the hospital or through the NTPF.

36.8 This 'active' PTR is the focus of NTPF action, and its current total is the number usually quoted as the national in-patient waiting list. It includes those waiting for surgical and non-invasive medical treatments which may be provided on a day-case basis or may require one or more overnights in a hospital.

Validation of Data by NTPF

36.9 Hospitals are responsible for validating their waiting lists in line with national waiting list data management guidelines and for submitting that information to the NTPF. However, the validation of information received from hospitals in relation to persons waiting for treatment is also a statutory function of the NTPF. In 2007, following the introduction of the National Guidelines for the Management of Waiting List Data, the NTPF established a Review and Analysis Section to ensure by means of spot checks that the guidelines were being followed and that the hospital data was accurate. Further audits were carried out in 2008 and in 2009. Initially, the focus was on cases waiting for longer than 12 months, but this has since been widened to include those waiting in excess of nine months.

36.10 During the process, NTPF staff in conjunction with hospital staff examine the hospital records, and any necessary changes are agreed. Any resultant recategorisation of patients should take place either during the process or following receipt by the hospital of a subsequent NTPF report.

36.11 The results of the validation checks to date indicated that

- Only a small percentage of the cases reported to be longest waiting (ranging from 17% down to 8% in the three completed checks) were available for the offer of NTPF-funded treatment. In a partially analysed 2009 check, no cases were available. The NTPF indicated that this was a percentage of a constantly changing number of patients that totalled approximately 3,500 in 2008.
- The most common reason for unavailability for NTPF treatment (37% to 46% of cases) arose from the failure of hospital administration to follow up patients who had not responded to a previous contact e.g. the offer of a hospital admission date. In November 2008 three hospitals accounted for almost half of the numbers in this category – Letterkenny General (340), AMNCH Tallaght (228) and Sligo General (200).
- 29% or over 1,000 cases were removed from the active PTR as a result of the November 2008 NTPF validation process. Reasons included patients being unavailable for medical or social reasons who should have been removed to a 'suspended' list, as well as patients

¹¹² Approximately 8,000 patients were on the suspended patients list as at April 2009.

already scheduled for treatment. The largest number of removals were in Letterkenny General (100) and Sligo General (70).

- In a May 2009 partial analysis, 37% of patients or 226 out of the 612 cases analysed to date are recorded as unsuitable for treatment, for clinical reasons, other than in their own hospital – this is a major increase over previous findings¹¹³.
- In 2008, the NTPF validation process showed that for patients listed as waiting over 12 months, an average of 17% of this cohort were reported as having declined the option of treatment in another hospital under the NTPF scheme. The highest number 124 (or 44%) of the 282 patients in this category in November 2008 related to Letterkenny General Hospital.

36.12 A general summary of the initial three validations together with partial results from 2009 is set out in Figure 120. The NTPF has pointed out that the figures are influenced by the size of samples and actual hospitals examined.

Figure 120 Results of NTPF Validation of Cases on the PTR

Validation Scope	Nov 2007	May 2008	Nov 2008	May 2009^a
Hospitals Examined	27	26	33	20
Case Type Sampled	12 Months+	12 Months+	9 Months+	9 Months+
Number of Cases Examined	2,729	2,711	3,555	612
Audit Results				
Cases on the PTR not open to NTPF action due to failure of the hospital administration to follow up patients and keep records updated	46%	37%	46%	37%
Cases incorrectly on the PTR under the Guidelines, and to be removed	18%	25%	29%	14%
Cases for treatment in own hospital	15%	7%	9%	37%
Cases reported as declining NTPF intervention	4%	17%	8%	12%
Percentage not available for NTPF intervention	83%	86%	92%	100%

Note:

- a These are provisional results based on the analysis by the NTPF of 612 or 52% of the 1,177 cases examined.

Review of Waiting List Totals and Longer Waiting Cases

36.13 The NTPF provides extensive detail and analysis on hospital waiting lists through the medium of the on-line PTR, periodic reports on the PTR, and its Annual Report. The general classifications are between surgical and medical patients, and the main waiting periods of between 3-6 months, 6-12 months and over 12 months. Figure 121 details the numbers of patients recorded in these categories as at December 2007, December 2008 and April 2009.

¹¹³ The NTPF indicated that, in effect, a static number of untreated cases are forming a larger portion of a reducing overall total in each category.

Figure 121 Waiting List Totals as at December 2007, December 2008 and April 2009

Waiting Period	December 2007 ^a		December 2008		April 2009	
	Surgical	Medical	Surgical	Medical	Surgical	Medical
3-6 Months	7,279	1,597	7,280	1,932	7,080	2,090
6-12 Months	5,831	1,143	5,007	1,554	4,927	1,380
>12 Months	4,637	893	1,576	872	1,186	828
Sub Total	17,747	3,633	13,863	4,358	13,193	4,298
Total	21,380		18,221		17,491	

Note:

- a 2008 was the first year in which all 44 hospitals provided their waiting list details to the NTPF. 2007 includes all hospitals except Mayo General, Louth County, Monaghan General and Naas General.

36.14 The data in Figure 121 indicates that the numbers in each category across the three periods remain quite consistent, with the exception of the >12 month surgical category which has experienced a fall of the order of 75%. This category has been the main focus of the NTPF validation activity since 2007.

36.15 Examination of the 1,576 cases waiting more than 12 months for surgery at December 2008 revealed that

- The total was evenly split between day-cases and cases requiring at least one overnight stay in hospital. The NTPF indicated that hospitals have reported the vast majority of the day-case patients were unavailable for NTPF action as hospital administration follow-up was required, an offer of NTPF treatment had been declined or the patients were clinically unsuitable to be referred to the NTPF.
- While children accounted for 356 of these cases, the adult cases were spread quite evenly across age categories as follows: 19-40=>396, 41-60=>367, 61-80=>365 and 81+=>92.
- From a review of a listing of 1,319 of the 1,576 cases, a number of surgical procedures were somewhat more prevalent e.g. excision of skin lesion (143), male circumcision (97) and fibre-optic colonoscopy (93). However, overall there was a very general spread of required procedures with only one patient waiting in the case of each of 159 different procedures.

36.16 A review of the 13,193 cases awaiting surgical procedures for over three months at April 2009 showed that 66% of that number was accounted for in 11 hospitals, each of which had in excess of 500 patients on its waiting list. These hospitals included some of the largest in the State. Figure 122 indicates which of those 11 hospitals continue to have high numbers waiting in the 6-12 month and over 12 month categories. In the over 12 month category, two hospitals account for 89% of the children waiting and a further three hospitals record 49% of the equivalent adult list.

Figure 122 Hospitals with more than 500 Patients on the PTR as at April 2009

Hospital	Total	>300 for 6-12 Months	>60 for >12 Months		
			All Cases	Adult	Child
Cork UH	520	—	—	—	—
Letterkenny General	574	—	—	—	—
Mater	1,293	486	130	130	—
Mid-West Regional Dooradoyle	731	—	138	126	12
Midland Regional Tullamore	531	—	—	—	—
OLHSC Crumlin	841	356	146	—	146
Sligo General	641	354	—	—	—
St James's	808	—	—	—	—
AMNCH Tallaght	783	344	130	128	2
Temple St (CUH)	541	—	209	—	209
Galway (UCH)	1,466	501	—	—	—

Conclusions – Waiting List Management

The validation process that commenced in 2007 has found that fewer than 10% of those listed as waiting longest for elective treatment are available for treatment under the NTPF scheme. Consequently, it is difficult to see how the NTPF can discharge its functions in relation to those waiting longest for treatment.

The validation procedure suggests that the main categories of patients not open to an NTPF offer of treatment arise where

- hospitals did not follow up on patients that failed to respond to previous contacts
- patients should have been temporarily or permanently removed from the list.

These administrative weaknesses militate not just against effective provision by the NTPF of faster treatment, they must also reduce the ability of hospitals to schedule their own patients for treatment.

The finding in the most recent validation exercise that an increased proportion of patients (up to 37%) are now being reported by their own hospital as unsuitable for treatment elsewhere due to clinical reasons reflects a significant growth over previous validations.

Also, the number of patients waiting over nine months that have been recorded by their hospital as unwilling to accept an offer of private treatment under the NTPF scheme is surprising and must be a matter of some concern to the NTPF.

The fall of 75% in the number of patients waiting over 12 months following the validation raises questions regarding the integrity of the listings for shorter periods and as to whether the NTPF should perform some spot tests in those areas.

A review of the 1,576 patients waiting for over 12 months at end 2008 indicated an even spread across age groups and procedure categories. However, that long-term waiting list could more reasonably be considered to have a hospital focus, with two hospitals accounting for 89% of children on that list and a further three hospitals having 49% of the waiting adults. These concentrations would appear to provide an opportunity to the NTPF for a focused partnership approach beneficial to the long-term list.

Views of NTPF

36.17 With regard to availability of patients for treatment, the NTPF stated that as well as producing national waiting list guidelines for the management of hospital waiting lists it had directed specific campaigns at three hospitals. These campaigns were aimed at the longest waiters in those hospitals and resulted in a significant reduction in the number of the longest waiters in Letterkenny and Sligo.

36.18 The May 2009 results in relation to patients recorded as unsuitable for treatment other than in the hospital where they are waiting for treatment are based on a small cohort of patients and may not be representative. However, there has been little evidence of movement off that list. The evidence suggested that patients previously audited in this cohort were slow to be treated by hospitals. Hospitals needed to put structures in place on an ongoing basis to admit these patients.

36.19 The NTPF stated that its figures suggested that the number of long waiters reported as declining NTPF treatment was nearer 10%.

36.20 The NTPF stated that experience to date did not demonstrate that the same trends and validation issues relating to longer waiters also applied to persons waiting shorter periods. It was expected that the application of the waiting list guidelines should minimise those issues particularly in relation to five hospitals which it stated were not currently adhering to the guidelines¹¹⁴.

36.21 The NTPF was very conscious of problems in individual hospitals particularly in relation to the number of patients waiting greater than twelve months for surgery. Earlier in 2008, problems existed in a number of hospitals which were tackled on an individual basis. Joint approaches were arranged in association with the Department and the HSE.

Views of the Department

36.22 The Accounting Officer of the Department of Health and Children noted that prior to the establishment of the NTPF, the validity, comparability and accuracy of waiting list data was open to question and difficult to verify. He stated that the NTPF, working with the co-operation of acute hospitals, had developed a meaningful data set which could be validated according to nationally agreed guidelines.

36.23 He considered it to be unsurprising that validation exercises, especially when the subject of particular focus in a concerted national effort, would reveal large numbers not needing or not ready for treatment at that time. The NTPF had always been aware of this issue, and worked accordingly when planning its activities and arranging for treatment of individual patients. He did not consider that the efficient or effective functioning of the NTPF was impaired.

36.24 The Accounting Officer emphasised that the validation of waiting lists was as much a matter for individual hospitals as for the NTPF. The Department had placed considerable emphasis on ensuring that lists were validated, and that patients' treatments were not delayed unnecessarily because of administrative issues. The Department had been working with the NTPF and the HSE to ensure that hospitals liaised closely with the NTPF on speedy referral of patients who needed treatment, and on validation of patients who should not appear on the PTR. He considered that it was equally important to validate the waiting lists of those recorded as waiting for shorter periods, and he stated that the Department would work with the NTPF and the HSE on this issue.

The Provision of Treatment

36.25 The NTPF is required by the Department to maximise its activity levels while remaining within the resource budget provided. The key elements in the efficient management of treatment provision by the NTPF are

- the setting of budget and activity levels
- identification of patients for treatment
- procurement of treatment, and
- control over the cost of treatment.

¹¹⁴ The hospitals are – Mater, MWR Dooradoyle, OLHSC Crumlin, AMNCH Tallaght and Temple Street (CUH).

Budget and Activity Levels

36.26 As well as covering patient treatment, the overall budget also includes allocations for other activities including the provision of MRIs and out-patient appointments, and the development of the Fair Deal for the Elderly Scheme.

36.27 Annual proposals on activity levels and expenditure requirements are submitted for the approval of the Department of Health and Children. Detailed targets for levels of treatment provision are agreed with the Department in conjunction with the approval of the annual funding allocation. For instance, an allocation of €90.3 million has been approved for 2009 based on the anticipated treatment of 18,875 in-patients including an estimated breakdown as between the waiting categories of the order of 3-6 months – 30%, 6-12 months – 40% and over 12 months – 30%. The Department requested the setting of a target of having no one waiting for longer than 12 months at the end of 2009.

36.28 In response to an audit request for a breakdown of the number of treatments provided as between the 3-6 month, 6-12 month and over 12 month waiting list categories, the NTPF stated that it did not routinely collect this information because public hospitals were treated differently depending on progress achieved to date. It considered that to do otherwise would penalise the better performing hospitals.

36.29 The NTPF informed me that the monitoring of waiting lists was carried out on a number of levels by median wait time, by procedure, by surgical and medical group and, importantly, by hospital. The movement in those figures was the indicator by which the effectiveness of the funds allocated to the NTPF was measured.

36.30 Details were provided of the number of patients treated in 2008 and during the first half of 2009 who were more than 12 months waiting. For 2008, the monthly proportion of referrals of long waiters ranged from 47% down to 13%, with an overall average of 24% for the year. During the first six months of 2009, 16% of referrals were from the over 12 months group.

36.31 The NTPF also provided details of its current Hospital Eligibility Timeframes which govern their dealings with the different hospitals and specialties. For instance, in the case of St. James's Hospital, patients waiting more than three months can be referred to the NTPF while in the case of Temple Street Hospital the limit is twelve months. The NTPF stated that the reason for this variability was that, in the case of St. James's Hospital, there are not many long waiters while in Temple Street the opposite is the case.

36.32 The Hospital Eligibility Timeframes for the five hospitals referred to in paragraph 36.20 above as holding a significant number of those adults and children waiting over 12 months are set out in Figure 123.

Figure 123 Selected Hospital Eligibility Timeframes

Hospital	Adults >12 Mths	Children >12Mths	Eligibility Timeframe
Mater	130	—	6 Months
MWR Dooradoyle	138	—	12 Months
OLHSC Crumlin	—	146	6 Months
AMNCH Tallaght	128	2	8 Months/3 Months
Temple St (CUH)	—	209	12 Months

Identification of Patients for Treatment

36.33 The annual treatment work list comprises patients that are referred to the NTPF either by a patient's hospital or directly by a patient or his/her representatives. In addition, the NTPF may make unsolicited offers of treatment to patients based on the PTR.

36.34 Referrals by hospitals are the source of over 90% of the NTPF treatments provided each year. Following NTPF negotiations with hospitals, on the basis of the active PTR, each hospital commits to a quota of patient referrals together with a quarterly and monthly schedule of procedures to be referred. That even flow enables the NTPF to plan for the provision of treatments on a regular and financially sustainable basis. Within these patient identification negotiations, the NTPF prioritises the referral of the longest waiting patients that are on the PTR. However, the NTPF notes that there is no statutory provision to support this.

36.35 In addition to seeking hospital referrals, the NTPF also handles direct referrals from patients or their representative e.g. family members or GP. Once it is established that the patient is on the active PTR, that patient is included in the treatment provision process alongside the hospital referrals. Over 26,000 such referral contacts were received by the NTPF during 2008, and 6,281 were eligible for the provision of treatment by the NTPF. The NTPF stated that essentially all of these 6,281 patients had been treated. In discussions with public hospitals provision was made for the impact of directly referred cases¹¹⁵ although the scale of what is required varies from hospital to hospital.

Procurement of Treatment

36.36 The NTPF annually negotiates service level agreements with private hospitals for the provision of various treatments, and agreements with public¹¹⁶ hospitals are generally on an longer cycle. The agreements provide for an all-inclusive rate of charge for each type of procedure, details of participating consultants, and other terms and conditions. Prices for each procedure are negotiated individually with each hospital, and are based on standard¹¹⁷ surgery with a defined period of hospital accommodation where required. In cases where the length of stay is exceeded, provision exists for some degree of risk sharing. The actual cost associated with individual patients can vary substantially depending on an individual's medical history and response to

¹¹⁵ As treatment may have been arranged by NTPF following discussions with the patient's hospital, or separately in another hospital, there is undoubtedly an overlap between the figures for hospital referrals and direct patient-driven referrals.

¹¹⁶ Under direction of the Department the NTPF may not incur more than 10% of its treatment expenditure on public hospitals. This requirement is intended to ensure that only treatments which cannot or should not be provided by the private sector (e.g. specialist paediatric surgery) are funded by the NTPF in publicly funded hospitals. The intention is to avoid a situation where the NTPF double-funds procedures in public hospitals which would otherwise be provided under their existing budget.

¹¹⁷ The type of treatments funded by the NTPF includes complex surgery such as cardiac work and joints, and the standard rates agreed with hospitals include the normal mix of cases where some will be straight forward and some will give rise to expected complications. The understanding between NTPF and public hospitals is that cases of undue complexity or abnormality are not referred under the scheme.

surgery. Between contracts, prices for new or evolving treatments are negotiated on a case-by-case basis.

36.37 Patients referred for treatment and approved by the NTPF are allocated to client hospitals taking into account considerations such as the location of the patient, hospital capacity, procedure price and degree of medical complexity. Invoices for payment, together with supporting documentation, are received monthly from client hospitals following completion of treatment.

Cost Control

36.38 The commercial environment of price negotiation and competition requires a sensitive approach to publication of cost data from the NTPF, but full details of all transactions were available for audit review. Two separate exercises were performed with the objectives of seeking a measure of NTPF performance in regard to the setting of price levels and, subsequently, to holding payments to the contracted value.

36.39 A review of the 2008 contracts that had been entered into with both private and public hospitals established the average price for seven common procedures. The average prices were expressed as a percentage of a benchmark price derived¹¹⁸ from the national hospitals Casemix standard cost index. The results are set out in Figure 124 and indicate that

- The average contracted price for private hospitals is less than the adjusted Casemix figure in five of the seven procedures
- Over all seven procedures, the average contracted price for private hospitals is 5% below Casemix
- The contracted price for public hospitals is at least 23% below adjusted Casemix for all procedures, and averages 31% below. The Department has pointed out that the prices paid by NTPF for work in public hospitals do not contain a remuneration element for the treating consultant, as these personnel are in receipt of a public salary.

Casemix

Casemix is an internationally recognised multi-purpose calculation index based on the classification of diseases and procedures together with financial accounting data and is used to reflect the relative cost of a hospital's mix of cases compared to a national mix of cases. It is used by the HSE as a basis for part of the revenue funding provided to individual public hospitals.

Casemix does not take account of factors such as a return on investment or of the cost of capital which are significant elements of private hospital costs. On the other hand, it does include a training element not necessarily included in the private hospital sector.

¹¹⁸ It was agreed with NTPF that 2007 Casemix figures (the latest available) should be increased by 5% to anticipate an expected increase in 2008 Casemix due to additional costs. A further amount was added to reflect costs of pre- and post-operation appointments that are not included in Casemix but are included in the 'all-in' NTPF prices.

Figure 124 NTPF 2008 Average Contracted^a Prices in Relation to Adjusted Casemix

Procedure	Private Hospital	Public Hospital
	Contract Price	Contract Price
	%	%
Knee Replacement	109	77
Hip Replacement	89	75
Cataract Extraction	93	71
Tonsillectomy	94	74
Unilateral Squint	118	75
Coronary Artery By-pass	85	55
Hernia Repair	76	58

Note:

- a Information is expressed as a percentage of adjusted Casemix due to commercial sensitivities about absolute prices.

36.40 For the second test, a specific individual invoice payment was selected for each of the common procedures giving four invoices for each procedure split between private and public hospitals. The invoiced costs paid were expressed as a percentage of the agreed contract price. There were three instances of significant uplift for which NTPF provided detailed explanations as follows

Procedure	Cause of Price Uplift
Knee replacement	Requirement for extra hospital stay
Cataract Extraction	Requirement for overnight stay
Cataract Extraction	Artificial lens inserted

36.41 In one instance, the amount paid was less than the contract price as a procedure for which there was an overnight contract was performed as a day case. The overall results of the second test are set out in Figure 125.

Figure 125 Invoice Price as a Percentage of the Contract Price for Public and Private Hospitals

Procedure	Private Hospitals		Public Hospitals	
	Q2 Invoice	Q4 Invoice	Q2 Invoice	Q4 Invoice
	%	%	%	%
Knee Replacement	108	100	100	100
Hip Replacement	100	100	100	100
Cataract Extraction	112	113	100	100
Tonsillectomy	94	100	100	102
Unilateral Squint	100	100	100	100
Coronary Artery By-pass	100	101	100	— ^a
Hernia Repair	100	100	— ^b	102

Notes:

- a An invoice was selected from each of the second and fourth quarters of 2008.
 b No payment in the Quarter.

Conclusions – Management of Treatment Provision

Most procedures purchased from private hospitals cost less than the casemix adjusted benchmark cost.

Two procedures – knee replacement and unilateral squint, which cost 109% and 118% of the benchmark respectively - are outside of this pattern, while a similar departure is not evident in the case of related public hospital prices. There were three ‘post contract’ cost uplifts in the small sample subjected to detailed examination. These arose due to claims for additional work or a necessity for an additional night in hospital.

In light of the fact that cases are pre-selected by the referral system as relatively straightforward, and taking account of the volume and the value of NTPF business, consideration might be given to acceptance by the private hospitals of a greater share of risk.

The cost of treatment purchased from public hospitals is of the order of 25% less than private hospital cost. However, public hospital prices are not commercially sustainable, being on average only 70% of adjusted Casemix cost and exclusive of consultant fees.

Views of the NTPF

36.42 The NTPF stated that prices were negotiated in advance of treatment and include costs for the entire episode of care (routine visits before and after surgery, medical professional fees and hospital accommodation are included in NTPF prices). While the treatment was provided free of charge to eligible public patients, getting value for taxpayers’ money was a priority. Prices offered by hospitals were subject to a number of tests to help make sure this was achieved. These tests included comparing prices offered against

- Cost information for similar treatments in public hospitals.
- Prices offered to NTPF for similar treatments in peer hospitals.
- An NTPF estimate of a reasonable price based on the component parts of the particular treatment (e.g. likely medical professional fees, theatre costs, whether prosthesis costs are likely, drugs, etc.). NTPF have built up a knowledge base of typical patterns of treatment costs that helps with this comparison.
- Where publicly available, prices paid by private medical insurers for the professional fee and hospital accommodation elements of hospital care.
- International data on treatment prices where relevant.

36.43 In recent years, additional capacity in the Irish private health sector had provided further value opportunities to NTPF and these had been availed of. For 2009 the NTPF had negotiated procedure prices downwards. Examples were in the case of hips, knees and cataracts where prices have reduced by between 5% to 15%. In addition, prices paid by the NTPF were competitive compared with published public hospital costs.

Overall Conclusions

NTPF Administration

The examination suggests that, relative to the casemix benchmark, procedures purchased from private hospitals by the NTPF generally cost less than those carried out in the publicly funded hospital system. The initial cost of these procedures is necessarily set on the basis of complication free surgery. In general, the samples examined suggest that cost uplifts are limited to cases demanding extra care.

The extensive removal of longer-waiting patients from hospital waiting lists as a result of on-site validation reviews by NTPF staff has left less than 10% of those previously listed now available for treatment under the NTPF scheme. This creates a particular difficulty for the NTPF in addressing its primary target group.

There may be a need for an in-depth review of a sample of cases removed from the PTR following NTPF validation in order to determine

- the factors that give rise to those removals, and
- why the delay in removing them from the register arose in the first place.

That type of analysis may uncover opportunities for more proactive waiting list management.

The NTPF contribution to clearance of the PTR is essentially programmed on foot of agreements with hospitals. However, as 30% of its cases arose from direct patient-driven referrals, it may also be useful to examine

- the source of demand for its services, and
- the extent to which its activity, in current circumstances, actually targets the longest waiting patients.

Wider System Implications

From a more general perspective, it is clear that the volume of procedures purchased by the NTPF from private hospitals represents only a small proportion of the overall annual publicly funded hospital throughput of elective treatments – of the order of 3% of total elective treatments or about eight days work of the overall system. Given the issues noted in regard to the management and clearance of the waiting list during this examination, it would be worth exploring

- whether and to what extent an increase in public hospital capacity (due to the recent agreement of an extra four hour time commitment from consultants under Consultant Contract 2008) or the elimination of any spare capacity already existing could be used to reduce or eliminate the waiting list
- whether throughput norms for specific procedures can be set for each publicly funded hospital so as to manage demand effectively
- whether there might be a need to broker exchanges between the public hospitals so as to achieve more cost effective waiting list clearance and
- how hospitals might be incentivised to maintain more accurate waiting list information.