

Chapter 14

Health Service Executive

14.1 Discretionary Medical Cards

Introduction

Section 45 of the Health Act 1970 (the Act) provides that adults and their dependants have full eligibility for health services if they are “unable without undue hardship to arrange general practitioner, medical and surgical services for themselves and their dependants”. The Act gives the Minister for Health and Children the power to make regulations specifying a class or classes of people who may be deemed to meet this criterion. No such regulations have been made.

There are a number of groups who are entitled to full eligibility for health services regardless of means. These include people over the age of 70, certain EU migrant workers, persons affected by the drug thalidomide and persons with retention entitlement under government schemes designed to encourage people into employment. Apart from these groups, medical cards are issued by the Health Service Executive (formerly by the health boards) to persons who, in the opinion of the HSE are unable to provide general practitioner medical and surgical services for themselves and their dependants without undue hardship. In practice, cards are issued largely on the basis of an assessment of the applicant’s income. Income guidelines for the award of medical cards are drawn up each year by the HSE. People whose income is below the guideline figure for their circumstances get a medical card⁵⁰. In general, those whose income is above the guideline figure do not qualify unless they have particularly high medical expenses or there is other evidence of hardship. The term “discretionary medical card” has come to be applied to cards awarded to persons whose income exceeds the guideline figure.

Payments to Doctors for Discretionary Medical Cards

In 2001 the Department of Health and Children agreed with the Irish Medical Organisation (IMO) that, pending an examination of the discretionary medical card area, a sum of €2.54m would be paid to doctors under the General Medical Services Scheme (GMS) in respect of services to certain discretionary medical card holders. The figure of €2.54m was arrived at in the light of the Department’s understanding that there were about 20,000 discretionary medical cards in issue. The money was allocated to individual doctors in proportion to GMS patient panel size as at 1 January 2001. The payment was in addition to the normal capitation payment made to doctors for their GMS patients.

In informing the health boards of the agreement with the IMO, the Department indicated that the examination of the discretionary medical card area would commence in 2001 and would seek to determine the nature and extent of discretionary cards in the GMS scheme. In the event of the examination not being completed by the year-end, with appropriate agreed alternative arrangements put in place, the sum of €2.54m adjusted for national pay increases would also be paid in 2002 on the same basis.

In April 2002, the Department wrote to the Chief Officer in the General Medical Services (Payments) Board, now the Primary Care Reimbursement Service (PCRS) and part of the HSE, stating that the payments for 2001 should be increased from €2.54m to €9.52m. This was on the basis that the Department now believed that the estimated number of discretionary medical cards was 75,000 and not 20,000 as previously thought. The arrears for 2001 were to be paid in 2002 and the payment for 2002 was to be made on a monthly basis in proportion to the size of each doctor’s GMS patient panel. A second letter in April 2002 from the Department to the health boards and the GMS clarified that the additional payment to doctors in respect of discretionary cards was not intended to remunerate them in respect of all discretionary card holders. The Department indicated that, in this context “discretionary medical cards are understood to refer to those given to persons who, although significantly above the income guidelines

⁵⁰ A new GP Visit Card scheme was introduced in the 2005 Budget. The scheme provides free access to GP services only, for eligible individuals and families. Income guidelines are 25% higher than for medical cards.

for medical card eligibility, would by virtue of a condition or illness, necessitate a GP visitation rate significantly above the norm, thereby incurring increased costs.” This was a significant narrowing of the definition of a discretionary medical card for the purpose of paying the extra amount to GPs.

The Department also indicated that when the actual numbers covered by discretionary medical cards became known an adjustment to the aggregate amount for each year, e.g. the €9.52m for 2001, would be made. The Department also asked for details of required changes to the systems in the GMS and at health board level in order that these more narrowly defined discretionary cards could be identified and payments could be made on foot of actual numbers. In a letter to the health boards, the Department stated “health boards should take the necessary steps to ensure that it is possible in future to associate discretionary medical cards with individual doctors for payment purposes.”

€10.046m was paid in 2005 in respect of 75,000 cards. Each year since it issued the original instruction, the Department has confirmed in writing that payments should continue under the arrangements. A total of €50.7m has been paid out to GPs under these arrangements up to 31 December 2005.

Audit Objectives

The audit objectives were

- To determine if the discretionary medical card scheme operated in a uniform way across the health service
- To review what progress had been made in moving towards paying doctors for the actual numbers of discretionary card holders on their panels, as originally envisaged by the Department in 2001.

As part of the audit, the HSE regions were asked to provide details of all current GMS Medical Cards on their systems as at 31 December 2005 and the numbers which had been awarded on a discretionary basis. The PCRS provided details of the number of GMS medical cards on its system.

Audit Findings

Operation of Scheme

Table 46 shows the total number of discretionary medical cards issued by region, discretionary cards as a percentage of eligible individuals and discretionary cards as a percentage of eligible family units.

Table 46– Discretionary Medical Cards by HSE Region

Region	Number of Discretionary Medical Cards Issued	Discretionary cards as % of eligible individuals	Discretionary cards as % of eligible family units
Eastern	7,418	2.17	3.19
Midland	4,885	6.98	10.33
Mid Western	4,950	4.94	7.18
North Eastern	1,428	1.43	2.17
North Western	2,915	2.95	4.76
South Eastern	8,415	6.06	9.09
Southern	11,878	6.85	9.64
Western	3,794	2.84	4.17
Total	45,683	3.95%	5.84%

As the results shown in Table 46 seem to suggest that the scheme is not administered across the country in a uniform way, I asked the Accounting Officer the basis on which discretionary medical cards are

awarded and for an explanation for the significant variations in the percentage of discretionary cards to eligible persons between the different HSE regions.

The Accounting Officer informed me that in the first instance every application for a medical card is assessed based on the national income guidelines. In cases where applicants are deemed to be in excess of the guidelines the HSE can take account of extenuating medical and or social circumstances of applicants. Medical circumstances might relate to a person or indeed family unit who, despite being in excess of the income guidelines, require frequent visits to their GP and outlay on drugs or medicines due to family member(s) having an established medical condition, such that the costs of meeting their medical needs outweighs the assessed income excess. An example of a social circumstance could be a family unit where, despite being assessed as being in excess of the means guidelines, the HSE becomes aware that the bread winner has an addiction problem and is not adequately supporting the spouse and children. To alleviate the ensuing hardship, the HSE can exercise its discretion and grant a medical card to the spouse and children in such circumstances.

The Accounting Officer stated that geographical variations in the percentage of discretionary medical cards as a proportion of all cards is an issue that warrants further examination and this will be conducted as part of a process currently under way to validate the total number of discretionary medical cards. It should be noted however, that the HSE has issued standardised national guidelines in the last year which deal with, among other things, the exercise of discretion in the issue of medical cards.

Establishing the Number of Discretionary Cards

The remuneration of doctors for medical cards assumes the existence of 75,000 discretionary cards. The figures provided by the HSE regions suggest the real figure may be far lower, perhaps as low as 45,600. The figure recorded on the PCRS database is lower still at 36,000. The Accounting Officer has indicated that the ongoing validation exercise in all HSE regions is likely to reveal that the figure is between 65,000 and 68,000.

These figures refer to all discretionary cards regardless of the circumstances that gave rise to their issue. On the other hand, it is clear from the Department's correspondence to the health boards in 2002 that the intention was to pay additional remuneration to doctors only in respect of cards issued to persons whose income was "significantly" above the income guidelines and who by virtue of a condition or illness required a rate of GP visit "significantly" above the norm.

The HSE's national guidelines on medical card entitlement lists the following matters as factors to be taken into account in considering whether undue hardship arises in any case

- Illness or medical circumstances
- The cost of providing general medical and surgical services
- The cost associated with the provision of medical, nursing and dental treatment
- The cost of physiotherapy and speech and language therapy
- Transport cost to hospitals and clinics
- Addictions such as drink, drugs and gambling
- Poor money management
- Social deprivation – including poor home management
- The cost of medical aids and appliances.

It is clear from this list that there is a range of circumstances in which discretionary medical cards might be issued that might not involve a rate of GP visit in excess of the norm. It follows that the discretionary

cards that give rise to the extra payment to doctors is likely to be less than the total number of discretionary cards recorded on the HSE systems.

I was concerned that payments continued to be made on the basis of the 75,000 estimate, which now appears to be too high, and that the payments continue to be made to doctors in proportion to patient panel size instead of on the basis of the actual number of their patients holding discretionary medical cards.

In response to my enquiries, the Accounting Officer informed me that at the time of the agreement with the IMO the former health boards were not routinely collecting details such as frequency of GP visits by individual patients or details of patients' income levels. The best available figure was the estimated number of all cards where the applicant's income was above the guidelines. He considered this to be a critical point because the number involved i.e. 75,000 was not and could not be sufficiently refined to reflect only those whose incomes were considerably above the guidelines and who require frequent visits to their GP.

The Department, as the brokers of this agreement, had been requested on a number of occasions to give a working definition of the discretionary cards that were intended to be comprehended by this agreement (i.e. what is the threshold for "significantly above the guidelines" etc.). As part of the Schemes' Modernisation Programme, the HSE has even gone as far as suggesting a definition to the Department, but a determination on this is still awaited. In anticipation of a clear definition against which an actual assessment of discretionary cards can be based, the HSE has introduced a coding system in which discretionary cards are categorised according to income excess bands. This enhancement will make it easier to calculate the exact number of such cards going forward. On renewal of each discretionary medical card, HSE areas are collecting data which enables coding of the card into one of four income bands above the qualifying income thresholds. All new discretionary medical cards are subject to this coding system also. The income coding bands are up to 25%, 25%-50%, 51%-85% and in excess of 85% above the qualifying income threshold for a medical card. The coding exercise was rolled out nationally in mid-2005. Given that the average period of issue for medical cards is 2 years, the majority of cards will be re-issued and appropriately coded within a 2 year timeframe. A definition from the Department is still a necessity however.

The Accounting Officer said that in his opinion payments can be made in respect of actual numbers of discretionary medical cards, subject to clarifications of definitions by the Department and application of those definitions to each individual record thereafter. There would, however, be a considerable workload in doing this first time off, but, once done, it would then become a data management issue. The recalculation of amounts paid to date would have to be considered with the Department following the validation exercise and clarification of definitions.

Views of the Department of Health and Children

In light of the comments of the Accounting Officer, I asked the Department of Health and Children for its observations on the matter.

The Department's Accounting Officer informed me that the arrangement regarding medical cards agreed with the IMO arose in the context of difficult industrial relations negotiations aimed at giving effect to the Government's decision to extend eligibility for a medical card to all persons aged 70 or over. During those negotiations, the IMO tabled a wide range of issues which they sought to have resolved before their members would agree to provide a service to all over 70s, free of charge to the patient. In particular, the IMO sought extra payment in respect of discretionary medical cards on the basis that these were cards awarded to a significant number of persons not by reference to their means but because of a requirement to visit a GP frequently. The IMO argued that these patients represented a predictable high workload and that, instead of having a balance of low and high workload patients, GPs' patient panels were becoming

increasingly skewed towards high demand clients. Payments were made on a notional figure of 20,000 discretionary medical cards, subject to review.

In 2001 and 2002, the Department made a considerable effort to obtain information from the health boards in relation to the number of discretionary cards. In several cases, the health boards were unable to provide the information and it became clear that the interpretation of the term “discretionary medical card” varied considerably between health boards.

A further difficult industrial relations situation developed in March 2002 and there was a threatened withdrawal by GPs from the GMS scheme. The issue of discretionary cards was again raised by the IMO who contended there were an estimated 75,000 persons covered by discretionary cards. The information the Department had by then obtained from the health boards supported this figure and it was decided payment would be made on the same basis as previously in respect of 75,000 discretionary cards.

The Department continued to request the health boards to put systems in place to identify the actual number of discretionary cards so they could be associated with individual GPs’ panels. The Department’s standard definition of “discretionary medical card” which it issued in April 2002 was meant to enable the health boards adopt a common approach. The definition was intended to differentiate between persons awarded a card based on means, even if they were marginally above the income assessment threshold, and those where the impact of a medical condition was the main determining factor. It was anticipated that when the health boards had established accurately the number of discretionary medical cards, it would provide a basis to re-engage with the IMO on the matter.

The Accounting Officer also stated that the whole issue of discretionary medical cards will now have to be addressed in the context of a major review of all aspects of the GMS contract which has been underway since late 2005 under the auspices of the Labour Relations Commission (LRC). He said it would be inappropriate at this stage to deal with the matter outside of the LRC process and that there were a number of other issues that would need to be taken into account in addressing the matter -

- The significant adjustments made to the system and guidelines for assessment of applicants for a medical card in 2005
- The introduction of the new GP visit card
- A current review of eligibility legislation
- The draft national partnership agreement “Towards 2016” which provides for a review of the eligibility criteria for the assessment of medical cards.

14.2 Nursing Home Subventions

The Health (Nursing Homes) Act 1990 (the Act) provided for the introduction of the Nursing Home Subvention Scheme by health boards. The purpose of the scheme is to provide financial support for eligible persons who avail of private nursing home care. Eligibility is determined by reference to two criteria

- The degree of dependency of the person
- The person's means and circumstances.

The way in which these two criteria should be assessed is set out in detail in regulations introduced in 1993 and amended on a number of occasions up to 2005. Application for subvention can be made either by the person concerned or someone acting on his or her behalf. The HSE became responsible for administering the scheme in 2005, following the dissolution of the health boards.

Assessment of Dependency

Dependency is determined by means of a clinical assessment. The assessment involves an evaluation of the ability of the person, in respect of whom a subvention has been sought, to carry out the tasks of daily living, the level of social support available to the person and the medical condition of the person. Assessment is based on of degree of mobility, ability to dress unaided, ability to feed unaided, ability to communicate, extent of orientation, level of co-operation, ability to bathe unaided, quality of memory and degree of continence. There are three levels of dependency:

Medium Dependency – the person requires nursing home care because the appropriate support and nursing care required by the person cannot be provided in the community.

High Dependency – the person's independence is impaired to the extent that s/he needs nursing home care but is not bed bound.

Maximum Dependency – the person's independence is impaired to the extent that s/he requires constant nursing care.

The level of dependency assessed under the scheme determines the maximum weekly rates of subvention. The current rates are

- Medium Dependency €114.30 per week
- High Dependency €152.40 per week
- Maximum Dependency €190.50 per week.

Assessment of Means and Circumstances

The regulations provide that in assessing the means of a person the HSE must take all sources of income into account, including wages, salary, pensions, allowances, payments for part time and seasonal work, income from rentals, investments and savings and all contributions from whomsoever arising. The HSE is permitted (but not obliged) to consider any assets of the person in assessing the means.

While the HSE has discretion as to whether or not to take assets into account in assessing means, there are specific rules set out in the regulations in relation to how assets are to be taken into account should it choose to do so. In particular, the HSE may refuse to pay any subvention if either of the following apply

- the claimant's principal residence is valued at €500,000 (for properties in the Dublin area) and €300,000 (for the rest of the country) and the claimant's income is greater than €9,000 per annum or
- the value of the claimant's assets (excluding principal residence) is greater than €36,000.

There are two significant exceptions to these rules

- the first €11,000 of any assets must be disregarded
- a claimant's principal private residence is not taken into account if it is occupied immediately before the application and continues to be occupied by the claimant's spouse, a child aged under 21 or in full-time education or a relative in receipt of disability allowance, blind person's pension, disability benefit, invalidity pension or Old Age Non Contributory Pension.

Enhanced Subvention Payment

Articles 22.3 and 22.4 of the Nursing Home (Subvention) Regulations make provision for the payment of enhanced subvention. Effectively, this means that the HSE may make an enhanced payment in addition to the maximum weekly rate. The sum of these amounts, when taken in conjunction with the individual's available income can in some cases meet the full cost of the bed in the private nursing home. Enhanced payments arise in situations where, even with the maximum subvention, the family or individual cannot afford to meet the shortfall in costs of nursing home care and there are long waiting lists for public beds. The amount of each enhancement will differ, as the amount granted is based on the person's income, their level of dependency, the nursing home fees and on budgetary constraints.

There are no clear rules in the regulations about who is entitled to get enhanced payments. In practice, the making of enhanced payments is a matter for each HSE Area and each case is assessed individually. There is no maximum amount for enhanced subvention in the regulations and it is a discretionary matter for the relevant Local Health Office (LHO) areas.

Legal Cases

A number of High Court challenges (104 at July 2006) are being taken to test the constitutionality of the Health (Nursing Homes) Act 1990 and the related regulations. The legal cases relate to entitlement and eligibility, with the claimants arguing that they had to use private nursing homes, as there were no public beds available.

Expenditure - 2005

The total amount paid out under the scheme in 2005 was €109.8m of which €49.2m was in respect of enhanced subvention.

Audit Findings

In the course of the audit, the 19 LHOs responsible for administering the scheme were surveyed to establish the extent of the different approaches to the treatment of principal residence in assessing means and the payment of enhanced subvention. The survey did not seek to establish whether the means testing of income was carried out in a consistent way.

Assessment of Principal Residence

The survey revealed that there were some inconsistencies in how a principal residence is treated in assessing means. Specifically, 7 LHOs indicated that they do not take a principal residence into account if the house is occupied by a relative. This is not in line with the regulations which provide that the principal residence should only be disregarded if it is occupied by a spouse, a child aged under 21 or in full-time education or a relative in receipt of certain Social Welfare benefits. While the other 12 LHOs took the principal residence into account for means purposes in accordance with the rules, two areas indicated that they had not done so until December 2005. The main reason advanced for this approach was that property prices in these areas were low.

Payment of Enhanced Subvention

The survey also indicated widely different practices in calculating the amount of the enhanced subvention. In summary

- 10 LHOs pay a maximum payment between €360 and €680 -less assessable income
- 3 LHOs pay up to the cost of the bed less assessable income
- 5 LHOs pay between €38 and €250 - plus the standard subvention
- 1 LHO pays an agreed amount.

Applying the different practices to a typical case showed that an individual or supporting family members could end up paying varying amounts to meet the cost of private nursing home fees depending on the area in which they were located. For example, in the Southern, North East and three Dublin/East HSE areas no contribution would be required, whereas in the South East, Mid-West and Western areas a substantial contribution could be required. Moreover, in some counties in the Midland and North West areas a substantial contribution could be required, while in other counties in the same areas no contribution would arise.

The results of the survey reflect the approach taken by LHOs in the generality of cases. However, in cases of hardship LHOs may exercise discretion to increase the amount of enhanced subvention to cover the balance of the cost of a nursing home bed not met by the individual. The LHO will often seek to negotiate an agreed charge with the nursing home or to fix the charge for a period of around 12 months. The instructions used by LHOs do not give any guidance on how such discretion ought to be exercised, and it is not possible to say whether discretion is exercised in a reasonably consistent basis across LHOs.

Audit Concern

In light of the apparent inconsistencies in approach, both to assessment of means and to the payment of enhanced subvention in the HSE regions, I sought the views of the Accounting Officer.

Accounting Officer's Response

The Accounting Officer informed me that the discretionary nature of the enhanced subvention, as it operated in the old Health Board system, is fundamental to the inconsistencies which now exist and which are being addressed by the HSE in the context of a unified delivery system. In the old Health Board system, each Health Board established criteria for a methodology of payment of basic and enhanced subvention arrangements which generally would have been reported formally to the Health Boards' members in the context of the monthly Board meetings, etc. However, the overall extent of discretionary support would be influenced by budgetary constraints and the amount of funding provided by the Department of Health and Children.

Health Service Executive

In the old system each individual Health Board was a legal entity in its own right and was entitled to provide for such arrangements as part of the annual service plans agreed with the Department.

The Accounting Officer detailed the underlying issues giving rise to the inconsistencies in the operation of the Nursing Home Subvention Scheme nationally

- The 1993 Subvention Regulations were open in a number of sections to varying interpretations
- The guidelines which accompanied the regulations were not detailed and comprehensive
- Lack of communication between Health Boards led to inconsistencies in interpretation of the legislation and guidelines
- There was a significant degree of variation between Health Boards in resources available to services for the elderly e.g. long stay beds, etc.
- There were varying per capita budgets allocated to Health Boards for the subvention scheme
- Differing demographic and geographical profiles between Health Boards resulted in differing emphases within Health Boards.

The demand for enhanced subvention in any area tended to be influenced by a number of factors

- The percentage of the population over 65 in need of continuing care
- Total number of continuing care beds available, both public and private, to meet that need
- Number of public beds available.

The ratio of public beds to the number of people over the age of 65 varied significantly between Health Boards. Where there were a large number of public beds available in local Health Board long stay hospitals, the demand for subvention within that area was reduced. Likewise, if a Health Board had few public beds available, proportionate to the local need, the pressure for support from the subvention scheme tended to be greater. In practice, this may have led to a more comprehensive enhanced subvention scheme in such Boards.

The cost of private nursing home care also varied widely between Health Boards. Currently, fees charged by private nursing homes can range from €550 per week to €1,100 per week depending on location. The main factors that determine these costs include local supply and demand for places and local costs such as building and staffing. The variation in private care costs is reflected in the value of enhanced payments.

As part of the transition of the Health Board system to the HSE, a comprehensive risk assessment was undertaken by the outgoing CEOs of the Health Boards at the time and this was provided by way of a report to the then CEO of the HSE. This document identified the risks associated with the merging of 11 Health Board structures to a unified system with the inconsistencies of interpretation of various services including the Nursing Home Subvention Scheme.

In the context of the varying degrees to which these inconsistencies existed in the old system, the Accounting Officer stated that there are arrangements which existed in the Health Boards, and continue to exist in the HSE, to deal with individual cases which arise where anomalies are highlighted arising from inconsistency in interpretation or application of the scheme. These cases are generally dealt with by the Appeals Officers and are also dealt with by Local Health Managers and Assistant National Directors as appropriate.

The HSE recognises that the move towards a unified system with a standardised interpretation and application of the legislation and regulations can only be implemented on a phased basis. This is because

of the resource issues involved and the necessity for arrangements to underpin the legislative and regulatory amendments through the Department.

Since the establishment of the HSE, arrangements are now being put in place to address the inconsistencies. In relation to Services for Older People, a National Steering Group has been established and through this process arrangements are being made to progress this agenda on a systematic basis. Within this national framework, a Working Group has been established and one element of its work relates to the development of a standardised approach towards the implementation of the Nursing Home Subvention Scheme across the health service. The Working Group's terms of reference include the effectiveness of current legislation in terms of

- The legislation's implications regarding equity of access
- Clarification of the HSE's legal obligations
- Identification of gaps and risks and the highlighting of their implications (financial and other) to the HSE.

The approach being taken by the HSE is to standardise the arrangements within the existing legislative and regulatory framework, while at the same time working with the Department to ensure a more appropriate and equitable legislative framework for the future. The underlying issues related to eligibility and entitlement and funding arrangements in relation to the provision of Long Stay Care for Older People, both public and private, have been the subject of ongoing consultation with the Department in the old Health Board system and also since the establishment of the HSE. The Department, in the Health Strategy and more recently following a Supreme Court decision on Long Stay charges, has confirmed that it is at an advanced stage in developing a comprehensive legislative and regulatory framework which will address the overall eligibility and entitlement for these services including the Long Stay Care for Older People.

The Accounting Officer concluded by stating that significant work had been undertaken over the past couple of years in this area and the Government established a high-level Departmental group chaired by the Department of An Taoiseach to address Long Stay Care for Older People, which will also address equitable arrangements for the funding of Long Stay Care for Older People going forward. This work is grounded in the Mercer and O'Shea Reports, and the HSE understanding is that recommendations will be going to Government shortly on the matter. The HSE is working closely with the Department in relation to these issues.

14.3 Extra Remuneration

Public financial procedures prescribed by the Department of Finance require that each Appropriation Account shows the total amount charged to the Account in respect of overtime and extra attendance, the number who were paid overtime and the highest individual overtime payment in the year. Because of the nature of the health service, the HSE Appropriation Account also includes details of extra remuneration in respect of allowances, night duty, weekend pay, on-call and other payments. Total expenditure on extra remuneration in 2005 was €585,651,417 as shown in Table 47.

Table 47

	€
Allowances	92,528,783
Overtime	187,148,078
Night Duty	64,451,495
Weekends	166,379,057
On-Call	49,019,852
Other ⁵¹	26,124,152
Total	585,651,417

It should be noted that certain individuals receive extra remuneration in more than one category.

Total payroll costs for the HSE for 2005 (per the Income and Expenditure Account) was €4,029,586,638 of which extra remuneration represented 14.5%.

The results of an audit analysis of the 30 highest recipients of extra remuneration in the different categories⁵² in each of the 10 former health board areas are shown in Table 48.

Table 48 – Analysis of high earners

€	Overtime	Weekends	Allowances	NightDuty	On-call	Other	Total
125,000 - 150,000	7	0	0	0	0	0	7
100,000 - 125,000	15	0	4	0	0	1	20
75,000 - 100,000	66	0	4	0	3	2	75
50,000 - 75,000	161	0	9	0	17	5	192
25,000 - 50,000	51	2	73	0	254	35	415
0 - 25,000	0	298	210	300	26	167	1,001
Total	300	300	300	300	300	210⁵²	1,710

A further analysis showed that the 22 largest overtime payments (i.e. all those greater than €100,000) were to Non-Consultant Hospital Doctors (NCHDs). The 3 highest earners worked for 3,530; 3,193 and 2,419 hours in 2005 on top of their normal working week of 39 hours. This involved average overtime hours of 75; 68 and 51 hours per week respectively, for 47 working weeks.

⁵¹ Other pay includes group and individual arrears apart from national agreements and miscellaneous allowances.

⁵² Not all HSE areas categorise payments in the "other" category.

It should be noted that 28 of the 300 highest overtime earners were also in the top 30 recipients of payments from the other extra remuneration categories in their areas and received amounts ranging from €6,311 to €61,226 in this respect. Other high overtime earners may have been in receipt of payments in the other extra remuneration categories but were not in the top 30 recipients for their area.

While accepting that a level of extra remuneration payments will always be necessary and desirable because of the nature of HSE operations, I asked the Accounting Officer

- what measures the HSE has in place to ensure that resources expended on extra remuneration payments are used economically and efficiently
- what day-to-day management, budget control and monitoring procedures are in place in the HSE in relation to extra remuneration
- whether the HSE is satisfied that its attendance and rostering systems and controls are adequate to manage such significant additional payroll expenditure.

The Accounting Officer said he was acutely conscious of the need to ensure optimum use of resources, while minimising cost exposure or reliance on additional allowance / overtime etc, and always maintaining the levels of coverage for the provision of care. The HSE's Medical Manpower Managers continuously examine NCHD rosters in the interests of safe service provision, training and value for money, with a particular focus on reducing hours in the context of the European Working Time Directive (EWTID).

Day-to-day management and control of NCHD overtime relies on a requirement that all NCHD hours, including overtime, must be signed off by the supervising consultant. These hours, as recommended for payment by the consultant, are then matched against agreed service rosters for each grade and specialty. Claims for payment are checked against rosters and on-call rotas by payroll or medical administration staff under the supervision of a Medical Manpower Manager or Hospital Manager.

The nature of acute health service provision is such that emergency situations or delays at scheduled theatre or clinic sessions will arise intermittently, with a consultant requiring additional unrostered NCHD cover. Prior to 2006, monitoring and control of the cost of unrostered cover was effected by obtaining details of unrostered hours and routinely auditing and verifying them against hospital activity before payment for this additional unscheduled work. Where patterns of unrostered hours were developing, these were addressed with individual NCHDs and their supervising consultants as necessary.

The Accounting Officer informed me that the HSE is aware that NCHDs are working increasingly beyond their rostered hours, resulting in unsustainable overtime costs. In May 2006, the National Hospitals Office issued directions to all Hospital Managers in relation to unrostered NCHD overtime. The directions require that all NCHDs work in line with their rostered hours. Hospital Managers were instructed to approach individual consultants and inform them that the current budget cannot support unrostered NCHD overtime.

The new directions require Hospital Managers to

- confirm the roster for each individual specialty on the basis of service need
- remind all NCHDs directly of their individual unit roster and
- advise NCHDs that they will be paid for their rostered hours only and must finish duty at their rostered time.

A new control was introduced to the effect that any requirement for NCHD to work beyond his/her rostered hours must now have the prior approval of the Hospital Manager. This arrangement took immediate effect. It is supported by a policy of monitoring all overtime sheets to verify that the hours claimed have been approved by each Hospital Manager. Overtime claims which do not have the required approval will not be paid and will be returned to the individual NCHD for correction.

The Accounting Officer added that the use of sophisticated rostering IT solutions may present local management with potential advantages in managing attendance levels and rostering arrangements. He indicated that the integrated HR information and payroll system (PPARS), which had been planned by the former health boards had been intended to address, inter alia, some concerns in this area. However, the HSE had suspended any further roll-out of this project until it is satisfied as to the value proposition involved.

Consequences for Service Delivery

I also asked the Accounting Officer whether the recruitment of additional staff would increase the quality and quantity of service provided and reduce costs.

The Accounting Officer informed me that in certain cases the availability of additional resources would assist the situation and would have possibilities in terms of reducing reliance on overtime arrangements. There are, however, many factors which would be part of this equation including availability of skill mix etc. He assured me that the quality of service is never compromised. He also made the point that, at present, the HSE does not enjoy full flexibility to recruit additional staff, regardless of whether or not this would result in a reduction in extra remuneration levels or reliance on agency staff. There is an employment ceiling allocated to each element of the service and additional staff may not be recruited in excess of this ceiling. Dialogue is on-going with the relevant Government Departments on an overall adjustment to the HSE employment ceiling.

Implication of the European Working Time Directive (EWTD)

The provisions of the EWTD, as they apply to NCHDs, were introduced into law in Ireland in 2004. As a result, the working hours of such doctors have been limited by law to a maximum average of 58 hours per week since August 2004. The 58 hour maximum is to be reduced to 48 hours on a phased basis over the period to August 2009. The Directive, and case law that emerged in recent years in relation to it, imposes other significant constraints on doctors' working hours. Doctors must not work more than 13 hours in each 24 hour period, and are entitled to 35 consecutive hours rest in every 7 day period, or 59 hours rest in every 14 day period. In addition, where the daily 13 hour limit is exceeded, then the doctor concerned will be obliged to take sufficient rest to meet the terms of the Directive and this will have implications for starting times on the following day. In the light of the levels of overtime noted in the course of the audit, I was concerned that the HSE was not complying with the terms of the Directive.

The Accounting Officer informed me that the terms of the EWTD are being adhered to in full in respect of 30% of NCHDs. In relation to the remaining 70% of NCHDs, discussions are continuing with the Irish Medical Organisation, under the auspices of the Labour Relations Commission, to agree arrangements which will effect a reduction in the hours of NCHDs to comply with the working hours and rest provisions of the EWTD.

An industrial relations process is in place which will oversee a number of pilot attendance arrangements for NCHDs in nine locations and which will be EWTD compliant. The pilots will last for 4 to 6 months during which they will be evaluated. In addition, it is envisaged that discussions on a revised contract for NCHDs will take place concurrently. The successful pilots should then be mainstreamed and a revised contract for NCHDs agreed.